Next Steps for Achieving Person-Centered Care in Nursing Homes

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To what extent are nursing home residents’ preferences for daily care and recreational activities being met? In their article in this issue of the Journal, Van Haitsma and colleagues report on the development and pilot evaluation of an Excel-based toolkit designed to help nursing homes address this question.1 It is an important question for nursing homes to both ask and answer, especially in light of recent emphasis on person-centered care (PCC) and culture change in long-term care settings.

PCC is considered by many to be the “true north” in health care quality as described by Berwick.2 Not only is such care consistent with promoting quality of life, it also is considered critical to achieving quality of care and improved clinical outcomes.3,4 For this reason, “the experiences of patients” are, as Berwick observed in an often-cited essay, “the fundamental source of the definition of quality.”5 This dictum seems especially applicable to nursing homes, which, as the term implies, serve not just as nursing facilities but also as home for the many older adults who reside there in what is often their final years of life.

Only recently has the nursing home industry embraced PCC, both in policy and practice, generally operationalizing this multifaceted concept by emphasizing the fundamental importance of individual choice, particularly as it relates to daily care and recreational activities. Federal regulatory guidelines implemented in 2009, for instance, now identify choice over daily schedules as a resident right and explicitly instruct surveyors to ask and observe whether residents are offered choices about daily life activities, such as bedtimes and dining.6 Similarly, the Centers for Medicare and Medicaid Services have directed federally funded Quality Improvement Organizations to work with nursing homes in all states to enhance PCC.7 Among providers, a culture change movement to de-institutionalize and transform nursing homes into more home-like environments with residents at the center has spread rapidly with broad support from multiple long-term care stakeholder groups.8 In 2007, one-third of nursing homes reported that they had implemented some aspects of culture change and another one-third reported they were planning to follow suit.9 To promote faster uptake, the national collaborative Advancing Excellence in America’s Nursing Homes has advocated for culture change in nursing homes through various initiatives and dissemination efforts, including involvement in the Van Haitsma et al1 study in this issue. In addition, a few states have launched pay-for-performance programs that provide financial incentives for nursing homes to deliver and monitor PCC,8 while the Veteran’s Administration currently uses new performance measures to incentivize culture change in its nursing homes, also referred to as “community living centers.”

Given this rush of incentives and initiatives, the PCC Toolkit developed by Haitsma et al for the Advancing Excellence collaborative could not be more timely. The toolkit aims to help nursing homes measure “the quality of PCC delivery in a way that is concrete, feasible, and provides immediate, actionable, and up-to-date information about quality.”10 In our view, there is a lot to like about the toolkit as a means for nursing home providers to measure their progress toward this goal.

For starters, the PCC Toolkit’s 16 resident assessment items, which address such daily care and recreational activities as choosing one’s own bedtime and doing favorite activities, align directly with the care and preference items used in the latest version of the Minimum Data Set (MDS) assessment instrument (version 3.0), which virtually all nursing homes are required to complete for all residents as part of routine assessments.8 Here it should be noted that completion of this particular section of the MDS (section F) is required only upon admission and annually thereafter, or whenever a resident’s clinical condition changes significantly, which may not be sufficiently frequent to adequately assess residents’ daily care preferences. Nonetheless, this dovetailing with a well-known, required assessment instrument makes the PCC Toolkit more feasible for nursing home staff to use as part of routine care practices, in particular care planning conferences, which should occur at least quarterly. Pilot-test results seemed to confirm the feasibility of the toolkit, for nursing home staff members needed just 30 minutes of instruction to learn how to conduct the recommended resident interviews (there are 2 of them: the first assesses the importance of each of the 16 care/activity items; the second, follow-up interview assesses residents’ satisfaction with the fulfillment of preferences rated as “important,” which the developers deemed “preference congruence”).10 On average, these resident interviews took approximately 15 minutes to complete per person, with multiple types of staff being able to assist with the interviews. It should be noted, however, that most of the interviewed residents had only mild to no cognitive impairment in this study.10 Once completed, a staff member at each test site entered resident...
responses into the Excel spreadsheet component of the toolkit. Most staff members who tested this software tool reported that it was easy to use and produced analyses that helped enhance PCC. The instruction manual that accompanies the toolkit, now available online from the Advancing Excellence website (https://www.nhqualitycampaign.org/files/tools/AE_PersonCenteredCareInstructions_4-30-13.pdf), is just 16 pages long and includes lots of helpful graphics and is easy to read and understand.

With its numerous strengths, we believe that the PCC Toolkit can help support nursing home efforts to achieve PCC. At the same time, however, we doubt that use of the toolkit alone is sufficient to achieve this outcome. Previous research strongly suggests that the toolkit must be paired with additional change strategies if nursing home providers are to truly engage in and sustain quality improvement (QI) efforts. The unfortunate reality is that many improvement initiatives are unsuccessful, in part because these efforts focus solely or mostly on forces outside organizations to spur change (eg, new initiatives or regulations) while failing to address forces within organizations that constrain change. In nursing homes, the latter have proved to be especially powerful deterrents to QI efforts. In this editorial, we identify common barriers to delivering PCC in nursing homes and suggest strategies to counteract these barriers so that the care improvements intended and facilitated by the PCC Toolkit are more likely to be achieved and sustained.

**How Do You Assess PCC?**

**Resident Interviews Alone Are Insufficient**

One challenge to implementing PCC is the multifaceted nature of this construct, which can encompass a broad range of environmental (eg, home-like setting), staffing (eg, consistent resident assignment, special in-service training sessions), and care practice components (eg, expansion of dining options, adjustments to daily schedules). This complexity can make it difficult for a facility to determine when and to what degree it has actually implemented PCC. At its core, however, PCC is about offering residents choices about their daily care and recreational activities. This makes “choice” a reasonable focal point for improvement efforts. Resident interviews, such as those advocated in the PCC Toolkit, as well as staff reports help shed light on whether staff members are offering residents choices in their daily care activities. But these retrospective reports may be biased or flawed by recall error and so should not be the sole sources of this critical information.

**Supervisory Observations Are Needed**

The true measure of whether PCC is being provided is most reliably assessed by directly observing staff-resident interactions. Are staff members, in fact, offering residents choices during daily care provision? One can reasonably contend that most, if not all, residents should be offered choices about their daily care activities to enhance autonomy, wellbeing, and overall quality of life. At a minimum, staff members should routinely offer choices to residents who have reported in assessment interviews (eg, an MDS assessment or PCC Toolkit interview) that choice is important to them for certain aspects of care (eg, choosing one’s own bedtime or selecting what clothes to wear each day).

Based on this rationale, we developed and evaluated an observational tool to reliably assess staff offers of choice for specific morning care activities, including when to get out of bed, when to get dressed and what to wear, where to dine for breakfast, and the need for toileting assistance (www.VanderbiltCQA.org see Training Modules/Providing Resident-Directed Care). We focused on these care activities because most nursing home residents require some level of staff assistance for one or more of them. These activities also tend to co-occur daily, usually within a predictable timeframe. As a result, it is feasible for researchers, surveyors and nursing home supervisors to observe whether staff members are offering residents choices in these care areas. Using this tool to conduct hundreds of observations across 12 weeks in multiple nursing homes, we found disappointing results. Staff members infrequently offered residents choices in the targeted care areas (only 8% of the time for breakfast dining location and a high of 21% for when to get out of bed in the morning). This occurred despite reports from the residents during interviews that choice was important to them. Equally surprising, however, was that few of these same residents reported being dissatisfied with the lack of choice offered. Other studies have found that nursing home residents often report being “satisfied” with suboptimal care quality.

These findings underscore the importance of augmenting resident and staff reports of PCC with intermittent observations of daily care practices. These observations, conducted by nursing home supervisors or other designated personnel (eg, Quality Assurance or MDS nurses), may target those residents who have recently reported in an MDS assessment or PCC Toolkit interview that choice is important to them or residents who are due for a care planning conference, as suggested by Van Haitsma and colleagues. Ultimately, however, these observations should include even those residents who have reported that having a choice is “not very” or “not at all” important to them as well as residents who have reported being “satisfied” with current care practices, for it is possible that these responses simply reflect the residents’ reduced expectations for care. If these residents were routinely offered more choices by the staff, they might change the level of importance they attach to certain aspects of their daily lives. The key point is that PCC is observable—and should be observed—in the form of daily, routine staff offers of choice to residents across a range of daily care activities.

**Who Is Responsible for PCC?**

**Staffing Constraints**

A second common challenge to implementing PCC is related to staffing: who will take responsibility for PCC assessments, both resident interviews and staff observations? How much time do these tasks require and how often do they need to be done? Numerous studies have shown that staffing constraints often limit the ability of nursing homes to implement and sustain improvement efforts. In Van Haitsma et al’s evaluation, participating nursing homes reported inadequate staff time (55%), staff resistance (44%), and staff turnover (11%) as challenges to implementing PCC. The majority of these sites were 4- or 5-star, highly staffed facilities. The real challenge will be getting lower performing nursing homes to engage in quality improvement efforts. Van Haitsma and colleagues note that “nursing homes with a low (CMS quality) rating are more likely to focus on basic quality of care than PCC improvement.” This might, at least partially, explain why only 12 of 40 invited homes (30%) chose to participate in this pilot evaluation. Even among this select group of high performing homes, participants were required to submit data from only a small number of resident interviews (ie, with 5 short-stay and 5 long-stay residents) at only 1 point in time. In addition, as mentioned earlier, residents selected for interview had only mild to no cognitive impairment, which may have influenced the amount of time required to complete each interview (15 minutes, on average). Starting small with residents who are most likely to be responsive is a reasonable approach for a pilot test, but likely underestimates the time needed to complete interviews with a larger number of residents with a wider range of cognitive functioning at multiple time points.
points, all of which would be necessary to maintain this effort facility-wide over a longer period of time.

**Staffing Innovations**

The good news is that staffing constraints may be addressed through more creative staffing models. Van Haisma and colleagues, for instance, note that various types of staff can be trained to assist with PCC interviews, and these investigators appropriately recommend that different staff members interview residents about their preferences (eg, nurse aides, MDS nurse) vs their satisfaction with how these preferences are being met (eg, social workers, recreational therapists, licensed nurses). Similarly, multiple types of supervisory-level staff can be trained to conduct standardized observations of daily care quality.

Both resident interviews and observations of care quality can be completed for small groups of residents each week (eg, 5 interviews or observation periods per week). To affect real change over time, however, both tasks—interviews and observations—must occur on an ongoing basis and include most residents, not just the most capable residents. Fortunately, although these changes may sound daunting, they are feasible to implement. Nursing home staff often assume that conducting care observations for QI purposes is impractical for 2 reasons: (1) the amount of time required, and (2) the belief that staff members perform differently (ie, better than usual) when under observation. We have found both assumptions to be erroneous. In reality, 1 supervisory-level staff member can effectively conduct observations of morning care activities for 3–6 residents per week in 1–2 hours or less. Observations of other daily care activities require even less time. For example, supervisors can observe mealtime activities for 6–8 residents dining within one area in 1 hour per week or less and in that time gain useful information about the availability of entrée options, dining location, and feeding assistance quality.

In terms of the influence of observations on staff behavior, we have conducted hundreds of such observations in nursing homes across the country and, while we have observed staff care behaviors in need of improvement, we have found little to no change in routine staff behavior prompted by these observations alone.

One caveat is worth mentioning here: consistent staff-resident assignments and documented care plans do not preclude the importance of offering residents choices on a daily basis. The reality is that most nursing homes have high staff turnover rates, particularly among nurse aides, who are responsible for most aspects of residents’ daily care. In addition, many facilities use temporary staff on a frequent basis. Thus, there are a sufficient number of different staff members providing care to individual residents each day that staff members should routinely offer residents choices at the point of care delivery. In practice, this means that residents should be offered choices daily, multiple times a day, and this staff behavior should be observable during most any staff-resident care interaction. Offering choices whenever possible communicates respect for residents and has been cited as central to the enhancement of individual wellbeing, autonomy, and quality of life. In addition, resident engagement in decisions about their daily activities can help combat apathy and depression, both of which are common among nursing home residents and may contribute to resident reports that having a choice is not important to them.

**How Do You Change Staff Behavior to Be More Person-Centered?**

**Attention to Change Strategies May Be Short-Changed**

Now let’s turn to possibly the most significant challenge to implementing PCC: what to do with assessment information after collecting it. Once you know that choice is important to residents (based on interviews) and that staff members are not offering it routinely (based on supervisory observations), what do you do to effect change in staff care behaviors? This is where the PCC Toolkit, at least as described by Van Haisma et al, potentially falls short. The researchers found in their evaluation that care conference attendance rates were lowest for direct care staff (ie, nurse aides). This is potentially a significant problem because, presumably, it is during care conferences that strategies to meet resident preferences are identified and agreed upon by the resident, family members, and staff. Within the online toolkit itself, the “optimized care planning” spreadsheet, where staff can record the strategies identified for addressing resident preferences, is labeled an “optional worksheet,” an unfortunate designation for what some would argue is the most important step in implementing PCC.

Changes needed to address residents’ preferences may occur at the resident-level (eg, making nurse aides aware of individual resident preferences) or may require system-level adjustments. In either case, change can be challenging to achieve. Consider an example Van Haisma et al. use in their study: “If the data reveal low preference congruence for snacks between meals, the nursing home can adjust snack service delivery as desired.” Sounds simple, but such a change can be surprisingly challenging to implement. For instance, consistent delivery of between-meal snacks multiple times per day, 7 days per week requires careful coordination between dietary and nursing personnel. In addition, an adequate number of staff members must be available both to deliver snacks to residents and offer appropriate assistance so that residents can enjoy the snacks. These changes typically translate into the need for staff members other than nurse aides to help out at snack times. Federal regulations allow non-nursing personnel to assist with feeding tasks, but here again, system-level changes would be required to recruit, train, deploy, and supervise new snack-time assistants. Other system-level strategies that might be needed include better coordination of services among multiple departments, such as encouraging social activities personnel to incorporate snacks into routine group activities. As this example demonstrates, care quality improvements can be complex changes to make even when they appear to require only a simple adjustment to the resident’s care plan.

**Quality Improvement Strategies**

To succeed, QI changes demand thoughtful planning, implementation, and ongoing monitoring. With respect to monitoring, our research has shown that standardized observations of daily care practices are needed to evaluate whether new interventions are meeting their goals. Returning to snack provision as an example, we have found that nursing home efforts to improve this process often have resulted in snacks being offered immediately prior to, or even during, scheduled mealtimes, which defeats their purpose. Then, too, nursing homes often offer few snack options for residents to choose among and/or inadequate staff assistance to promote consumption. The best and probably most efficient way to identify such process problems is by systematically observing new care practices as they are implemented.

The next step, aimed at rectifying problems so as to improve processes, is to provide feedback from the care observations to all relevant staff members. In several studies, we trained nursing home supervisors to do just this, to conduct standardized observations of a daily care activity, such as snack delivery between meals, and then to conduct structured, brief (<15 minutes), weekly feedback sessions with staff to facilitate improvement. The observations combined with weekly feedback allowed staff members to discuss barriers, problem-solve, and track improvement over time. In this way, all staff...
members were held accountable as a team. Even modest improvements from week-to-week were acknowledged and praised as successful, incremental steps toward a defined goal. This approach is consistent with the widely advocated health-care quality improvement strategy known as Quality Assessment and Performance Improvement, which combines performance improvement with data monitoring and features a feedback system that actively elicits input from staff and residents.14 Numerous studies across a range of fields have shown that this QI approach is associated with measurable improvements in outcomes.33,36

**Recommendations for Other Change Agents**

Although we believe that PCC in nursing homes is achievable—and facilitated by such tools as the PCC Toolkit—we also believe that supporting efforts from other changes agents are needed to ensure lasting improvements take root in nursing homes. Below we present change recommendations for policymakers, advocacy organizations, and researchers to consider.

**Policymakers**

We strongly advocate policy changes that eliminate the stigma that often results when nursing homes identify care areas in need of improvement. Our well-intentioned federal regulations, surveyor guidelines, and publicly-reported quality measures have inadvertently created a system that often is more punitive than constructive for nursing homes, particularly those with fewer resources. State Quality Improvement Organizations help mitigate the negative, unintended consequences of regulatory mandates by providing education, information and, in some states, financial incentives to support nursing home QI efforts, but more support is needed. Going forward, less emphasis should be placed on nursing home clinical outcomes (ie, quality indicators) and more on day-to-day care processes. Ultimately, nursing homes should receive recognition for attempting genuine QI efforts. Based on years of conducting research in nursing homes, we have found that facilities that proactively identify areas in need of improvement tend to do better at assessing—and addressing—unmet resident needs than those that purport to have few problematic areas. In 2 separate studies, for instance, we found that nursing homes reporting high prevalence estimates for pain and depression performed significantly better on care process measures related to assessment and treatment for these two conditions than nursing homes with low prevalence estimates for these clinical outcomes. Moreover, when we independently assessed pain and depression among residents in both groups of homes, the actual prevalence rates for these conditions were comparable.37,38 In other words, the “low prevalence” facilities simply failed to identify pain and depression among a substantial proportion of residents. These findings contradict the underlying assumption of publicly reported nursing home quality measures for pain and depression, whose premise is that higher rates indicate poorer care quality. We should keep these findings in mind when we ask nursing homes to report on their QI efforts in other areas, including PCC. Nursing homes that have proactively identified problems to address through QI initiatives are likely off to an excellent start and should be commended for their efforts.

**Advocacy Organizations**

Organizations such as the Advancing Excellence collaborative that disseminate toolkits, best-practice guidelines, and other QI materials should recognize that education in these forms is necessary but insufficient to affect real change in nursing homes.11,22 Often missing from such materials are specific strategies related to who completes assessments, how often assessments are completed, and, most importantly, what to do with the information once collected. Well-intentioned nursing homes may add another assessment tool to their “to do” lists but lack the necessary knowledge for translating the assessment information into actions (eg, staff behavior change) that lead to measurable improvements, which we believe is the most important step in the QI process. In our experience, many nursing homes tend to view QI as a serial process, whereby a problem is addressed, resolved, then forgotten as the next problem is addressed. To sustain improvements, however, QI must, instead, be a continuous process.33,36

**Researchers**

Researchers who test clinical or educational interventions in nursing homes or conduct program evaluations should avoid relying solely on nursing home staff reports or even medical record documentation of outcomes, for both data sources are often inaccurate and biased in the direction of over-estimating care quality.17,39 Ideally, researchers should directly observe daily care routines or staff behavior to determine whether desirable practices are occurring as intended. Equally important, such observations also shed light on the potential barriers from which we can learn for future efforts.

**Conclusions**

In our view, the PCC Toolkit is a welcome resource that can help nursing homes achieve PCC, but users should recognize that the toolkit guides them through just one step toward a much larger goal. PCC is not evidenced by completed toolkit worksheets; rather, it should be demonstrated by observable changes in daily care practice.

**References**
