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Resident Choice: A Nursing Home Staff Perspective on Tensions and Resolutions

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Abstract

A central component of person-centered care, resident choice in daily life, has received little research attention in the U.S. context. This study investigated nursing home staff experiences in realizing resident choice. Twenty-six qualitative staff interviews were conducted in an opportunistic sample from two Veterans Health Administration (VHA) Community Living Centers (CLCs, i.e., nursing homes) implementing the Green House Model. Thematic content analysis surfaced several key tensions at the intra-personal, inter-personal, and organizational levels. Most salient were staff mental models within the intra-personal level. Staff conveyed a lack of clarity on how to realize resident choice when faced with varying tensions, especially the competing goal of resident medical and safety needs. Staff-employed resolutions to resident choice-related tensions

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also emerged (e.g., preventive practices, staff reinforcement, and staff deliberation). This study offers specific and concrete insights on how resident choice in daily life, and thus resident quality of life, can be advanced.

Introduction

The culture change movement within nursing home care has built momentum. Culture change envisions person-centered care (PCC) as better addressing nursing home quality of care and resident quality of life than the traditional medical model. (Zimmerman, Shier, & Saliba, 2014) A key component of person-centered care is resident choice in daily life (e.g., self-made decisions regarding meals, grooming, entertainment, and sleep schedule). Some research evidence suggests that the resident choice process (more specifically than culture change) is tied to quality of life (Cox, Kaeser, Montgomery, & Marion, 1991) and quality of care outcomes. (Colorado Foundation for Medical Care, 2006) In additional studies, residents have indicated their own desire for such choice. (Kane et al., 1997)

To date, evidence suggests that U.S. nursing homes have not fully realized resident choice in daily life. Two studies have documented the extent of staff realizing everyday resident choice. (Schnelle et al., 2009; Simmons et al., 2011) The results are discouraging; structured observations found staff not offering residents morning care choices a majority of the time. Given these findings, the question arises: What are the challenges to achieving the resident choice care process?

Limited nursing home-based research addresses this question. A few U.S. studies examine barriers and facilitators to culture change generally but not resident choice specifically. (Robinson & Rosher, 2006; Scalzi, Evans, Barstow, & Hostvedt, 2006; Shield, Looze, Tyler, Lepore, & Miller, 2014; Sterns, Miller, & Allen, 2010) Qualitative investigations more relevant to resident choice and to challenges in realizing it have been conducted outside the U.S. Two international studies centered on daily life choices but were circumscribed to highly specific choice domains; one focused exclusively on resident hip protector use (Sims-Gould, McLay, Feldman, Scott, & Robinovitch, 2014), while another focused on length of time spent in bed at night. (Luff, Ellmers, Evers, Young and Arber, 2011) Another U.K. study most closely matched the topic of staff promotion of resident choice in daily life but within the context of interactions between service providers and individuals with intellectual disabilities. (Finlay, Walton, & Antaki, 2008) Thus, qualitative research on U.S. nursing homes has yet to explore resident choice broadly and comprehensively across an unlimited set of domains of daily living.

Our study seeks to redress this identified research gap on issues U.S. nursing home staff face in realizing resident choice in daily life. We conducted a sub-analysis of semi-structured interview data from a parent study. The parent pilot study explored the transition of two Veterans Health Administration (VHA) Community Living Centers (CLCs, i.e., nursing homes) to a Green House model. The VHA represents one of the nation's largest healthcare systems and has been actively implementing system-wide culture change.

Our research question was grounded in work that applies Deci and Ryan's (1991) self-determination theory (SDT) to the nursing home setting. SDT asserts the universal importance of autonomy for human beings. Kasser and Ryan (1999) empirically tested aspects of SDT in nursing homes, establishing the important role that staff "support" of resident autonomy played in achieving resident-related reduced levels of depression and heightened levels of well-being, vitality, and life satisfaction. We assert that one aspect of staff supporting autonomy is helping residents experience choice in daily living. This paper thus sought to build upon SDT's pre-existing conceptual foundation by asking the following research question: "What do staff see as facilitators or barriers to their ability to support resident choice in daily life?" No *a priori* hypotheses were established given the exploratory nature of our inquiry.

Design and Methods

Study Design

The parent study's staff interviews were semi-structured in nature. A qualitative approach was employed given the understudied nature of culture change in VHA CLCs and the benefit of gaining staff members' insider perspectives. Interviews were conducted at two opportunistically sampled VA CLCs. The two facilities were in the early phases of Green House model implementation, i.e., the planning and physical construction phases; residents had not yet been moved to the Green House homes and staff had not yet been selected to work in the Green House homes. Both CLCs served a mix of long-stay and short-stay residents. We obtained Institutional Review Board study approval from each of the investigators' University affiliates and VHA affiliates as well as from the two VHA CLC data collection sites.

Participants

A convenience sample of CLC staff members were interviewed. Recruitment aimed to reach CLC staff members with e-mail access and those without. The process involved sending staff an introductory e-mail from the CLC Director, following up with three recruitment e-mails from the Principal Investigator (C.W.H.), posting flyers, making announcements at staff meetings, and inviting staff individually through face-to-face contact during site visits. Approximately 329 staff members were contacted by e-mail across the two sites (154 at CLC #1; 175 at CLC #2).

No exclusion criteria were employed; eligible participants consisted of all CLC staff members (i.e., nursing staff, rehabilitation therapists, social workers, psychologists, physicians, chaplains, activities staff, housekeeping staff, and administrative staff). Senior leaders (i.e., CLC Associate Chief Nurse, CLC Medical Director, service line chiefs, and Medical Center Director) were also eligible. We thus triangulated our data sources across two sites, across multiple disciplines, and across hierarchical levels related to job position to ensure the richness and depth of the data. (Patton, 2001)

Interviews

The senior author conducted the qualitative interviews during a site visit at each of the participating CLCs. CLC #1's site visit occurred in April 2011, and CLC #2's site visit occurred in September 2011. The interviews averaged about 45 minutes in length. The parent study's interviews were conducted using two semi-structured interview guides, one for staff and one for senior leadership. The staff interview guide focused on both staff-specific concerns (e.g., culture change's impact on daily work, and efforts to empower staff in facility decision-making) and resident-specific concerns (e.g., quality of and mechanisms for providing resident recreational activities, and resident choice). Samples of the resident choice interview questions can be found in Table 1. The senior leadership interview guide asked questions related to broader facility goals (e.g. culture change's impact on quality measures, and perceived provision of support and resources needed to institute culture change).

Data Analysis

The parent study's interviews were digitally recorded and transcribed. NVivo 10, a qualitative analysis software program, was used to analyze each interview's entire transcript for the sub-analysis on experiences with resident choice. Both staff and senior leadership interviews were analyzed even though there were no specific resident choice-related interview questions in the latter's interview guide. This decision was made since spontaneous discussions of resident choice emerged in the senior leadership interviews.

We employed inductive thematic analysis of the interview data for our exploration of staff experiences with resident choice. Data analysis began with the first author repeatedly reviewing the staff interview data to identify inductively emergent codes and to assess connections amongst the codes to identify themes. (Boyatzis, 1998) During this process, the first author developed a preliminary codebook with code labels and definitions as recommended by DeCuir, Marshall, and McCulloch (2011). To ensure methodological rigor, the codebook was refined iteratively with repeat transcript coding by and consultative discussions with the senior author. The constant comparative method also guided analytic efforts. Prior data were constantly re-analyzed in light of codes that emerged in later analysis; thus, interviews coded earlier in the process were re-coded later on as the codebook developed into its final form.

Results

Twenty-six senior leaders, clinicians, and front-line staff members were interviewed for the parent study. (See Table 2 for “Staff Sample Characteristics”) Two main thematic categories emerged from the resident choice sub-analysis: 1) tensions in realizing resident choice and 2) resolutions to choice-related tensions. (See Table 3 for “‘Tension’ Thematic Category, Sub-Theme, and Code Definitions” and Table 4 for “‘Resolution’ Thematic Category and Code Definitions”). For the tensions in realizing resident choice thematic category, staff narratives revealed sub-themes at three levels: 1) the intra-personal, 2) the inter-personal, and 3) the organizational. The intra-personal tensions revolved around issues *within* an individual (e.g., for residents: resident personal characteristics, resident basic needs, and

resident medical and safety needs; for staff members: staff mental models, staff professional needs, and staff work demands). The inter-personal tensions surfaced *between* residents and staff (i.e., staff-resident power dynamics). Organizational tensions appeared regarding facility routines and policies. For the resolutions to choice-related tensions thematic category, staff-reported resolutions to tensions consisted of preventive practices, staff and resident education, staff reinforcement, staff deliberation, stakeholder collaboration, and supportive leadership.

Intra-Personally-Situated Tensions

Resident personal characteristics—Participants expressed their beliefs that resident personal characteristics (i.e., age, gender, and disease severity) could affect the resident choice situation. A participant's words below illustrate how rationale and methods for achieving resident choice can vary by, for example, a resident's age; particular choices for the young might cause staff members to question the choices' appropriateness more so than they would for the elderly:

In our particular facility you have lots of young veterans who are not at the end of their lives, totally not at the end of their lives. And yet they make these poor decisions that will shorten their lifespan and that to me is the big conflict. You know, we've got an 89-year-old lady who has diabetes and wants to eat a Moon pie once a week. Fabulous, let her do it. [Participant #1]

Resident basic needs—Participants also shared their perceptions that a resident's basic needs, such as adequate nutrition, sometimes competed with realizing resident choice. In one example, a participant expressed concern that a resident's choice to sleep competed with his/her need to eat for sustenance:

...our veterans, they get to stay in bed a little later. They can eat breakfast later. It's more to their preference. But also we have to realize that they have to be in line in the care for their safety: not to let them sleep too long, to make sure that they get all their meals and everything they need. [Participant #2]

Resident medical & safety needs—Participant descriptions sometimes revealed perceived tensions between a resident's medical and safety needs and resident choice. This staff perception arose particularly within the context of a resident's diet. One participant saw an urgent need to limit resident choice when it would put the resident's health significantly at risk:

...I don't think we should let people eat themselves to death. So that we have patients that are on the units with their baseline diseases that they actually came in here for to be treated with at baseline, but now they have five new chronic diseases that they're being treated for because they're eating themselves to death. [Participant #3]

Staff mental models—Staff mental models entail a staff member's cognitive representations. In the context of this study, these mental models can embody tensions both within and/or across staff members on how to achieve resident choice in the face of

competing demands. Participants' mental models reflected tensions with regards to 1) whether or not the CLC's mission was to act primarily as a proponent of person-centered constructs such as resident choice and 2) a wide variety of views about resident choice itself.

Differing views of the CLC's mission: Participants expressed contrasting views on the mission of the CLC. The CLC was sometimes described as a medical facility exclusively and sometimes as the resident's home exclusively. These views mirrored the perceived appropriateness of resident choice within the CLC environment.

One participant, for example, saw the CLC's medical mission as central rather than its person-centered mission:

... the old medical model would be that he [a resident] would be on a proper diet, and he would eat within that diet prescription. He would not be saying '...this is my house and this is what I would do at home.' And the reality of it is if the people were at home, they would not have a nurse, they would not have a dietitian, they would not have a physician, a speech pathologist, all the therapies that we have here. They would not have that in their home, so clearly they need to be here for a medical reason... [Participant #1]

Another participant championed the home-like model and resident choice over the medical model:

We go back to what do we need to do to support what the veteran desires...this is their home. It's long term care. We're not here in a curative ... manner. It's a patient or a veteran who's here for long term. It's his home. What can we do to provide a home-like environment that allows that veteran to make choices? [Participant #4]

A spectrum of views on resident choice: Participants also expressed a spectrum of contrasting viewpoints towards resident choice itself: finding change difficult, seeking balance, being creative, and feeling uncertain as to implementation. These viewpoints as a whole represent staff perspectives that are not consonant with one another and that may differentially temper staff members' ability to realize resident choice.

Finding change difficult: One participant depicted their CLC's shifted focus to resident choice as contesting staff members' prior understandings, creating a sense of cognitive dissonance:

Well, you know, if I'd grown up at the VA, and it's all I've known, and all of a sudden you're telling me to change the way that I take care of patients. And 'Oh my God, they've got a choice? About what they eat and when they go to sleep...' That's a difficult transition for anybody. [Participant #5]

Seeking balance: A couple of participants found resident choice more acceptable when balanced with competing demands. These participants envisioned their ideal scenarios for realizing resident choice as tempered by a resident's medical condition. For example, one participant felt a resident with diabetes could have choice in food options if balance with his medical needs was achieved:

I would like to see more of a balance between honoring special requests, honoring preferences. I would like to see that be more balanced with what is in their best interest medically. So, for example, the person with uncontrolled diabetes. If he enjoys a piece of cake...let's say once a week that he wants that piece of cake. I'm okay with that as long as when he has the cake he doesn't have the roll, the rice, and the corn at the same time. [Participant #1]

Being creative: A couple of participants demonstrated a creative mindset towards realizing resident choice in the face of restrictions and/or resistance. One interviewee revealed how her creative thinking drives her efforts in promoting choice for residents with swallowing risks:

I'm pretty creative with it, and nobody stops me. I mean, as long as it's thickened to the right level...And I can't get the hospital to buy the Crystal Lite, but I can get families to do it. Or I get the funds from the Disabled Vets and go over to the commissary and buy the Crystal Lite flavoring. 'You want iced tea? You want peach iced tea?' You know what I mean?...You just work it. [Participant #6]

Feeling Uncertain: Participants did not always express definitive beliefs about resident choice and its appropriateness in the CLC. Uncertainty about how to appropriately and effectively implement resident choice was raised several times. One participant, along with others, discussed where to "draw the line" on realizing resident choice:

A lot of people, when I do the Learning Circle [a culture change-focused discussion group], they ask me, 'Where's the line?...Where do we stop? Do we continue to just give them everything they want? Let 'em sleep all day and not eat? Or do we get 'em up? Let 'em eat. Sit 'em up for a couple of hours and let 'em go back to bed.' [#2]

Another common refrain was "what do you do?" as participants considered how to promote resident choice in the face of other competing needs. Such comments reflected these participants' lack of clarity and lack of sense of self-efficacy in navigating choice-related tensions.

Staff professional needs—Tensions also existed between staff-based professional needs and resident choice.

As an example, one participant touched upon the conflict she felt between her need to uphold her professional obligations as a health care practitioner versus her need to follow through on residents' wishes:

...well, you're the health care provider... you know their condition, you know the situation. You need to do what's best for them, but then on the other hand it's, it's cultural transformation, givin' 'em what they want...That's the question we're still asking and trying to find an answer for. [Participant #7]

Staff work demands—Participants discussed their belief that staff work demands limited the possibilities of offering resident choice. Such work demands included a perceived

inadequate staff to resident ratio accompanied by a large number of tasks per resident. One participant described a possible situation pertaining to medication pass:

But you got one LPN doing med pass on a 30-plus bed unit. And everybody's got 15 to 39 meds. It can take two hours to do the med pass, and let's not forget that we now have patient choice, so there's no regular med pass anymore. Med pass can go on all day because you would like your meds at 8:30, he wants your meds at 6...

[#3]

Inter-Personally-Situated Tensions

Staff-resident power dynamics—One participant's descriptions implied that power issues between staff and residents may create an environment in which staff have difficulty honoring resident self-determination. As the participant noted, staff who feel the need to “control” residents may work against resident choice:

...some of the barriers [to choice] that we talked about- some staff feel that they have to be in control...And it's just like a power struggle with some of our staff. And I've seen this especially so in some of our male nursing assistants, the older male nursing assistants who were military, who are veterans themselves, who have more of a firm approach with the residents. [Participant #8]

Organizationally-Situated Tensions

Organizational routines—Organizational routines sometimes complicated realizing resident choice. Some participants pointed to rigid daily schedules for residents as raising tensions with resident choice. One participant in particular, when asked about choice related to waking times, noted:

When I come from, let's say, first shift, and I have to work 3rd shift, and you're assigned a certain load of people. I know in my mind, 'Ok, well I got this whole list in order to get through it all and have everybody up and into the dining room by 7:15, I need to start at 5 o'clock in the morning.' Because I'm not just gonna take a resident and get 'em up and just slap clothes on them and stuff. I'm gonna clean them up and make sure they're freshened up.

[Interviewer: There's no choice about that?]

No, you're either in there, or you don't get your [breakfast] tray. [Participant #9]

Organizational policies—Organizational policies, such as medically-prescribed protocols, were occasionally seen as conflicting with realizing resident choice. One participant noted that the perceived tension between such protocols like diet orders and resident choice can lead to inconsistent staff behaviors:

...his [a resident's] preference is meat, and so he gets it. Well, what we are doing for this gentleman is honoring his request and making him have- giving him satisfaction. However, in the medical records, he has a prescribed diet, an order of a limited protein diet, and we are not doing it; we are not doing it, and that really

bothers me...If we're not going to adhere to the order than we need to change it...
[#1]

Resolutions

Preventive practices—Participants described how preventive practices can be implemented to address medical and safety concerns that appear to conflict with resident choice. Such implementation may lessen the perceived need to limit resident freedom. As an example, a participant noted how prevention efforts can facilitate resident choice in the face of fall risks:

...our falls increased and one of the reasons that we surmised that they increased was that- because we allowed our residents more freedom to move about as they saw fit...So our strategy went to what can we do to prevent injuries. If there are falls and then that's when we would go into like low beds, looked at our type of furniture, looked at the foot wear... [Participant #8]

Staff & resident education—Staff and resident education is sometimes used to resolve tensions in realizing resident choice. In the examples below, education focuses on staff training in resident rights and resident training in safety such as modified diet textures. One participant cited a facility effort to educate staff about resident rights as sensitizing staff to resident choice and how that effort had a positive impact on resident choice:

I just remember years ago the Nurses and the Nurses' Aide would just tell the patient what to do. Now it's like 'Mr. So-and-So, do you want this now or do you want to wear this?' [Participant #6]

Resident education, in turn, was perceived by a couple of participants as teaching veterans the reasons for making healthier choices for themselves. For example, when asked about choice surfacing as an issue for patients with swallowing problems, one participant described a resident-driven solution to conflicting priorities:

...I try and show patients...the videotape of the modified barium swallow... Because it's hard for them to accept the special diet unless they really can see the concept of what's happening...I try to make sure there's enough education around so that if they are refusing, they are making...an educated decision... [Participant #6]

Staff reinforcement—Staff reinforcement was discussed as another potential resolution to choice-related tensions. A few interview participants shared stories of internal forms of reinforcement for supporting resident choice (e.g., empathy and professional identity) and external ones (e.g., performance measures). One staff member explained how his/her own empathetic feelings with veterans were internally reinforcing when faced with a need to get the job done versus a need to honor a resident's choice:

I'm a disabled vet. He's a disabled vet. And if I can't mop a floor 'cause he needs a cup of water, then the floor won't get mopped! [Participant #10]

Participants' own self-reflection on their professional identity also sometimes served as internal reinforcement. The following quote demonstrated this view:

I'm trying to see myself as, you know, a glorified personal assistant. I don't take care of you. I don't tell you what to do. I'm not your counselor or your guide. I'm just here to, to offer- go get you a cup of water if you want it. But you decide how many pieces of ice you want in it, and you tell me what to do... [Participant #11]

External reinforcement may also play a role in staff promotion of resident choice. One facility used performance measures to outline expectations of staff with regards to resident choice efforts, especially to redress actions of those currently not advancing these efforts. An interview participant provided detail on this approach:

Because such transformation is part of our performance plan, I measured their involvement with the residents by they have to turn in a weekly patient-centered culture transformation worksheet on activities that they do that centered around the patient's preferences.... my slackers know they're slacking and what the expectations are, and they'll pick up. [Participant #12]

Staff deliberation—Staff deliberation is defined here as reciprocal staff dialogue focused on shared problem-solving. Some interview participants cited staff deliberation, whether informal or formal, as an important means to resolving tensions staff experience with regards to providing resident choice. For example, one interviewee highlighted the need for informal staff dialogue:

If a staff person doesn't agree with that [resident choice], there needs to be dialogue about it and maybe a reassignment... You have conversations. [Participant #4]

The organizational structure of formal ethics committees, in particular, was noted as potentially supporting deliberation about resident choice-related tensions. One interviewee stressed the importance of this formal structure when liberalizing residents' diets:

And so I think between having that discussion and having that opportunity for discussion- provides some sanctuary and safety for the person who's really uncomfortable...[if] they wanna bring it before the ethics committee, that's fine. [Participant #13]

Stakeholder collaboration—Stakeholder collaboration refers to staff, residents, and family members working cooperatively towards the goal of resident choice. One participant emphasized the need to make residents aware of their options and to work with residents directly to meet their choices:

...I always give my patients choices. I say 'Hey, do you prefer to be seen in the morning or afternoon?' ...A big thing is making sure that they're aware of the slots and that they really can have choice... [Participant #6]

Staff also enlisted family members to realize resident choice on occasion. The same interviewee involved family in providing residents with preferred food options in the face of conflicting medical concerns:

I try to find out what their favorite foods are... Sometimes I'll get wives to puree certain things at home... '... your spaghetti and meatballs obviously were his favorite, why don't you puree it and bring it in and we'll heat it up or do whatever we have to do?' Families are pretty good about that... [Participant #6]

Some staff members consulted each other, through the chain of command or at the peer level, to problem-solve about barriers to resident choice. An interviewee elaborated on such a scenario:

For me, I go through my chain of command. My staff come to me, and I start to take it up my chain... We start to work things up the chain and laterally... [Participant #14]

Supportive leadership—Supportive leadership also played a role in resolving tensions around resident choice. This included leading by example. A manager fostered optimal staff support for balancing resident choice with resident medical needs. S/he did so by adjusting her/his own actions:

So with culture transformation, I'm having to do some self-readjustment, so that I can lead by example in allowing residents to be able to sleep. If they want to sleep till 7, 7:30, 8 o'clock, and then get up and get their meds, and we'll find them some breakfast, fine ... I'm havin' to make sure that my staff balance the two. [Participant #8]

Discussion

Numerous tensions and resolutions surfaced during the interviews related to efforts at promoting resident choice. CLC staff discussed tensions at various ecological levels. These levels were intra-personally-situated (within the resident or within the staff member), inter-personally-situated (between the resident and staff members), and organizationally-situated. Resolutions that emerged related to preventive practices, resident and staff education, staff reinforcement, staff deliberation, stakeholder collaboration, and supportive leadership.

Our study adds to the extant body of literature in a number of ways. The study's research question was guided by and builds upon the application of SDT research to the nursing home setting. (Kasser and Ryan, 1999) Kasser and Ryan (1999) found staff support of resident autonomy as potentially enhancing psychosocial outcomes for residents; our study examined further the context of what may hamper or bolster such staff support. Our research pulled together VHA CLC staff views on tensions around and resolutions related to resident choice. Past studies specific to nursing homes have also examined resident choice from staff and resident perspectives focused on singular care concerns (e.g., hip protector use, and amount of time spent in-bed); but, our study expounds upon this work by exploring the staff perspective on resident choice across the breadth of care concerns encountered in daily living.

Our findings support and extend other studies' findings related to intra-personally-situated tensions within residents, such as the influence of resident demographics. Our study and an existing study (Luff et al., 2011) have pointed to how resident personal characteristics such

as disease severity can raise challenges to staff realizing resident choice. Our study additionally highlights that staff may feel the need to promote choice differentially based upon an individual resident's gender and age.

Resident choice vs. resident medical and safety needs marked a salient intra-personal-to-residents tension in others' work and in our work as well. Several previous studies have revealed how staff concerns about resident safety constrained staff in realizing resident choice. (Bland, 1999; Davies, Laker, & Ellis, 1997; Palacios-Cena, et al., 2013; Palmer et al., 2012; Secker, Hill, Villeneuve, & Parkman, 2003) For example, staff may actively override resident choice about hip-protector use out of a sense of duty to keep residents safe. (Sims-Gould et al., 2014) Throughout our interviews, staff conveyed uncertainty and divided feelings around this tension. We found, however, that staff were not necessarily unilaterally opposed to achieving resident choice in the face of medical and safety concerns; they were rather conflicted.

In this vein, our research sheds light on the influence of staff mental models (an intra-personally-situated tensions for staff). Staff mental models conflicted within individuals and across individuals. First, some staff members were unclear on the key mission of their facility: was it a medical facility or a resident's home? Second, different staff felt differently about adopting resident choice, either finding such change difficult or assuming a balanced, creative, or uncertain stance towards it. The expressed polarity, lack of clarity, and uncertainty are of great concern. Scalzi et al. (2006) validated this concern; effective culture change relies on the cohesion of enculturated members' internal values.

We found additional tensions intra-personally-situated within staff members. Staff professional needs competed with resident choice. This highlights another dimension to realizing resident choice: the deeper internal conflicts staff encounter when trying to meet their own needs. Sims-Gould et al. (2014) felt that staff attitudes related to promoting resident choice could benefit from training; our findings add further nuance: such efforts must acknowledge the potential underlying roots of such attitudes, including natural self-interest, and must help staff develop alternative mental models for resident choice considerations.

Our study pointed to inter-personally-situated tensions as well. Power dynamics shaped staff promotion of resident choice, according to at least one participant, in that staff may feel a personal need to control residents. This finding supports other authors' discoveries. Research has conveyed how relational issues like power dynamics hinder resident choice. (Finlay et al., 2008; Luff et al., 2011; Sims-Gould et al., 2014) The asymmetrical relationship between staff and residents creates this tension; residents largely depend upon staff to meet their needs and thus depend upon staff to do so with residents' choices in mind. This theme was not as salient in our work, however, nor were staff-staff power dynamics. These themes may be hard to unearth due to difficulties capturing a high level of self-awareness and articulation in on-the-spot interviews; they may also seem to counter perceived social desirability amongst staff.

Our research resonated with prior findings on organizationally-situated tensions such as facility routines. Luff et al. (2011) found a similar result. The authors documented with diary-keeping a significant association between resident “in-bed” time and staff shift patterns. Their subsequent resident interviews revealed how residents felt they compromised their own choice in this area of care. Our participants also provided insight on how organizational policies can act as an obstacle to resident choice, largely due to confusion around the primacy of medical orders and to inconsistencies in following them.

Culture change implementation research has highlighted several resolutions to tensions; we found that these strategies can be applied to resolve tensions surrounding resident choice more specifically. Shield et al. (2014) conducted qualitative interviews with nursing home administrators on the “why” and “how” of instituting culture change practices. In particular, the following proved fruitful implementation practices: communication at all staff levels; formal efforts in staff education; and open, inclusive, decisive, and flexible leadership styles. Our study supports these findings within resident choice promotion while additively underlining the value of resident education and the value of formal communication channels (i.e., organizational structures) for staff deliberation. Scalzi et al. (2006) also identified effective techniques to implementing culture change generally from their qualitative investigation. Similar to our resident choice-specific findings, these consisted of external staff reinforcement (i.e., incentives and rewards) and stakeholder collaboration (i.e., between all levels of staff and family members). Our interviews enhanced upon these two themes; internal staff reinforcement (i.e., empathy and professional identity) and stakeholder collaboration including residents proved beneficial as resolutions as well.

Preventive practices surfaced in our work as a resolution to resident choice tensions that represent a flexible, pro-active, and innovative approach. By implementing such practices (e.g., providing appropriate footwear), staff can find ways to prevent safety concerns (e.g., falls) while still honoring resident choice; the two aims do not have to conflict but can co-exist.

Limitations

There are a number of limitations to this study. Site selection was only purposive in relation to the parent study's research question; the sampling scheme was, in effect, opportunistic for the resident choice sub-analysis. Future research could strengthen analysis of facilitators and barriers to resident choice by expanding data collection to a broader variety of purposively sampled sites. It would have been more rigorous to have employed purposive sampling of individual interview participants as well. The parent study, a pilot study in nature, had limited time and resources to expend at each site rendering convenience sampling more feasible. Even with convenience sampling, however, the final participant sample had fairly broad participation from a variety of job types within and across the two sites involved in the study.

This study's research design was not developed to achieve thematic saturation. This design decision was based upon the aforementioned limitation on the parent study's resources which curtailed our ability to recruit and involve more interview participants. Perhaps this

study would have captured a wider range of opinion by pursuing the goal of thematic saturation, in which case further research would be needed to build upon this pilot work.

Our findings cannot be generalized beyond the nursing home setting. While it was beyond the scope of this study, it will be important for future research to explore ongoing efforts to advance autonomy in assisted living facilities, adult foster care, and home- and community-based programs. The findings also cannot be generalized beyond the VHA and, more precisely beyond VHA CLCs that are in the early process of adopting the Green House model; indeed, there is potential value in future research that studies this topic at additional time points prospectively to depict the resident choice situation as Green House implementation progresses. Further, our interview questions did not probe into the context of resident choice for specific populations with unique needs, such as the dementia population. We also cannot establish links between staff mental models and perceived tensions and, in turn, between perceived tensions and potential resolutions. Nor can we pinpoint how the varying ecological levels of tension (i.e., intra-personal, inter-personal, and organizational) interact with and affect one another. We would note, however, that qualitative research does not and cannot aim to be representative or to establish causality or interactive effects. Its strength lies in its ability to capture a rich, insider perspective on an underdeveloped line of inquiry.

Conclusions and Future Study

This study advances our understanding of staff realizing resident choice, a process increasingly conceptualized as leading to positive quality of care outcomes but sub-optimally realized to date. We envision two key research priorities for advancing resident choice based upon our work, one focused on resident choice-related tensions and one on the link between such tensions and their resolution. First, incompletely-informed staff mental models represented a key tension existing at the intra-personal level, especially when resident medical and safety concerns were in question. Future research should identify quality improvement methods that inform and coalesce these mental models and provide associated skills in promoting resident choice. It will also be critical to learn which resolutions best serve which types of tensions. Future research might also shed light on typologies of staff mental models towards resident choice and on perceptions of which resolutions should be applied to which tensions in which contexts.

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Table 1
Sample Interview Questions related to Resident Choice

•	How well do you think residents' wishes are “heard” at this CLC? That is, how much input do residents have about their daily living decisions?
•	Think back on a recent time when you were NOT able to offer a resident a choice about his/her daily living (e.g., socializing, activities/entertainment, meals, moving around the facility, sleeping, medical or personal care, etc.). <div>☐ Is it usually hard to find ways to offer residents choice? ➤[IS USUALLY HARD:] What makes it hard to offer residents choice? ➤[IS <u>NOT</u> USUALLY HARD:] What helps you to offer residents choice?</div>
•	How are decisions made when resident desires conflict with medical or safety rules and regulations (e.g., a person with diabetes wants to eat a cookie OR a person who is a fall risk wants to go to the bathroom by him/herself)?

Table 2
Staff Sample Characteristics

Job Type	Site #1 (n=15)	Site #2 (n=11)
Senior Leaders ^a	4	2
Nursing ^b	4	2
Clinicians ^c	6	6
Other ^d	1	1

^aThis category includes Medical Center Directors, CLC Director and Associate Chief Nurse, and/or Service Line Chiefs.

^bThis category includes Unit Managers, Registered Nurses, Licensed Practical Nurses, and/or Nursing Assistants.

^cThis category includes all Non-Nursing Clinical Providers, e.g., Allied Health Professionals, Rehabilitation Therapists, Social Workers, Dieticians, and/or Pharmacists.

^dThis category includes all other job types not listed in the prior 3 categories, e.g., Administrative Staff and/or Housekeeping Staff.

Table 3
“Tension” Thematic Category, Sub-Themes, and Code Definitions

Thematic Category	Definition
Tension	Situations where a sense of conflict exists or does not exist between resident choice and a competing priority
<u>Sub-Theme 1</u>	
1. Intra-Personal	Factors that contribute to resident-choice tensions that derive from an individual (e.g., resident, staff member)
<u>Code</u>	
1A. Resident personal characteristics	How a resident's personal characteristics (i.e., physical, cognitive, emotional, social, language skill, demographics, etc.) foster or do not foster conflict with realizing his/her choice
1B. Resident basic needs	How resident's basic needs (e.g., sleep, food and drink) foster or do not foster conflict with realizing his/her choice
1C. Resident medical & safety needs	How a resident's medical and safety needs (e.g., co-morbidities, swallowing risk, nutritional needs, medication interactions, pressure ulcers, falls, risk of infection) foster or do not foster conflict with realizing his/her choice
1D. Staff mental models	How staff cognitive schema (i.e., mindsets) foster or do not foster conflict with realizing resident choice
1Di. Differing views of the CLC's mission	How staff mental models of a CLC's primary mission foster or do not foster conflict with realizing resident choice
1Dii. A spectrum of views on resident choice	How staff mental models of resident choice and its feasibility (e.g., finding change in shifting from traditional care to person-centered care difficult, seeking balance between perceived competing priorities, being creative in the face of restrictions, feeling uncertain about how to address perceived competing priorities) foster or do not foster conflict with realizing resident choice
1E. Staff professional needs	How staff professional needs (e.g., honoring one's own professional identity, disciplinary traditions, and professional expectations/requirements) foster or do not foster conflict with realizing resident choice
1F. Staff work demands	How staff work demands (e.g., staffing levels, staff to resident ratio) foster or do not foster conflict with realizing resident choice
<u>Sub-Theme 2</u>	
2. Inter-personal	Factors that contribute to resident-choice tensions that derive from interactions between individuals (e.g., between a resident and a staff member)
<u>Code</u>	
2A. Staff-resident power dynamics	How interpersonal power differentials (between staff members and residents) foster or do not foster conflict with realizing resident choice
<u>Sub-Theme 3</u>	
3. Organizational	Factors that contribute to resident-choice tensions that derive from organizational structures or culture
<u>Code</u>	
3A. Organizational routines	How organizationally-sanctioned daily routines foster or do not foster conflict with realizing resident choice
3B. Organizational policies	How facility, managerial, or cultural “rules” or policies foster or do not foster conflict with realizing resident choice

Table 4
“Resolution” Thematic Category and Code Definitions

Thematic Category	Definition
Resolution	Action-based solutions to the existence of conflict between resident choice and a competing priority, e.g., achieving coexistence between both priorities, expanding resident choice in the face of the competing priority
<u>Code</u>	
A. Preventive practices	The role of prevention (i.e., avoiding unnecessary negative consequences with pro-active care processes) in addressing perceived competing priorities with resident choice
B. Staff & resident education	The role of formal or informal education of staff members, residents, and/or family members in addressing perceived competing priorities with resident choice
C. Staff reinforcement	The role of self-imposed personal or professional expectations or job-related, externally imposed performance expectations (e.g., quality standards, performance appraisals, etc.) in addressing perceived competing priorities with resident choice
D. Staff deliberation	The role of reciprocal staff dialogue / shared problem-solving (e.g., staff consulting staff from other disciplines, staff consulting their supervisors or ethics committees) in addressing perceived competing priorities with resident choice
E. Stakeholder collaboration	The role of cooperative efforts amongst residents, family members, and/or staff members, in addressing perceived competing priorities with resident choice
F. Supportive leadership	The role of senior, managerial and informal leader support (e.g., leaders' vision, leadership style) in addressing perceived competing priorities with resident choice