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“We can't provide season tickets to the opera”: Staff perceptions of providing preference based person centered care

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Abstract

Knowledge of a nursing home resident's everyday living preferences provides the foundation for ongoing individualized care planning.

Objective—The purpose of this study is to identify nursing home (NH) staff perceptions of facilitators and barriers to learning about and meeting residents' preferences and reasons why staff feel residents change their minds about preferences.

Methods—Focus group sessions and interviews were conducted with 36 NH staff members working in a facility that has been actively assessing resident preferences for five years.

Results—Thematic codes classifying *facilitators*, *barriers*, and *dependencies* were identified. Staff shared ways they are able to help meet residents' preferences as well as barriers to fulfilling resident preferences through their own behaviors, facility characteristics, the social environment, and resident characteristics. In addition, staff believe that residents change their minds about important preferences 'depending on' several factors including; global environmental characteristics, social environment, resident characteristics, and general staff perceptions.

Conclusions—This work identifies key facilitators and barriers to consider when implementing quality improvement efforts designed to improve the person-centered nature of care in nursing homes and is intended to further inform the culture change movement, which aims to transform NHs by empowering staff and delivering person-centered care.

Introduction and Rationale

The Affordable Care Act (US Department of Health and Human Services, 2014) places the individual at the center of the health care delivery process (Kietzman, 2012). Individuals are seen as key participants in shaping the goals and outcomes of their care. This policy is in line with the growing consensus among long-term care stakeholders that person-centered

care is an important component of quality (Center for Excellence in Assisted Living, 2010; Centers for Medicare and Medicaid Services [CMS], 2006, 2011a, 2011b). It is consistent with the goals of the Centers for Medicare and Medicaid (CMS), in which the 8th Scope of Work endorses culture change efforts by directing state Quality Improvement Organizations (QIOs) to work with Nursing Homes (NHs) to “improve organizational culture” to honor the individual (Centers for Medicare and Medicaid Services, 2009). And recently, CMS proposed enhanced person-centered care processes during the 2015 White House Conference on Aging (LeadingAge, 2015). Such a focus on the individual further aligns with new federal regulations directed toward incorporating the assessment of person-centered activities into NH survey procedures (Hamilton, 2009).

Nursing homes (NH) are embracing person-centered care (PCC), an approach that emphasizes “knowing the person” and honoring each resident's preferences. A recent expert panel on PCC released this definition:

““Person-centered care” means that individuals’ values and preferences are elicited and, once expressed, guide all aspects of their health care, supporting their realistic health and life goals.” (American Geriatrics Society, 2015, p. 2).

Thus, one key element of individualized, person-centered care (PCC) is customizing care processes to fit the unique needs and preferences of each resident (Edvardsson et al., 2014). The literature has strongly supported the beneficial outcomes associated with tailoring care in nursing homes (e.g., Cvengros, 2009; Jahng, Martin, Golin, & DiMatteo, 2005). Vallerand and O'Connor (1989) reported that nursing home residents who experience greater autonomy in self-care, religious, interpersonal and recreational activities report lower depression – as well as higher self-esteem, life satisfaction, meaning in life, general health and psychological adjustment. Meanwhile, Kasser and Ryan (1999) found that greater self-determination was associated with higher levels of psychological adjustment in nursing home residents. These findings partnered with the shift in regulatory focus to the individual underscore the critical importance of nurturing the needs of older adults through preference-based care in NHs.

As such, the focus of recent research has been directed toward developing tools that enable long-term care providers to efficiently customize care. One approach is to measure preferences for care delivery and aspects of everyday living (Van Haitsma et al., 2012; Curyto, Van Haitsma, Towsley, *in press*). This strategy honors the experiences and continuity of likes and dislikes that individuals have developed over a lifetime (Brooker, 2007). In addition, it empowers residents, helping them to maximize their potential for retaining relationships, capabilities, interests and skills by acknowledging what they prefer in the context of their strengths and needs (Menne, Johnson, Whitlach, & Schwartz, 2012). Person-centered approaches have been found to empower direct care staff and facilitate delivery of individualized care (Caspar, O'Rourke, & Gutman, 2009), as well as improve job satisfaction (Edvardsson, Fetherstonhaugh, McAuliffe, Nay, & Chenco, 2011).

Since 2010, NH facilities have been assessing 16 preferences annually through Section F of the MDS 3.0 (Saliba & Buchanan, 2009; Housen, Shannon, Simon, Edelen, Cadogan, Buchanan, Saliba, 2009). Examples of these preferences include asking the resident to rate

how important it is to choose what clothes to wear, choosing one's own bedtime, and/or listening to preferred music. The MDS requires input from multiple personnel to assess care outcomes for NH residents (therapy, social work, and clinical care staff). MDS coordinators, who are typically nurses, are responsible for completing the MDS assessment (Straker & Bailor, 2008). In 2013, Advancing Excellence in America's Nursing Homes, a campaign to advance the quality of care in NHs, released a PCC toolkit that took the MDS preference assessment one step further to look at preference congruence (Van Haitsma et al., 2014). Preference congruence is an indicator of how well preferences align with care delivered and was measured through the reports of satisfaction by residents. Facilities are using the PCC toolkit to track preference congruence and are discussing ways to better align care with resident preferences during care planning meetings. However, while some advancements have been made in providing care that is more person centered, uptake of the implementation of PCC has been slow (Grabowski et al., 2014).

Prior work in this area highlights constraints of the institutional culture on allowing staff flexibility in care (Ulsperger & Knottneurs, 2011; Persson & Wästerfors, 2008). In addition, even in organizations with PCC supportive cultures there is a tendency for direct care workers to revert to care practices that are traditionally focused on tasks related to 'bed and body work' (Doyle & Rubinstein, 2013). Communication breakdowns, time, and inadequate staffing are viewed by staff as major barriers to providing PCC (Kolanowski, Van Haitsma, Penrod, Hill, & Yevchak, 2015). Staff believe that 'word of mouth' is the most efficient and reliable way to communicate knowledge about residents to one another because reading charts is too time consuming (Kolanowski et al., 2015). However, preferences for communicating PCC information by 'word of mouth' sparks concerns for determining the accuracy of the information as well as how information is shared consistently across disciplines and shifts (Kolanowski et al., 2015).

There is still much to learn from the perspective of staff members regarding their perceptions of facilitators and barriers they encounter in their day-to-day work in honoring resident preferences. As key stakeholders in delivering individualized, preference-based care, understanding the specific biases and/or interpretations of direct care workers is critical. The culture change movement has focused on empowering direct care workers. Staff have been called upon to have consistent assignments, respond to resident needs, offer choices, and be flexible, but there has been less of a focus on incorporating their views regarding how they go about providing preference-based person centered care (Koren, 2010). The person centered initiative initially bypassed staff input due to perceived conflicts of interest; however, direct care staff are critical in facilitating the delivery of such care.

Drawing upon the experience of a range of providers (e.g., social work, dietary, nursing, therapy) who have been actively working to incorporate resident preference information into practice using *The Preferences for Everyday Living Inventory* (PELI; Van Haitsma et al., 2012) for five years at a five-star 324 bed nursing facility, we sought to better understand the staff's perspective on delivering preference-based care to residents. The PELI has been administered by research staff and recreation therapists and asks residents to rate the importance of their preferences on 72-items in 5 domains: social contact, leisure and growth activities, diversionary activities, self-dominion, and enlisting others in care. Results are

documented in each resident's medical record. All staff members are aware of the process. The purpose of this study was to identify: (1) main ideas of what staff think of the preference questions (i.e., *general reactions*), (2) how staff feel they help meet residents' preferences (i.e., *facilitators*), (3) barriers staff encounter when trying to meet residents' preferences (i.e., *barriers*), and (4) reasons staff perceive residents change their mind about preferences (i.e., *dependencies*). This work is intended to further inform the culture change movement in long-term care which aims to radically transform the nation's NHs by empowering staff and delivering person-centered care (Rahman & Schnelle, 2008). This research is important to better understand the implementation issues in the movement away from a narrowly defined "medical" model toward a more holistic, bio-psycho-social model of care.

Methods

Sample recruitment

We utilized a convenience sample of 36 staff members from a 324 bed long-term care skilled nursing facility (270 long term beds and 54 short term rehab beds). The facility was chosen due to the fact that all staff having daily contact with residents had been involved in assessing and attempting to meet resident preferences for five years. This is not a common practice among nursing home facilities and we wanted to ask staff for their reflections on assessing and providing preference-based care because of their unique experiences. The authors were affiliated with a research institute that was embedded within the chosen facility. Eligible staff members were required to work at the facility and have direct contact with residents on a regular basis, be English speaking, and aged 18 or over. Staff needed to have permission from their respective supervisor to participate. Staff were recruited from Social Work, Recreation Therapy, Dietary, Certified Nursing Assistant (CNA) Morning Shift, CNA Evening Shift, and Nursing to gather a breadth of perspectives. Participants' discipline, race, and gender were recorded by the focus group moderator. See Table 1 for sample descriptive characteristics.

Procedures and Analysis

Three different procedures were followed to collect data based upon staff availability and schedule. Four in-person focus groups were conducted, 4 open ended questionnaires were completed, and one individual interview was completed. More specifically, full focus groups were not conducted with Social Work due to scheduling demands. Instead, Social Work staff ($n = 4$) voluntarily responded to the open-ended questions electronically by email. In addition, the Dietary department had a limited number of staff dietitians that could participate in a focus group. As a result, we completed one, in-person interview with a member of the dietary staff referred by the department head.

Participants were asked to respond to 4 broad questions: (1) What do you think about the preference items we are asking; (2) Describe an example of how you feel you have helped to do what a resident likes or prefers; (3) Describe an example of when you were not able to do what a resident prefers; and (4) Describe a time when a resident changed his or her mind about the importance of a given preference. In regard to this final question, prior work

recognizes that NH residents' preferences may change or shift due to contextual factors (Heid et al., 2014), as a result we recognized the potential for staff to also see a "shift" in importance of a resident's preference as impacting their ability to provide preference-based care. Thus, staff perceptions on contextual dependencies impacting residents' preferences were also assessed. Appropriate follow-up questions were used to further probe for staff experiences with each question. Focus groups/interviews lasted on average 40 minutes.

All data were compiled by question and de-identified. For the in-person interview and the in-person focus groups, comprehensive field notes were taken during the interviews to document main ideas that were expressed (Stewart, 2006). To demonstrate rigor, interviews were audio recorded, transcribed and listened to for accuracy. To build a preliminary understanding of staff perceptions, all possible participants approved by supervisors were recruited.

Informed by content analysis strategies of Graneheim and Lundman (2004), data were read by two members of the research team independently, including the second author, to identify common categories or domains of responses. Codes were developed that captured each unique idea, or the manifest content (Graneheim & Lundman, 2004). The data were coded utilizing each response given by a participant as a unit of analysis for the group interviews (i.e., for each participant's mention of an idea) and each unique thought following an interviewer prompt for individual interviews. Coded instances were counted to develop a sense of magnitude for each phenomenon (Wilkinson, 2011). Thematic codes started broad and were subsequently refined as factors were identified. The two Research Assistants met regularly to flesh out the application of the coding scheme; discrepancies were resolved by a team based consensus approach. A codebook was used to assure consistent application of codes.

A comment was coded as both a dependency and a barrier if it made reference to both a situation that would change the resident's preference importance rating and a situation that would restrict preference fulfillment. Similarly a comment was coded as both a dependency and a facilitator if it made reference to both a situation that would change the resident's preference importance rating and a situation that would enable preference fulfillment. A barrier or facilitator code did not indicate that participants would change their minds in any way around the preference if the barrier was removed.

Results

Focus Group sessions and interviews were conducted with 36 nursing home staff members representing social work ($n = 4$), dietary ($n = 1$), nursing ($n = 6$), recreation therapy ($n = 8$), and direct care (first shift $n = 9$; second shift $n = 8$) (See Table 1). Staff revealed several key findings regarding their perceptions. Verbatim quotations of themes illustrated most frequently are presented in this section.

Significance and Methods of Discovering Preferences

General reactions fell into two categories: 1) why it was important to ask about preferences and 2) the method by which staff discovered a preference. Staff reflected upon why it was

important to ask nursing home residents' their preferences, articulating five primary reasons: *to honor residents' rights*, *to provide better care*, *to promote or support choice or control*, *to ensure resident satisfaction with care*, and because it is *a normal part of the human experience* and should be done. Two examples of the most frequently mentioned reasons for why it was important to ask about preferences included the following.

If I were here, and I were coming in to live, I would want to be able to choose what clothes to wear and what time I go to bed and I wouldn't want to listen to music that someone else is choosing, so that essentially is it. I think everyone has strong feelings about how they want to live their day to day life and they should really have the option to continue. (Importance of choice/control)

It's really no different than what my preferences are either. You know I think when they come in here we sometimes forget that they still have a life and we just, it gets so busy and it's not putting down the staff, it's easier just to go in and get your stuff and start providing care instead of asking them what they want. We forget they were something or somebody prior to coming here; they are not just old people waiting to their last day. (Importance of normalcy)

Staff also shared the methods by which they learn about resident preferences. They learned about residents' preferences through: *formal organizational communication channels* (i.e., software programs, assignment sheets, care planning processes, surveys, or committees), from *other people* (i.e., family members, the interdisciplinary staff, or other residents), and from *residents* themselves. When learning from the residents themselves, staff reflected on both direct ways of garnering resident self-report (i.e., asking the resident, listening to the resident, or the resident self-advocating), as well as ways of learning about their residents' preferences through care delivery (i.e., seeing residents' personal belongings, building a relationship, trial and error, interacting with the resident, getting to know the resident, or observing the resident) or residents' past history.

You ask them. Or like if someone has dementia or something you can tell by their reactions what they want and don't want. So like I said if you take care of them every day you ask them what they like and what they don't like and you build a relationship and you go from there. (Learn from Resident (ask))

If they come in not talking, you know, like end stage, then you communicate with the family or POA to give us their feedback of their likes and your dislikes to let us know your everyday routine so we can help take care of them. (Learn through Others)

Yea, eye contact, it kind of like depends on that person too, like if someone is a very introverted person, is going to be engaged in that group more passively, but you can still tell from their body language that they are enjoying the group or involved in the group. (Learn from Resident (observe))

Staff members see the value in learning about resident preferences and believe there is a benefit to the process. Staff have intuitively discovered multiple ways of collecting preference information from residents, other staff members, and through observation. Direct care staff are in a unique position to observe preferences and their knowledge and

experiences can be leveraged by administrators when building PCC practice initiatives. See Table 2 for examples of all ways staff learned about preferences.

Facilitators of preference fulfillment

Interviewed staff also shared ways in which they were able to help meet residents' preferences. Facilitators included *staff behaviors* (i.e., staff accommodating the preference, offering an opportunity or choice, adapting the activity to meet a resident's needs/abilities, advocating for the resident, anticipating a resident's needs, making oneself available to address residents' preferences, educating residents or family, or gaining access to resources for the resident), *facility characteristics* (i.e., use of software, staff schedules, facility values, or physical facility environment), the *social environment* (i.e., family support, staff relationships, relationships with other residents, respect, supports from the community, or support from the interdisciplinary care team), and *resident characteristics* (i.e., health/functional status change; see Table 3).

Some of them [preferences] are not possible here. We try to satisfy preferences but we can't provide season tickets to the opera kind of thing. (Staff Behaviors)

Do rounds, when we come in, we talk to them. "Oh, Mrs. Such and such, she had a bad day today, or she didn't want this done today, she wanted to have this done today. Or she might not be in a good mood today so she might just want to stay in her room". You just give the next person information about them. (Social Environment)

Staff recognize that there are many factors that support their ability to provide preference-based care. The two most highly mentioned facilitators were staff providing or suggesting an opportunity for meeting a resident preference and garnering support from other staff members (See Table 3). Staff members are one of the most important, if not the most important element, to facilitating preference-based care. An environment where staff can work together in interdisciplinary teams to support resident preferences may prove critical in advancing PCC practice.

Barriers to preference fulfillment

Staff also reflected on barriers they encountered in trying to fulfill a person's preferences. These barriers included *within-person characteristics of the staff* (i.e., perceived lack of accuracy by staff of resident preferences, negative staff perceptions of residents, lack of control felt by staff, or lack of perceived ability to complete preferences in a timely manner), *facility characteristics* (i.e., facility policy, lack of facility resources, facility scheduling, the community living environment, staff overload, time constraints, staffing ratios, financial resources, government policy, or safety concerns), factors related to the *social environment* (i.e., perceived lack of resident networks, negative social contagion, family involvement, negative resident relationships, generational gaps, lack of support from administration or interdisciplinary team, lack of respect for staff, or staff feeling threatened by sanctions or loss of job), and *resident characteristics* (i.e., behaviors, persistence in ideas, different interests, mood, personal physical health, mental health, personal resources, personal schedule, functional ability, sensory ability, status change, cognitive ability, or competency).

I think a lot of it is education too of residents and families and the understanding of what community living is all about. And that it may be okay for your loved one but there may be a risk to somebody that is demented that wanders into rooms and try to explain and educate why decisions are made and plus we are under the guides of Department of Health. I think in a lot of ways that is a big thing, for people that want to have fans or humidifies, or heating pads or the mattresses or the refrigerators in the room. [CHIMING IN FROM OTHERS, “heating pads”, “curling irons”]. And everything can be, we have to follow the higher than us, which is the Department of Health. A lot of time that is where the regulations come into play. Some understand better than others. (Facility Characteristics: Policy & Regulation)

If you're incontinent you can't go in bath. If usually you are a person that would get a bath, but now you are incontinent. Then that status change, now you are incontinent, so you are not able to go in the bath any more. So now we have to change to a shower where you sit. And, just like it breaks their heart it breaks our hearts too. Because we are knowing the fact that we can't meet your needs, but there is no way around it. It is difficult both ways. (Facility Characteristic: Facility Policy)

It is just kind of trying to meet the preferences of all 324 people and sometimes their families are involved in that too. So it becomes a very large challenge to do that. (Facility characteristic)

I think sometimes family can be a barrier. Like sometimes they want their mother or father to be up and out of bed. And sometimes the resident or patient doesn't want to. And sometimes they over step that bounds of listening to their mom or dad if they are awake, alert, and oriented there is no reason they cannot make decisions for themselves. And sometimes families are too pushy and it's not for the good of the mom or dad, it is actually doing more harm than good. (Social Environment)

I think every day people experience the changes their residents go through. Every day you come in sometimes it is something different from yesterday, every day you come in, “okay what is going to happen today”. You never know when you come in. (Resident Characteristics)

Staff enumerated far more barriers than facilitators to providing preference-based care with facility policy being the most frequently cited barrier (See Table 4). Facility regulations were cited as restricting the ability of staff to fulfill preferences or acted in opposition to resident rights. Opening up a dialogue between regulators and providers surrounding these barriers will be a critical step toward mitigating these major barriers in providing preference based care.

Dependencies

Last, staff reflected on reasons for why they think residents' may change their minds about the importance of their preferences, indicating that residents' preferences “depend on” many different factors, which can impact care delivery. These dependencies included *global environment characteristics* (i.e., the weather), the *social environment* (i.e., family

relationships, relationships with other residents, or staff relationships), *resident characteristics* (i.e., personal physical health, mental health, mood, functional ability, sensory ability, perceived social acceptability, general changing of one's mind, envy, having the opportunity or choice to change one's mind, cognitive ability, competency, or interest) and one other general *staff perception* (i.e., that residents' are just like children).

Just because their preferences change. I'm not the same person I was 10 years ago you know what I mean. I might decide I want to do more, or not want to go to bingo because last time I didn't win enough quarters, I don't know. People change their mind. They say the only constant in life is change. It is part of the human element in my opinion. (Resident Characteristic)

You might find out much later that they have had a tiff with someone they are close with (Social Environment)

Staff members were keenly observant of times when residents changed their minds about an important preference. Memory loss was the most frequently cited reason by staff for why they perceived residents changed their mind (See Table 5). Staff who work with residents with dementia recognize that preferences are not static, but dynamic and in need of frequent assessment. As we found with residents (Heid, et al., 2014), staff perceived that residents also changed their minds due to relationships with other residents, their mood, envy, and level of interest which can challenge their efforts to meet a given resident's preference on a given day (See Table 5).

Discussion

This study helps to understand nursing home staff members' perceptions regarding the importance of resident preference assessment, with a particular focus on how they learn about residents' preferences and the facilitators, barriers, and dependencies related to providing preference-based, person centered care. This study allowed for the inclusion of the voice of the direct care provider, whose buy-in is critical in honoring residents' preferences. This initial descriptive work identifies a host of key factors, from the perspective of staff, which must be considered when implementing quality improvement efforts directed at improving the delivery of person-centered, preference-based care.

Overall, staff felt that understanding residents' preferences was "reasonable and the right thing to do". Staff learned about preferences directly from residents, family, other staff members, and through paying attention to residents' actions and behaviors. Staff with more developed observational skills may be able to more quickly adapt care to resident preferences; such skills can be a focus for hands-on staff training. Electronic medical records and care planning were formal organizational channels through which staff accessed information about resident preferences. However, these may not be the most reliable and efficient means for staff to obtain preference information based upon previous studies (Kolanowski et al., 2015). Therefore, organizations can encourage staff members to explore how they informally learn about resident preferences and develop a systematic way of conveying this information across all shifts and disciplines. One example is including direct care workers in care planning meetings or resident conferences on a regular basis.

Communicating resident preferences and discussing successful strategies from multiple disciplines can assist in empowering direct care staff in providing more individualized care (Kolanowski et al., 2015).

Facilitators supporting staff in honoring resident preferences included staff behaviors to accommodate, adapt, advocate, and anticipate resident needs, wants, and preferences. The leadership values of the facility in supporting PCC as well as environmental changes to the building to deliver PCC were also identified as facilitators. The social environment, which encompassed family support, staff relationships, and resident relationships, facilitated the provision of preference based PCC as well as resident characteristics such as improved resident health. Supporting staff in being creative in brainstorming ways to meet residents' preferences can empower staff to be thought leaders in PCC quality improvement efforts within a facility.

However, as expected, staff perceived far more barriers than facilitators. Facility characteristics such as policies, resources, scheduling, staffing ratios, and safety prevented staff from fully honoring resident preferences. The social environment also functioned as a barrier when family preferences differed from resident preferences or when residents did not get along with one another. One opportunity facilities may have is to group residents with similar recreational and leisure preferences, even if resident physical and functional ability differs, in order to allow for a focus on offering preferred activities. Additionally, negative staff perceptions of residents, the lack of control felt by staff, and staff not being able to address a preference in a timely manner were also barriers that inhibited resident preference fulfillment. The biomedical model of task efficiency is an underlying force even in nursing homes who have adopted PCC as part of the culture (Doyle & Rubinstein, 2013). Therefore, continuous conversations among direct care staff and supervisors/champions who can role model PCC practices is crucial for sustaining person-centered care (Kolanowski, 2015).

Staff also identified that behaviors of residents restrict preferences from being met. We argue that behaviors of wandering, anger, and resistance to care can be reflections of preferences not being met. In addition, resident interest, mood, physical and mental health all lead to difficulties in staff meeting preferences. Some staff perceived the resident's personal schedule as a barrier to meeting preferences, along with functional ability. Hearing, visual, cognitive, and functional impairments greatly restrict staff ability to fulfill preferences. It is in these situations that Certified Therapeutic Recreation Specialists (CTRS) can thoughtfully adapt activities to meet resident important preferences based upon physical, functional, and cognitive limitations (Van Haitsma et al., 2014).

Lastly, staff identified a series of reasons for why residents may change their minds about preferences. We have labeled these 'situational dependencies' that affect the staff's ability to deliver PCC because they create uncertainty. This uncertainty is met on a daily basis as staff are required to quickly assess not only resident characteristics that may have changed overnight, but contextual and relational characteristics that impact how important a preference will be to a resident at a given time. Staff discussed global characteristics, such as the weather changing if a resident wanted a preference fulfilled. Social environment dependencies were based upon the relationship between the resident and his/her family,

other residents, and staff that made fulfilling some resident preferences ‘dependent on’ the people they were doing the activity with. The category with the most dependencies, according to staff, focused on resident characteristics. Staff felt that meeting resident preferences was difficult sometimes based upon such things as the residents’ health, changing their minds, interest level, and cognitive ability. Training staff to be aware of such contextual dependencies is important to help staff recognize the many ways meeting a preference can ‘depend upon’ how a resident is feeling, who the activity is with, and of course, the weather.

Of interest, staff reports of barriers and dependencies paralleled residents’ perspectives found in prior research (Bangerter et al., *in press*; Heid et al., 2014). We found that there were 14 similar barriers reported and 25 additional unique barriers discussed by staff. Some of the overlapping barriers included facility policies, resources, and schedule as well as resident characteristics such as interest, mood, health, and ability. We also found that there were 11 similar dependencies reported and 6 additional unique perceived dependencies discussed by staff. We found overlapping dependencies related to the weather and resident characteristics (e.g., health, mood, functional and sensory ability, and choice). Such results validate residents’ perspectives, highlighting systematic barriers and contextual circumstances that affect the importance of residents’ preferences and whether their preferences can be fulfilled. The similarities also can be a way of uniting residents and staff through common successes and frustrations, instead of focusing on an ‘us vs. them’ mentality (Tajfel, 1979).

As with all studies there are limitations to this research. The staff perspectives gathered were from a single five star facility located in the northeast United States that has been formally performing preference assessments for five years. Staff needed to have received permission from their respective supervisor to participate, which may have biased the sample of staff members who volunteered. Further results did not compare perceived barriers or facilitators across educational level. Additional work should explore staff members’ perceptions within other facilities and larger samples to ensure saturation of results demonstrated here and examine factors that may influence differential perspectives in care. In addition, multiple methods of data collection were employed in order to work around staff schedules. Some perspectives were from individuals, while other perspectives grew out of group discussions (focus groups). Future research exploring staff perceptions on the facilitators, barriers, and dependencies of providing preference-based, PCC should seek additional staff perspectives, such as housekeeping supervisors or environmental services, and examine the role of interdisciplinary team approaches in addressing preferences in care. In addition, sharing these findings with stakeholder groups to identify key practice recommendations based on staff members’ perspectives of residents’ preferences is crucial. The development of clinical recommendations for addressing barriers and supporting facilitators of resident preferences will empower staff to continue to move toward more preference congruent care.

Conclusion

This work assists in developing an understanding about how to optimize delivery of preference-based, person-centered care through identifying the major facilitators and barriers

at the facility, staff, and resident levels. Staff training and education can be tailored to develop facilitators and address barriers as care teams. Major facility policies that limit staff ability to provide preference congruent care can be explored and potentially revised. Negotiations of risk may be needed in order for residents to fulfill preferences despite possible safety concerns. Overall, we find that most of the staff members interviewed here strive to deliver preference based care to nursing home residents, yet important constraints remain.

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Table 1

Demographic characteristics of sample

Variable	Staff (N = 36)
Gender (Female)	92% (33)
Race	
African American	50% (18)
Caucasian	47% (17)
Other	3% (1)
Discipline	
Direct Care Worker (Morning 7am to 3pm)	25% (9)
Direct Care Worker (Evening 3pm to 11pm)	22% (8)
Nurse	17% (6)
Dietician	3% (1)
Recreation Therapist	22% (8)
Social Worker	12% (4)

Table 2

How Staff Learn about Residents' Preferences

Code Name	Theme Description	Groups ^a	Citations ^b
Learn Resident Preferences through Formal Organizational Communication Channels			
Software	Software (i.e. Geri-Menu- Dining tray system); Electronic Medical Record system	1	3
Assignment Paper	Learn from assignment paper in charts completed by each shift	2	3
Care Planning	Through care planning	2	2
Survey	Resident completes printed survey (i.e., admission assessment when arrive)	4	6
Committee	Program to gather feedback as a group (i.e., focus groups)	1	1
Learn Resident Preferences through Others			
Family	Learn from family what resident likes/liked; Learn from Power of Attorney (POA)	6	18
Interdisciplinary Team	Learn about resident preferences from other staff (informally or through rounds)	5	10
Other Resident	Other resident advocates for a resident	1	1
Learn Resident Preferences from Residents			
From Self-report			
Ask	Ask residents	6	23
Listen	Listen to residents' perspectives; Resident talks about preference	4	12
Advocate	Resident self-advocating	2	4
From Care Experience			
Personal Effects	Seeing what is in the resident's room; Pictures, knick knacks	2	3
Relationship	Build a relationship with resident	2	3
Trial and Error	Trial and error to figure out what resident likes	2	4
Interact	Staff interact with residents; Being with them	3	5
Know	Get to know residents/person, experience with them; Learn what can do	5	14
Observe	Just watch the residents to see what like/dislike	4	16
From Past Experience			
History	Learn about past preferences	5	11

Note. N = 36 staff members within 6 groups.

^a Indicates the number of groups (Dietary staff, Resident Care Assistants – Morning shift, Resident Care Assistants – Evening shift, Nursing staff, Recreation staff, and Social Workers) the theme presented for.

^b Indicates the number of citations of each theme in the transcripts.

Table 3

Facilitators that Support Staff in Honoring Residents' Preferences

Code Name	Theme Description	Groups ^a	Citations ^b
Staff Behaviors as Facilitators			
Accommodate	Staff physically assisting or accommodating resident to meet needs/preference; Staff workaround policy to meet preferences	5	14
Opportunity	Staff provide/suggest an opportunity for resident preference	5	18
Adapt	Staff adapt activity or match activity to meet needs/abilities, functionally and sensory; Offer hand over hand support or adapt own abilities to meet resident needs	3	10
Advocate	Staff advocate for residents	1	4
Anticipate	Staff anticipate needs/wants/preferences	1	2
Available	Staff make self available to do request or be there to support residents in preference	4	4
Education	Staff teach resident or family what can do to meet preferences	3	5
Resources	Staff gather resources for the preference to be met; Help make resources available	4	4
Facility Characteristics as Facilitators			
Software	Data system helps show staff preferences to meet them	1	1
Staff Schedule	Nursing schedules support it	1	1
Values	Values of facility supported philosophy, facility buy in	2	2
Environment	Physical environmental changes to building to deliver type of care	3	8
Social Environment as Facilitators			
Family Support	Staff garner family support, family helps in some way to meet preference	1	1
Contagion	Social contagion (i.e., enthusiasm, positive group emotions) facilitates preferences	1	1
Staff Relationships	Staff building positive relations with resident; Consistent assignment	3	4
Resident Relationships	Staff connect residents with other residents	2	6
Respect	Staff respect resident wishes and respect each other to support preferences	3	3
Community Support	Staff bring in support from community- in and out of facility	1	1
Interdisciplinary Team Support	Garner support from other staff (i.e., supervisors or other nurses/CNAs); Teamwork approach; Communicating persons preferences/needs to others	5	18
Resident Characteristics as Facilitators			
Status Change	Improved resident health/functional condition helps meet resident preferences	1	1

Note. N = 36 staff members within 6 groups.

^aIndicates the number of groups (Dietary staff, Resident Care Assistants – Morning shift, Resident Care Assistants – Evening shift, Nursing staff, Recreation staff, and Social Workers) the theme presented for.

^bIndicates the number of citations of each theme in the transcripts.

Table 4**Barriers that Prevent Staff from Honoring Residents' Preferences**

Code Name	Theme Description	Groups ^a	Citations ^b
Within Person (Staff) Barriers			
Accuracy	Staff perception of concern of accuracy of preferences or match of stated to real preferences	4	6
Staff Perceptions	Negative staff perceptions of residents	1	2
Control	Lack of control felt by staff	1	1
Timeliness	Staff not being able to address preferences to resident liking on resident's timeline	1	1
Facility Characteristics as Barriers			
Facility Policy & Regulations ^{**}	Facility policies and regulations restrict preference or act in opposition to resident rights	4	25
Facility Resources ^{**}	Staff cannot get things need to meet preferences at the facility level; Quality of resources not what needed/liked by resident	3	6
Facility Schedule ^{**}	Facility schedule restricts preference fulfillment	3	4
Community Living	Not like at home, it is a community living environment; Sheer number of people serving and preferences to be met constrains preference fulfillment	3	4
Overload	Staff given overloaded expectations by resident or other staff/admin, stretched beyond capacity	2	5
Time	References to staff time constraints; Scheduling constraints	5	10
Ratio	Staff to resident ratio is too low to achieve care; Multiple people at the same time	3	7
Financial Resources	Lack of money (of resident or facility) to do preference	1	2
Government Policy	Department of Health, etc., policies restrict preferences	1	2
Safety	Safety or health risks restricts preferences (i.e., Wandering, elopement risks, ulcers)	4	8
Social Environment as Barriers			
Lack of Network	Resident perception of lack of social peer network or lack of network with matched interests	2	5
Contagion	Negative social contagion prevents/restricts preference	1	1
Family	Family preferences differ from residents and affects how can help resident	6	11
Resident Relationships	Resident lack of fit with others, do not get along	1	2
Generations	Gap of generations between residents which makes it hard for staff to please	1	1
Support	Lack of support from administration or other staff as barrier to staff	2	3
Respect	Lack of resident/other staff respect to staff	1	2
Threat	Threats to staff by residents to call authorities, be fired, get in trouble, etc.	2	7
Resident Characteristics as Barriers			
Behaviors	Behaviors of resident restrict preference from being met	4	7
Persistence	Resident very persistent on what/when/why	2	4
Interest ^{**}	Different interests in activities/preferences, etc., as a barrier to fulfillment, or a lack of similar interests	2	3
Mood ^{**}	Resident mood restricts preference fulfillment	2	2

Code Name	Theme Description	Groups ^a	Citations ^b
Personal Health **	Physical health affects ability to participate	4	7
Mental Health	Mental health is a barrier to preference being met	4	4
Personal Resources **	Lack of family resources/support for care (i.e., no family to support care)	1	1
Personal Schedule **	Resident personal schedule restricts preference fulfillment	1	2
Functional Ability **	Physical ability of resident, speech, incontinence, etc.	4	11
Sensory Ability **	Hearing/vision impairment of the resident restricts fulfillment	2	3
Status Change	Change in ability of resident as a barrier to meeting preferences	2	3
Cognition **	Cognitive ability prevents preferences from being met	5	9
Competency **	Resident lacks ability to do the task, or thinks lack of ability/defeat	3	6
Past Experience	Resident past negative experience impacts current inability to meet preference	1	1
Social Acceptability **	Resident embarrassment, or concerns about fitting in	2	2
Choice **	Resident choice is restricted which prevents preference from being met	1	1
Education	Lack of understanding/education of disease/needs/diagnosis by resident or family	2	3

Note. N = 36 staff members within 6 groups.

** Denotes barriers that were also listed by residents as barriers to preference fulfillment (see Heid et al., 2014).

^a Indicates the number of groups (Dietary staff, Resident Care Assistants – Morning shift, Resident Care Assistants – Evening shift, Nursing staff, Recreation staff, and Social Workers) the theme presented for.

^b Indicates the number of citations of each theme in the transcripts.

Table 5

Staff Perceived Reasons of why Residents may Change their Minds about their Preferences (i.e., Dependencies)

Code Name	Description	Groups ^a	Citations ^b
Global Characteristics as Dependencies			
Weather **	Weather changes resident preferences	1	2
Social Environment as Dependencies			
Family Relationships	Relationship of resident with family members affects preferences; Family pushed for something that made resident change mind; "Provoked preference"	2	3
Resident Relationships	Other residents at activity or involved in activity change person's mind	2	7
Staff Relationships	Relationship of resident with staff doing activity with them	3	6
Resident Characteristics as Dependencies			
Personal Health **	How resident is feeling, rested/tired	4	6
Mental Health	Mental illness of resident	2	3
Mood **	How resident feel emotionally that day/time	3	7
Functional Ability **	Physical ability of resident	1	2
Sensory Ability **	Vision/hearing impairment of the resident	1	1
Social Acceptability **	Resident embarrassment or fitting in; Idealized sense of self	3	3
General Change **	General changing of one's mind by resident; "It is a woman's prerogative"	5	5
Envy	Residents want what other resident has; "Grass is greener"	4	7
Choice **	Resident ability to choose or have opportunity; Sense of control of resident	2	2
Cognition **	Residents' global cognitive impairment and specifically memory loss creates change in preferences	5	10
Competency **	Not matched to resident competence level, too high or too low; Success in activity	2	3
Interest **	Resident interest in type of activity or doing something	4	7
Other Staff Perception as Dependencies			
Kids	Staff reference to residents change of mind because they are like kids	1	1

Note. N = 36 staff members within 6 groups.

** Denotes dependencies that were also listed by residents as dependencies to preference fulfillment (see Heid et al., 2014).

^a Indicates the number of groups (Dietary staff, Resident Care Assistants – Morning shift, Resident Care Assistants – Evening shift, Nursing staff, Recreation staff, and Social Workers) the theme presented for.

^b Indicates the number of citations of each theme in the transcripts.