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Person-Centered Care in Nursing Homes: Potential of Complementary and Alternative Approaches and Their Challenges

BACKGROUND

A traditional medical model has been used in nursing homes (NHs) for many years to manage residents' chronic conditions, however it fails to address the individual needs of each patient. In this regard, a promising social model has been shown to improve residents' quality of life (QOL) through a person-centric care approach. Since every resident experiences different biographical, behavioral, psychological, family, and social contexts, using a person-centered approach of care would allow NHs to cater to each resident when it comes to improving their QOL. When implemented correctly, person-centered care (PCC) can address loneliness, helplessness, and boredom, which have been known to plague older adults within long-term care facilities. Complementary and alternative approaches (CAA), such as yoga and meditation, music therapy etc., offer care beyond the medical model in NHs that address the holistic health and QOL of the individual. Despite the promise of various mindful practices, the existing literature does not adequately address how the long-term care industry could effectively incorporate CAA practices to improve residents' QOL. The current study aimed to assess the barriers and facilitators to the implementation of PCC and how the integration of CAA has the potential to improve residents' QOL in NHs.

STUDY METHOD

The current study used data from a larger study, "Building Resources for Delivering Person-Centered Care in Georgia Nursing Homes." The participants for this study were recruited from a diverse group of NHs and divided into ten focus groups. The first focus group in each NH included direct care workers (DCWs) and auxiliary workers, while the second focus group included administrators, nursing, and other department leads; the study included 36 managers and 44 direct care or auxiliary workers. The focus groups first discussed their thoughts about PCC and its usefulness. They next discussed their views on the role of PCC in their organization and their perceptions of barriers and facilitators to implement PCC; third, they were asked about various engagement activities and if they felt those could improve residents' QOL. Finally, they were asked about what training topics would support participants' implementation of PCC. Using a qualitative descriptive approach, the current study analyzed how often NH staff use CAA activities, how intentional was the use of CAA, and what difficulties came with trying to implement PCC in their facilities.

FINDINGS

When the participants classified as supervisors were asked about their thoughts on PCC, the majority (22 out of 36) were able to explain PCC, but when DCWs were asked the same question,

only 16 of the 44 were aware of PCC. Although most supervisors were aware of PCC, they often struggled to implement the PCC strategies due to demands from NH authorities, DCWs, and residents. Most of the supervisors get caught up in institutional thinking which prevents them from being able to implement the PCC strategies effectively. Implementation of PCC has been difficult for a variety of different reasons ranging from individual concerns to systematic issues. Most DCWs struggled to implement PCC when the needs of the patient started to have a direct effect on the residents' health; for example, diabetic patients will often ask for treats that have a negative impact on their health, but since it is considered a resident's preference the DCWs become confused about what to do. PCC often fails to be implemented when DCWs are inadequately staffed; they are unable to cater to everyone's individual needs and often are not able to use PCC strategies. Competing attitudes and understandings between DCWs and supervisors about the others' authority and intentions were seen at every NH. While PCC strategies often go unused due to tension amongst staff most of DCWs enjoyed doing the CAA activities and often felt that they helped residents by promoting relaxation, reducing agitation, increasing QOL, and minimizing loneliness, boredom, and helplessness among residents.

POLICY IMPLICATIONS

The findings suggest that implementing and maintaining PCC was challenging in most NHs. PCC requires large amounts of teamwork to successfully be put into effect; however, with the lack of time and staffing it is hard to make sure whether PCC is used correctly. Policy and payment reforms are vital needs to properly implement PCC in NHs. The findings from this study highlight some of the specific reasons why PCC is difficult to implement and give us further clarity on how the situation could be resolved. This knowledge of the landscape of activities will help future researchers and policymakers identify and improve strategies for providing residents a better quality of care at a deeper, more meaningful level. CAA has the potential to be therapeutic for residents, however, it needs collaboration between caregivers and care-recipients.

Original Article

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