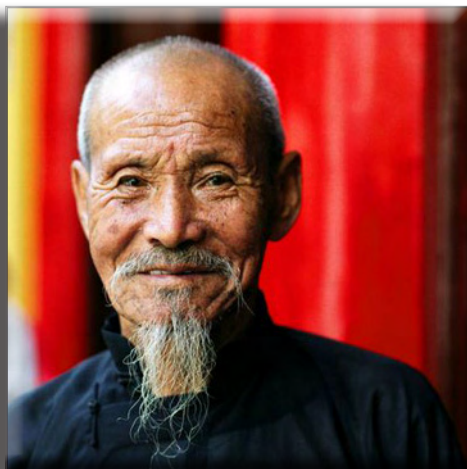


Person-Centered Care in Assisted Living: An Informational Guide



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Note to Readers

This paper is intended as a “what is” person-centered care informational guide, rather than a “how-to implement” person-centered care guide. Please use it as an opportunity to discuss and advance dialogue about person-centered care. This paper was commissioned by the CEAL Board; however, the views and opinions expressed are not necessarily reflective of every member organization represented on the CEAL Board.

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Introduction

To date, published information about person-centered care in assisted living has been sparse. This paper expands on a chapter entitled “Person-Centered Care in Assisted Living” in the National Association of Boards of Examiners of Long Term Care Administrators’ (NAB) *Residential Care/Assisted Living Administrators Exam Study Guide* prepared by this paper’s writer and Mauro Hernandez¹. This paper presents a comprehensive framework about what is needed to support person-centered care (PCC) outcomes based on evidence-based practices obtained through a broad review of peer-reviewed and grey literature². While there has been sparse assisted living-specific research conducted about any elements of PCC, studies conducted in other sectors such as nursing homes and the developmental disability population, as relevant, are cited. In addition, the paper draws on over 40 in-person and telephone interviews, and discussions with diverse PCC experts across the aging services network including leaders in the culture change movement, long-term care practitioners and consumers.

While the paper’s focus is to detail PCC in assisted living, it is important for the reader to understand that the national PCC movement (known by many terms, see page 4) is not new and encompasses the wide spectrum of people who are recipients of care and services (e.g., individuals of all ages who have physical, developmental, intellectual, behavioral, cognitive and/or mental health disabilities) and the providers that supply the care and services (e.g., hospitals, rehabilitation centers, primary care providers, nursing homes, group homes, subacute centers, assisted living, adult day care, home care). The general tenets and practices of PCC — honoring the person — are the same across settings and populations wherever he or she lives.

The goal of this paper is two-fold. First, the paper proposes a conceptual framework that can be tested and further refined through future research. Although the literature and discussions with a range of stakeholders indicate some degree of consensus around the key structural elements of PCC described within, much work remains to be done to understand the interrelationships and interconnectedness among these elements and to more fully explore the most successful means of operationalizing them. Second, it is hoped that this paper will inform current discussions of PCC in assisted living settings. While there are some assisted living providers that currently employ one or more of the elements needed to support PCC outcomes, many providers have not evolved beyond the core values of a home environment and improved service delivery (Utz, 2003). This paper is intended to help assisted living communities more fully understand the structural framework that underpin PCC outcomes.

The Center for Excellence in Assisted Living (CEAL), in collaboration with Sheryl Zimmerman, Ph.D., from the University of North Carolina-Chapel Hill, is currently developing a community-based participatory research project to identify and study the structures, processes and outcomes of PCC, both conceptually and operationally in assisted living. The research project will also examine the relationships between PCC structures, processes and outcomes, and in what combination and to what extent the structures and processes relate to different outcomes. It is hoped the findings from the project will advance knowledge and understanding about PCC, and inform operating practices and policies.

¹ Utilized with permission from NAB.

² “Grey literature” refers to published materials in non-peer reviewed sources such as trade and industry magazines.

Person-Centered Care Background



Over the past 20 years much has been written about PCC among different forms of aging services. PCC has become a dominant model in various models to improve quality of care and life embraced by consumers, advocates, and, in many cases, providers and regulators. The core principles of PCC include

the assurance of individuality, choice, privacy, dignity, respect, independence, a sense of being part of a community and connected to the larger community, and a home environment in which to reside. Interestingly, although not often explicitly recognized, the pioneers of assisted living also embraced similar principles in its foundational culture.

The early assisted living providers of the late 1980s used the term “person-centered care” to describe the collective changes they were implementing in this newly formed aging services sector. At the same time, the U.S. Congress legislated sweeping changes for certified nursing homes (skilled nursing facilities/SNF) through the Omnibus Budget Reconciliation Act (OBRA) of 1987, which mandated a national minimum set of standards of care and resident rights. One of OBRA’s significant changes included an emphasis on a resident’s quality of life in addition to the quality of their care. The person-centered focus of OBRA spurred people already committed to person-centered care for nursing home residents to form a movement to transform nursing home culture and environments into life-affirming settings in which elders direct their own care and

are treated with respect and dignity. The goal of transformation is to reorient the institutional, deficit-oriented and treatment-driven nursing home culture to one that is home and embraces resident self-determination and personal choice through relationships and community. This effort to transform nursing homes from institutions to real homes for the people who live there became commonly known as “the culture change movement.”

Both proponents of culture change and assisted living providers used the term PCC to refer to changes in the physical environment (to create home), service delivery (resident-directed) and core values (dignity, respect, choice, independence and privacy). As the ranks of the nursing home culture change proponents swelled and research efforts began providing knowledge to improve practices, the usage of the term PCC by culture change reformers began to refer to a widening set of elements that were not necessarily also being adopted by assisted living providers including: a relationship-based operational culture; leadership that fosters staff empowerment, including self-directed work teams; and helping elders optimize their well-being through meaningful activity and opportunities to experience self-worth and purpose in daily life. There are some assisted living providers that currently employ the wide set of elements needed to support PCC outcomes, but many providers have not evolved beyond the innovations to the core values, home environment and improved service delivery to create a fully transformed humanistic* culture.

* The term “humanistic” in this paper is used to describe a way of life centered on human interests and values that stress dignity, self-worth, purpose and self-determination for elders.

Historical Context of Person-Centered Care



Tom Kitwood, a British gerontologist, was one of the first to use the term “person-centered care” in aging services. He used it to describe an empowering philosophy of care that rebalances work priorities from a focus on accomplishing tasks to a focus on the person needing assistance. Care is not organized for staff

convenience, efficiency or other such criteria (Fazio, 2008). Critics of institutional long-term care view its focus primarily as task-oriented resulting from a focus on efficiency and the prevalence of hierarchical management systems that value the accomplishment of tasks. PCC rebalances the work priorities to focus on the elder instead of the tasks that need to be accomplished (Tellis-Nayak, V., 1988).

In the mid-1990s, a movement of nursing home pioneers began gathering and discussing the transformation of nursing homes from medically-oriented institutions into homes for elders by implementing the person-directed care philosophy and practices. In 1997, this movement became a non-profit national organization, now known as the Pioneer Network, dedicated to changing the culture of aging in the 21st century.

The Eden Alternative® was one of the first national efforts in the United States to create an organized infrastructure to transform the institutional culture of nursing homes into homes that included some features of PCC. Eden did

so by promoting the need to shift the nexus of decision-making to the elder, or as close to them as possible, ensuring that they directed their own daily schedules and preferences (Lustbader & Williams, 2006). Some critics view Eden’s approach as simply “fur and feathers,” referring to the inclusion of pets in nursing homes. Improving the environment by including pets is just one of many elements of the Eden model, but many people mistakenly describe it only in terms of pets and plants.

Other national examples of transformative nursing home care aimed at enhancing quality outcomes that incorporate some or all of the elements of PCC include: the Wellspring Program, the GREEN HOUSE® Project and the Household Model. The common goal of these approaches is the realignment of operational approaches to provide relationship-based assistance and support in an empowering and nurturing home environment for elders in which they can live and thrive. In addition to improved quality of care, anecdotal evidence abounds that these models also enhance quality of life for residents. Rosalie Kane and colleagues found that opportunities for meaningful activity, relationships, autonomy, privacy, dignity, security, physical comfort and enjoyment led to measurable improvements in quality of life (Kane et al., 2003). While there is growing agreement about what constitutes quality or how it should be measured in assisted living, there is strong consensus that optimizing resident well-being is the desired outcome (Zimmerman et al, 2008).

In general, the pioneers of culture change and the developers of assisted living generally worked on separate paths with little overlap

National organizations increasingly recognize PCC as the gold standard for care and services.

despite the many parallels of their sectors. The developers of assisted living eschewed anything that smacked of “nursing homes” and were intent on innovating new, improved senior living environments. Much of their attention was devoted to getting financed to develop this new model of care and resisting regulatory

efforts to impose nursing home-like requirements. The culture change proponents were initially immersed in their nursing home work and not focused on advances being made in other aging services sectors (e.g., adult day care, home care, assisted living). These sectors typically function as individual silos.

While assisted living homes and nursing homes were adopting innovations in physical design, service delivery and core values orientation, transformative efforts to advance quality outcomes were also underway in hospitals. Planetree, an organization initially formed to transform the acute-care culture in 1976, created a viable and cost-effective model for implementing PCC in hospitals (Charmel & Frampton, 2008).

National organizations increasingly recognize PCC as the gold standard for care and services. The Commission on Accreditation of Rehabilitation Facilities (CARF) includes PCC in its standards manual. The National Center for Assisted Living includes PCC in its “Guiding Principles for Quality in Assisted Living.” The American College of Health Care Administrator’s “Principles of Excellence for Leaders in Long-Term Care Administration” states that “PCC is the ultimate goal of long-term care,” and

the National Association of Long Term Care Administrator Boards recently included PCC in its study exam guides for both assisted living and nursing home administrators.

There are many terms used for person-centered care, sometimes interchangeably. The use of different terms is sometimes service sector related such as patient-centered care or patient-directed care within the hospital community, and person-directed services for individuals with physical disabilities. Sometimes the selection of a term represents a difference in philosophical opinion. For example, within the long-term care community there is variability among terms used (e.g., resident-centered care; resident-directed care; person-centered care; and person-directed care). In the nursing home sector, some have adopted the use of a continuum of terms to differentiate between a staff-directed and a person-directed culture (Misiorski & Rader). Some prefer the use of the term “person” to recognize the vital role and connection between the resident, family and staff. Others feel strongly about the use of the term “directed” instead of “centered” to connote the care receiver’s rights of independence and choice. This type of preference variability within a single service sector can also be found in the developmental disability community (e.g., person-centered thinking, person-centered planning and person-centered services).

The commonality among all the various terms is to signify that the elder is either personally involved and directs their care, or if not able, that care is provided in the manner and preference that best serves them. The term person-centered care (PCC) is used in this paper because it is the more widely used term in the aging literature (Bowers, 2009).

What is Person-Centered Care?



While there is as yet no official definition of PCC, its supporters generally agree that **PCC is defined as a comprehensive and on-going process of transforming an entity's culture and operation into a nurturing, empowering one that promotes purpose and meaning and supports well-**

being for individuals in a relationship-based, home environment.

Each of the elements in the description are fundamental to the essence of PCC: (a) a comprehensive and on-going process; (b) the transformation of organizational operations and culture; (c) adoption of nurturing and empowering practices; (d) enabling elders to experience purpose and meaning in their daily lives; (e) a relationship-based culture; and (f) a home environment. Giving priority to these components is supported by findings from a recent study of satisfaction surveys completed by assisted living residents. Researchers found that the features of an assisted living community that have the greatest impact on residents' satisfaction with their quality of life include: quality of daily life (what they do each day); their relationships with the staff and other residents; their level of control; and the degree to which they feel at home (Wylde, 2009). The findings from this study closely parallel the key elements that define PCC. The next section, "Framework of Person-Centered Care" provides details and context for these elements.

It has become almost politically correct to use the term "person-centered care" or alternatively culture change, but not everyone uses the term to signify the same thing. Some use the term PCC to refer to a process of instituting an operational change within their organization such as implementing a new dining program. Others use PCC to mean that elders can choose when to eat and bathe. In actuality, to realize PCC outcomes requires deep organizational and operational system changes that reflect different values and beliefs about what constitutes quality care, a nurturing environment in which to live, and a positive environment in which to work. Attaining PCC outcomes is a continual process. It can take years just to fully implement the structural elements of PCC depending on how evolved an organization is to begin with (Interviews, 2009). Incorporating even some elements of PCC without total transformation has beneficial results. However, to attain the full benefits and value of PCC, an organization must fully align its organizational culture and all of its operations systems to practices that support PCC outcomes.

It is possible to have good quality of care without good quality of life. For example, elders may be well cared for in terms of their health care, hygiene, nutritional needs and housekeeping (quality of care), but unhappy that they, for example: consume food that is unappealing; have to bathe in the morning when they prefer an evening shower; awaken to vacuuming in the middle of the night because that is when there is the least amount of foot traffic; and are lonely for companionship. PCC positively affects quality of life and quality of care for elders with the goal of transforming from efficiency-based, medical or "paternalistic" models of care to

Still needed is scientific inquiry into what is needed to realize PCC outcomes and how elements interact with and correlate to one another.

“consumer-directed” models that honor elders’ life experiences, choices, routines and the natural rhythms and spontaneity of daily life. These are often cost-neutral features that invaluablely contribute to elders’ psychosocial well-being, sense of self worth, purpose and physical health (Interviews, 2009).

To date, there has been no comprehensive research examining what specific elements are needed to support PCC outcomes in any of the aging service sectors. Some research and national initiatives such as “Better Jobs Better Care” have focused on singular elements of PCC such as workforce practices or environmental design. Still needed is scientific inquiry into what elements are needed to realize comprehensive PCC outcomes, and how these elements interact with and correlate to one another.

A published research study, entitled “Culture Change Management in Long-Term Care: A Shop-Floor View,” illustrates how a lack of research and understanding about what constitutes PCC can lead people astray and to wrong conclusions (Lopez, 2006). The study’s lead researcher, a sociologist, admirably committed to being fully trained and worked part-time as a certified nursing assistant in order to better inform his understanding of what he observed and experienced during the study. He unfortunately was not equally well informed about what was needed to support PCC outcomes. He inaccurately premised the research, conducted ethnographically, on his belief that the nursing home being studied was operationally culture changed (i.e., had person-

centered care outcomes). In fact, only parts of the operation were culture changed and included features such as: caring leadership; treating staff respectfully; staff recognized and appreciated for their efforts; and organizational commitment to staff training. Other parts of the operation were far from being culture changed including: night staff waking residents and getting them dressed to help alleviate the day shift’s burden of getting residents up and ready for 8 a.m. breakfast; intractable treatment of staff absences; and hierarchical-style management practices. The author found that culture change does not improve outcomes for direct-care workers in nursing homes. This is analogous to saying that good eating habits are not beneficial to health when the study participants only cut back on consuming dessert but continue to eat large amounts of other food such as bread, pasta and butter. The tenets of PCC suggest the necessity of effectively addressing all of the elements that contribute to successful PCC outcomes and understanding their interrelatedness and connectedness are as important as addressing *all* the elements in one’s diet for beneficial health.

Although research is needed to identify what elements are needed to support PCC, communities that have achieved PCC outcomes generally have a common understanding of what elements are needed and their interrelation and connectedness. There is a growing body of experience and information from approaches and models such as THE GREEN HOUSE® Project, the Household Model, Eden Alternative® and Dementia Care Mapping. The GREEN HOUSE® Project demonstrates that similar structural elements are needed for both nursing homes and assisted living.

There is anecdotal evidence that the financial ramifications of implementing PCC are cost effective. One study found that for a North

Carolina Continuing Care Retirement Community the financial savings alone from decreased staff turnover as a result of implementing PCC was in excess of a half a million dollars for one year (Gilster & Dalessandro, 2010). As with any quality initiative, there is an upfront cost involved. If an organization, however, stays with the PCC transformative effort and does not stop midway, the return on investment can be very positive. An organization may need to expend monies to implement strong staff training and mentoring programs, but the net cost savings from reduced staff turnover can be significant (see cost information on page 17). Similarly, an organization may incur higher expenditures to have the right amount of staff, yet experience cost neutrality from reduced workman's compensation and liability insurance rates. Factor in the cost benefit of averting a lawsuit and the expenses that go along with it, and the financial impact of PCC can swing to a positive equation.

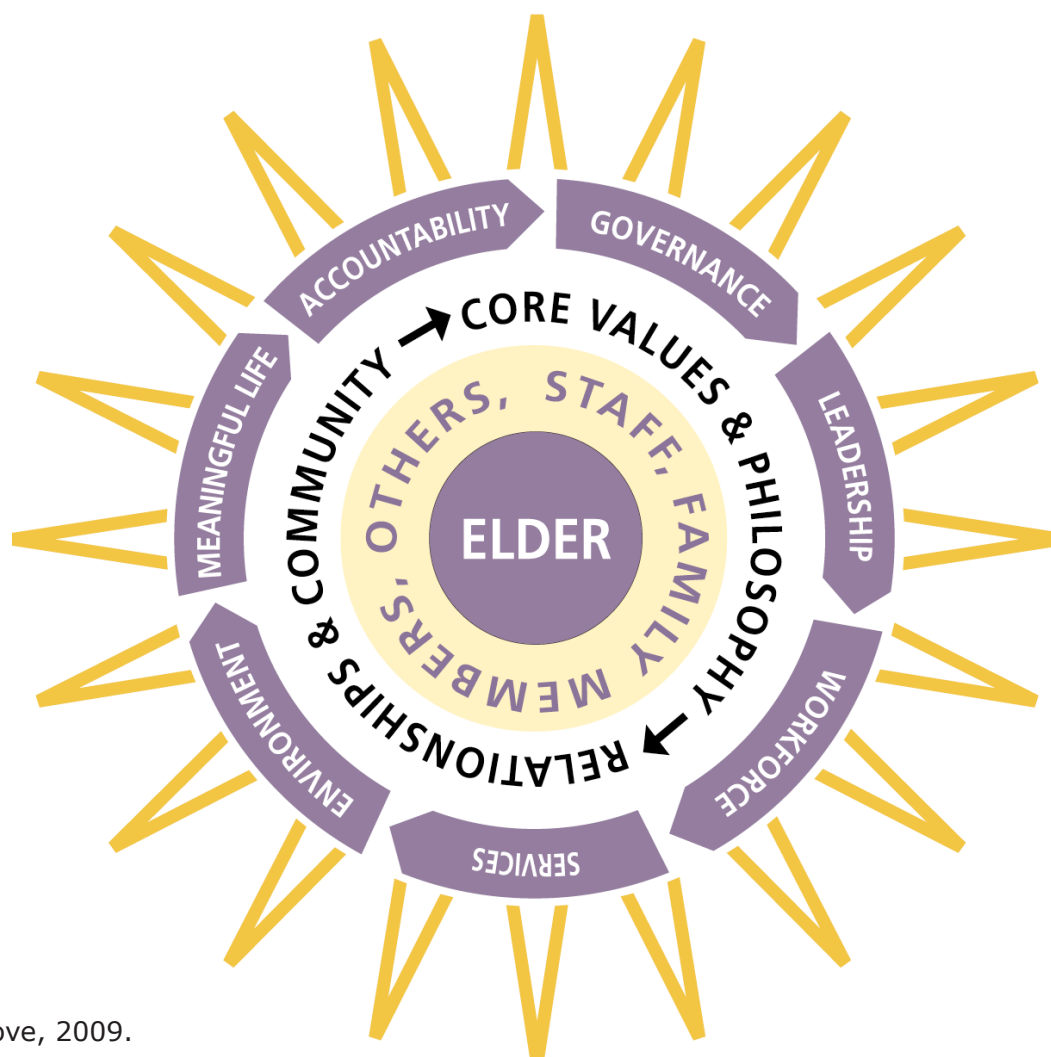
Framework of Person-Centered Care

This paper presents a comprehensive PCC Donabedian-based framework (structures, processes and outcomes) based on existing research, evidence-based practices obtained through a comprehensive review of peer-reviewed and grey literature, and in-person and telephone interviews and discussions with diverse PCC experts across the aging services spectrum. While there has been sparse assisted living-specific research conducted about any

element of PCC, studies conducted in other sectors such as nursing homes and homes for person with developmental disabilities, as relevant, are cited.

The **framework** for achieving PCC *outcomes* include: (1) the structural elements; (2) the *processes* to support the *structural elements*; and (3) the *outcomes*, which derive from the combination of the elements and processes.

PCC STRUCTURAL ELEMENTS FRAMEWORK



Source: Love, 2009.

While the structural elements for PCC are universal, the processes are not. Organizations will come up with their own processes to support the structural elements that reflect the circumstances and creativity of each organization. The processes are not prescriptive as are the structural elements.

The structural elements needed to support PCC in assisted living are:

1. Core Values and Philosophy
2. Relationships and Community
3. Senior Management–Owner–Governance
4. Leadership
5. Workforce
6. Services
7. Meaningful Life
8. Environment
9. Accountability

The structural elements are interdependent and interconnected. For instance, an organization may have an engaged, charismatic mid-level manager promoting strong workforce practices, but lack actively involved governance and leadership. The result may be positive workforce outcomes in the short-term, but these outcomes will not be sustained because governance and leadership are not invested. The following diagram illustrates the interconnectedness and interdependence of the structural elements.

These structural elements constitute the “building blocks” of PCC. There is an order to implementing the elements. The elements of Core Values and Philosophy (1), Relationships and Community (2), Senior Management–Owner–Governance (3), Leadership (4), and Workforce (5) need to be implemented and inculcated into the new PCC operational culture before an organization can effectively integrate the Services (6), Meaningful Life (7), Environment (8) and Accountability (9) elements.

The remainder of this section will describe and detail each of the elements. As noted, the processes used to implement the structural elements are flexible and not prescriptive. Some examples of possible processes are included in boxes periodically to provide the reader with sample ideas.

1. Core Values and Philosophy Element



The Core Values and Philosophy Element is strategically identified first because it creates the functional framework from which all the other elements flow. The foundation of PCC is based on the traditional assisted living core values of respect, autonomy (self-direction), dignity, choice, privacy and

independence, as well as a philosophy of services that optimizes elders' well-being. A culture of mutual respect honors and recognizes the unique interests, preferences, talents and life experiences of each member of the community — residents, family members, staff and volunteers. This understanding permeates all behaviors and serves to rebalance the environment from one that is task-oriented to one that is person-oriented. Task-orientation tends toward a one-size-fits-all approach that is depersonalizing and diminishing. Tom Kitwood refers to this as "human unbeing," and while it is not something caregivers consciously set out to accomplish, it often is the outcome.

A work culture that values each person and strives to optimize their well-being motivates completely different behaviors and outcomes. For instance, in a person-oriented culture, if a caregiver goes to help a resident who is temporarily in a wheelchair get to the dining room, the caregiver demonstrates an interest in how the person is doing and maybe, depending upon the person, engages in some gentle encouragement about being up and dancing

again in no time. In a task-oriented culture, this scenario likely would play out differently as the caregiver is intent on simply getting the resident from point A to point B. It's fair to say that the caregiver in the task-oriented scenario might also have treated the resident kindly. That is different, however, from an organizational culture based on valuing and investing in people, as this orientation drives all behaviors and decisions rather than depending on the happenstance of a kind caregiver.

The person-centered culture also seeks to transform the behaviors and interactions among staff to one also based on respect and consideration. Mutual respect lays the foundation for valuing each staff member and their contributions to the community. Practitioners in person-centered care find that this in turn gives rise to an altruistic nurturing and empowering culture in which everyone shares the common goal of optimizing the well-being of both residents and staff. With the core values and philosophy of PCC fully integrated into an organization's culture, assistance and services provided for the residents can be carried out with a focus on optimizing their autonomy, dignity, privacy, physical function and psychosocial well-being (Interviews, 2009).

2. Relationships and Community Element

Studies have found that for most direct caregivers, their relationships with *residents* are a primary, and for some the primary, source of job satisfaction (Ball et al, 2009, Gittell et al, 2008). In the words of one caregiver, "They (residents) are the reason I come to work" (Ball et al, 2009). It is through their relationships with residents that they find meaning in jobs that typically have low status and few tangible rewards. While the bonds of relationships mostly

offer positive interactions, direct-care staff can suffer emotionally when residents are in pain or dying. Relationships are also crucially important to residents: one recent study found that the rate of clinical progression of dementia may even be slowed by close relationships with caregivers (Norton et al, 2009).

Study found that socialization offered from organized group programs was not enough to support psychological well-being.

A study conducted in assisted living found that resident socialization offered from organized group programs was not enough to support psychological well-being (Cummings, 2002). The study determined that assisted living needs to develop strategies to enhance relationships among residents themselves, and between

residents and staff. In “Relationships 101: What Every Leader Needs to Know,” John Maxwell identifies five features necessary for successful relationships: respect; shared experiences; trust; reciprocity (looking out for one another); and mutual enjoyment. As each human being is unique, the type and quality of each relationship understandably will vary. For example, if an elder prefers formal interactions, relationships with that individual will be respectful, kind and compassionate, but perhaps not as informal as with someone who enjoys joking around.

Relationships are the *individual* interactions community members experience with one another. *Community*, on the other hand, is a unified body of individuals linked in this case by a common location — assisted living. The sense of belonging to a community is related to relationships. A resident new to an assisted living community may not know anyone and will likely not feel a sense of belonging. As relationships

are established, a sense of belonging — being part of something that reflects one’s values and interests — will develop and strengthen for the new resident over time.

Relationships and a community bond offer context and meaning to daily life. Spontaneous engagement occurs when people know and like one another. On a rainy day, a visiting family member might invite a small group of residents to do a puzzle together. A cook may have leftover dough and decide to bake small tarts to surprise people at the afternoon social. A housekeeper may see wild flowers on his or her way to work and pick a handful knowing a fellow co-worker loves flowers. Any number of things can bubble up; the point is that a solid foundation of relationships and sense of community are key ingredients for the recipe of fostering psychosocial well-being and purpose and meaning in daily living. Some communities decide to hold weekly community gatherings as an opportunity to bring everyone (e.g., residents, family members and staff) together. All GREEN HOUSES®, for example, have a large dining room table so residents, staff and visitors can eat meals together and enjoy each other’s company.

Two key features are needed in the work culture in order to support relationships and community:

1. An unwavering commitment by senior management—owners—governance and leadership to a culture that supports relationships and community; and
2. Establishing processes to support this element (e.g., orienting all new staff, residents, family members and volunteers to this culture; governance, leadership, managers model strong relationship skills; staff, residents and others are recognized and appreciated for ways in which they contribute to making a strong community).

“Relationships are not only the heart of long-term care, they are the heart of life.”

A person-centered culture involves more time upfront than a task-centered culture. It stands to reason that transforming operational practices takes time. A noted expert in workforce practices at the Harvard Business School writes that these upfront costs of learning have a payoff in future performance (Edmondson, 2008).

Nurturing relationships and community are a circular and on-going process. If staff make a comment such as, “I could get my work done if the residents didn’t interrupt me so much,” that is a clear indicator that person-centeredness is not being internalized and operationalized by this staff member and processes may need to be reevaluated, revised and/or strengthened.

The following, written by an elder, is a moving outlook on the value of relationships and community. “When I am with someone with whom I have a relationship, I know that I am living. Surrounded by people who are strangers, funneled into daily routines that are unfamiliar and uncomfortable, my life is unknown to others. I’m not sure I am alive. It’s as though I have fallen out of life...Relationships are not only the heart of long-term care, they are the heart of life” (Williams, 2003).

3. Senior Management–Owner–Governance Element

This element refers to the highest decision-making authority level of an entity such as senior management, owners or members of the board of directors. Different terms resonate with different entities depending on how they are structured. The Senior Management–Owner–Governance Element is an essential cornerstone of PCC since key decisions that impact the operation and culture of an organization, such as the budget and number of staff hired, are decided by them. Without their commitment and active involvement, PCC cannot be sustained over the long term.

Experiential evidence has found there is no substitute for truly understanding the transformational alchemy* that PCC ignites unless it is experienced first hand.

Active involvement can take many forms. One board of directors in Washington State, for example, started its PCC transformation process by going on a two-hour road trip to visit a community already integrating PCC practices. Each board member came away from this introduction energized and envisioning how they could become involved in the process in their own community. One board member volunteered to be a mentor to evening staff to help them reorient to person-centered skills. Another board member offered their services to the administrator to use however his/her skills were most applicable.

Active involvement is not the same thing as “micro-management.” To steer clear of that

* Alchemy is the power of transforming something common into something special (Merriam Webster’s Dictionary).

pothole, the senior management-owner-governing authority should view their PCC role as a “hands-on helper” as opposed to “executive decision-maker.” The hands-on involvement offers them first-hand experience about the transformation that takes place once a person-centered culture begins to take shape. This in turn will lead them to support operational decisions to further PCC.

The senior management-owner-governing authority should view their PCC role as a “hands-on helper” as opposed to “executive decision-maker.”

The following scenario helps to illustrate the value and importance of integrating this element. An assisted living owner hires a new administrator. The administrator attends a conference and upon learning about PCC decides to begin the process of implementing

it. The owner is aware of the decision and understands PCC at a theoretical level. Years pass and the owner is pleased with high resident occupancy, low staff turnover and strong satisfaction survey results. The administrator eventually leaves the organization for new challenges. The owner hires a new administrator who has no background in PCC. The new administrator begins to institute some operational changes that end up dismantling some key components of PCC. Staff try to explain why it is important to maintain the PCC culture, but the administrator misinterprets the feedback as resistance to new ideas and ignores them. Within six months, the culture reverts to pre-PCC culture resulting in staff turnover and satisfaction surveys showing high dissatisfaction. Would the outcome have been different with an owner actively involved in PCC? Most definitely as the owner would have understood and valued the PCC culture, and would have looked for an administrator with PCC experience.

4. Leadership Element

Formal leaders are those conferred the authority to execute certain responsibilities and include the executive director/administrator of the assisted living, and depending upon the size of the community, other staff members such as the Resident Services Director and middle managers and supervisors. There typically are also “informal leaders” who gain leader status through their influence. “If your actions inspire others to dream more, learn more, do more and become more, you are a leader” (John Quincy Adams). Strong formal leaders will identify talented informal leaders and use their natural leadership skills effectively.

Strong leadership is essential to effectively implement PCC in part because operational changes typically generate resistance. Resistance is normally fueled by comfort of the known and fear of the unknown. Effective leaders address the fear of the unknown directly and ensure that change decisions will be collaborative and will continually be evaluated. Through a participative evaluation process, leaders gain valuable feedback and are able to quickly respond to concerns.

For leaders who utilize a top-down, hierarchical management approach, the transition to a PCC culture will require dramatic changes in their management style and practices. Research and anecdotal evidence have demonstrated that the hierarchical, top-down style of leadership is not conducive to PCC (Donoghue & Castle, 2009; Holleran, 2007; Keane, 2005). Studies conducted in nursing homes have found that the hierarchical model limits direct-care staff involvement and participation in decision-making, and minimizes utilization of their skills and knowledge (Ochsner, Leana & Applebaum, 2009). According to Ken Blanchard, a national expert in leadership, “The key to successful

leadership today is influence, not authority” (Blanchard et al, 2009).

There are many collaborative leadership models including Greenleaf’s servant leader, Goleman’s emotional intelligence, Collins “Good to Great,” and Chait, Ryan and Taylor’s generative leadership model among others. The key feature of these models is an emphasis on relationships over tasks. Michele Holleran, a noted aging services leadership expert, calls this model transformational leadership (Holleran, 2007). Another leadership expert coined the term S.E.R.V.I.C.E. an acronym for: service; education; respect; vision; inclusion; communication; and enrichment (Gilster, 2005).

Hierarchical leadership structures of traditional LTC do not build a community culture that centers on people.

In addition to the emphasis on relationships over tasks, collaborative leadership is hallmarked by a circular organization chart as opposed to one that is tiered. The hierarchical leadership structures of traditional LTC do not build a community culture that centers on people, whereas collaborative leadership integrates the

culture of community and relationships that centers on people (Keane, 2007).

“Quality is found when service to others lives in the hearts of the people who work there” (Gilster, 2005). Herb Kelleher, the beloved CEO of Southwest Airlines for almost three decades, famously nurtured a staff-centric work culture. His management style is based on the belief that staff need to be treated as the number one priority because the way an organization treats its staff is the way they will treat its customers (Frandsen, 2009). Some organizations may

include this concept in their mission statement, but fail to transform systems and the processes to make it happen. PCC leaders need to not only understand the theoretical concept of a staff-centered work culture, but to also ensure that all of its operational systems and processes are realigned to practice it.

Other key characteristics of a transformational leader include (Interviews, 2009):

- Employing staff empowerment and decentralized decision-making practices;
- Investing in staff by fostering a continual learning environment both informally (through in-services and coaching) and formally (through professional trainings and educational opportunities);
- Continually recognizing and appreciating staff work efforts through genuine praise and encouragement;
- Modeling effective practices that motivate and inspire staff;
- Promoting creativity, innovation and problem-solving;
- Allowing staff to make mistakes from which they can learn and also become more empowered and engaged; and
- Taking time with all staff to periodically recognize and celebrate successes that can be easily identified through regular monitoring and evaluating outcomes.

Staff empowerment and decentralized decision-making are key leadership practices that support PCC outcomes (Donoghue and Castle, 2009; Holleran, 2007; Barry et al, 2005; Hannan, 2005; Kiefer et al, 2005; Dixon, 2003). Research provides abundant evidence that staff empowerment leads to higher rates of staff retention and lower turnover (Donoghue &

Castle, 2009; Castle & Engbert, 2006; Barry et al, 2005). Staff empowerment and decentralized decision-making practices go hand-in-hand as the act of empowering staff confers decision-making authority.

Senior staff, managers and supervisors entrust staff to address and make decisions that relate to their work responsibilities. This moves the nexus of action and decision closest to where it arises — a best practice management approach. This not only frees leaders to focus on the larger executive and managerial aspects of their positions, but encourages staff to participate in day-to-day decision-making. In PCC cultures, staff empowerment extends to all staff positions including food service, housekeeping and maintenance. (See the Workforce Element section of this paper for additional discussion about staff empowerment).

Leaders need to hold staff accountable for the outcomes generated by their actions and decisions. They first need to ensure that staff members possess the job competency needed and clear understanding of what authority is being delegated. Open communication channels are also needed so that there is information flow back and forth among leaders and staff, and outcomes are discussed and evaluated.

The Teaching and Learning Center at the Harvard Business School culled organizational research over the past two decades and found that there are three broad factors essential for organizational learning and adaptability — key features for any organization undertaking the transformative process of PCC. The three factors are: a supportive learning environment; concrete learning processes and practices; and leadership behavior that provides reinforcement (Garvin, Edmondson & Gino, 2008). These three factors are imbedded in the Leadership Element.

5. Workforce Element



A former United Nation's Secretary General noted that staff are the greatest asset of any organization (Annan, 2006). This certainly holds true for assisted living. Staff not only do the actual work of running an assisted living community, but just as importantly, are instrumental in creating (or not creating) a pleasant, welcoming and nurturing environment. A person-centered work culture values and shows the importance of its staff.

Senior management—owners—governance and leadership need to be knowledgeable about and committed to effective and evidence-based workforce practices. This is an example of the interrelatedness and interconnectedness of the elements in the PCC structural framework. If senior management—owners—governance and leadership are not modeling and committed to PCC's core values and philosophy, then they will not be able to successfully implement the Workforce Element, as one element builds upon another.

The Workforce Element incorporates PCC core values impacting everything from fundamentally respecting and empowering staff to recruitment and retention. PCC workforce practices are person-centered and as such are based on personal interactions and relationships rather than on task accomplishment. This rebalancing transforms the work culture from one that views the workforce as a "tool" to accomplish a set of tasks to viewing them first as people. Based on values in a PCC work environment, a manager

seeing a staff member in distress would seek to find out how the person is feeling. Based on the norms in a task-centered work culture, the manager is more likely to focus on whether the staff member is getting all of their work done. While each individual shift from a task driven to a person-centered work culture may seem relatively subtle, multiplied thousands of times, this shift can transform the workforce “esprit de corps.” It is for this reason that

the Workforce Element precedes, and is the foundation for, the Services Element. PCC services can not be achieved until workforce practices are transformed.

The following table illustrates differences between workforce practices in a PCC culture compared to those in a traditional long-term care culture (i.e., nursing home).

Person-Centered Care Culture	Traditional LTC Culture
Decentralized decision-making based on interests and needs of elder	Hierarchal decision-making based on needs of the organization
Empowered, multi-disciplinary self-directed work teams	“Departmental” modality — staff follow instructions from supervisors
Adaptive and flexible organization	Tightly managed organization
Elders and staff design routines and schedules based on the elders’ needs and preferences	Routines and schedules based on organizational needs
Any staff member assists residents	Direct-care staff provide assistance to residents
Staff value having “relationships” with elders	Staff value “professional” distance from elders
Addresses and resolves challenges as they occur	Addresses challenges only when they rise to problems
There is a sense of community and belonging	There is high structure and “order”
Continual assessment of outcomes	Sporadic assessment of outcomes
Low unintended staff turnover	Medium to high unintended staff turnover
Consistent staffing assignments	Rotating or varying staffing assignments
All staff involved in problem-solving	Leadership/management involved in problem-solving
Work culture fosters continual learning and opportunities for professional training	Work culture mostly trains through in-services
Staff, including direct caregivers, involved in care/service planning	No direct caregivers involved in care/service planning
All staff spend time socializing with residents daily	Activity staff spend time socializing with residents
Spontaneous socializing and meaningful activities occur throughout the day	Activities occur only when activity staff conduct it or have arranged it

Source: Adapted from the Pioneer Network

The “Better Jobs Better Care” national workforce initiative (IFAS & AAHSA, 2008), as well as other research studies, provide a wealth of information about effective, evidence-based workforce practices.

Hallmarks of a PCC work culture include:

1. Staff stability;
2. An appropriate number of staff (all shifts, all days of the week);
3. Leaders, managers and supervisors who are trained to lead and manage;
4. Staff who are effectively oriented, trained and mentored to build PCC skills and competencies;
5. Staff empowerment and delegated decision-making authority models;
6. Self-managed, multi-disciplinary work teams; and
7. Consistent staffing assignments.

Without staff stability, it is impossible to sustain PCC or any other quality effort. Research shows that assisted living staff turnover rates are comparable with the high rates of staff turnover in nursing homes (Ball et al, 2009; Sikorska-Simmons, 2005).

The intrinsic and extrinsic cost of staff turnover and the resulting negative outcomes destabilize not only efforts to provide quality care and services but also staff morale. Given multiple responsibilities, one study reported experienced staff training new employees often felt overwhelmed, thus compromising resident care (Barry et al, 2005). There are a cascade of negative effects caused by high staff turnover. For example, existing staff are continually orienting new staff members, which takes

away from their time and ability to properly attend to their responsibilities. In addition, new staff members need time to become familiar with the operational practices and to develop relationships with residents and staff which impacts PCC outcomes. Until staffing is stabilized, it may not be possible to optimize operational performance and see measurable progress toward PCC goals.

Providers may decide to use agency staff to fill temporary staff shortages, which generally only worsens the situation. Research indicates that agency staff have a negative impact upon staff morale, reduce service quality, and often lead to increased staff stress and frustration which in turn increases risk of on-the-job injuries (Dawson & Surpin, 2001). These findings explain why questions about an organization’s use of agency staff are increasingly being included in survey questions, disclosure documents and assessment tools. Use of agency staff is indicative of workforce instability issues. Staff satisfaction surveys and research demonstrate that job satisfaction is a key predictor of job stability; the less satisfied staff are, the more likely they are to leave (Donoghue & Castle, 2009; Barry et al, 2005; Castle & Enberg, 2005; Kemp et al, 2009; Sikorska-Simmons, 2005). An assisted living community with staff instability has reduced capacity to appropriately train, supervise, mentor and praise existing staff, as well as fewer opportunities for staff to form and nurture relationships with residents. This creates a cycle of negative outcomes for the organization, its staff and the residents.



Studies indicate that the estimated staff turnover cost for each direct-care worker is approximately \$2,500.

Studies indicate that the estimated staff turnover cost for each direct care worker is approximately \$2,500 (Ferrell & Dawson, 2007; Seavey, 2004)). This amount only includes the direct costs associated with recruiting and training new staff. One report estimated that in a typical assisted living residence with 67 staff and an average turnover rate of 73 per-

cent, the annual cost associated with turnover was approximately \$84,537 (Jacob, 2002).

Investing in workforce practices that enhance staff retention should be an easy executive decision even if only compelled by the financial ramifications. Imagine the benefits that could be reaped from an upfront financial investment of much less than \$84,537. Data from the “Better Jobs Better Care” research initiative found that retention strategies are not only inexpensive but are also an excellent return on investment (Ferrell & Dawson, 2007). Providers can experience financial benefits from: reduced workplace injuries that in turn lower worker compensation expense; improved operational performance and quality outcomes resulting in higher resident census; and a waiting list of people interested in working in the community, thereby reducing advertising fees, recruitment costs and administrative time.

Findings from a recent research study conducted in assisted living provide empirical evidence that having the appropriate number of care-giving staff to meet resident needs was directly related to residents’ emotional and physical health (Ball et al, 2009). While determining proper staffing levels is not complex, evidence

suggests that having an appropriate number of staff 24 hours a day, seven days a week is not systematically happening (Castle et al., 2009). Providers often respond that they can not afford to add additional staff, but there is mounting empirical evidence that entities that have fully functioning PCC operations realize significant financial savings. One entity experienced a financial savings of over half a million dollars due to decreased staff turnover alone (Gilster & Dalessandro, 2010). PCC outcomes cannot be achieved without the appropriate number of staff.

Before investing in staff orientation, training and mentoring, providers need to ensure that the right people have been hired for the right jobs: people who have strong skills, competency, interest, integrity, personality and temperament. According to a “Better Jobs Better Care” report (No. 3, 2005), “direct-care workers are put in situations that require unusually sophisticated interpersonal and communication skills. They are called upon to manage conflict, set limits, make ethical decisions, grieve and help others grieve, and support other members of their team. There is little in their training that addresses such complex psychosocial needs.” For staff to successfully master the complex skills required for their jobs, they need to be supported through thorough orientation, training and mentoring. Given this training and support, staff experience less stress, provide a more stable workforce and give improved levels of care (Hyde et al, 2008; Hollinger-Smith, 2005).

Staff members who are good at their jobs are often promoted to leadership positions. There are numerous benefits to promoting from within an organization. Candidates are already highly knowledgeable about the community and its operational practices, and their expertise, reliability and work ethic are known factors. Leadership positions, however, require

managerial and supervisory skills that staff being promoted may not possess, such as critical thinking skills and how to effectively manage people. In order for them to be successful, staff need to be trained and prepared for the skills needed for managerial positions.

Traditional teaching methods that rely on lecture and video are not an ideal training format (PHI & IFAS, 2005). Interactive and experiential training methods are more productive and beneficial. People have different learning strengths; some learn best visually, others by hearing information and still others by doing.

The more participatory and interactive the training, the more likely staff will integrate new knowledge and be able to use this information in their work. The best training methods allow staff to think through the barriers to integrating new practices and to work together to develop strategies for overcoming these barriers. By offering opportunities to develop team-based problem-solving, communication and critical-thinking skills, participatory training methods support decentralized decision-making and an empowered workforce.

PROCESS EXAMPLE

One PCC workforce process providers might consider is using a group interview process for hiring new staff. For example, when the assisted living community needs to hire a new resident assistant, four to six prospective candidates are all invited to one group interview facilitated by two to three staff representatives. The candidates are all screened by phone in advance about their skills and experience level, and understand that they would be participating in a group interview because they will be working in “teams.” The staff interviewers keep the tone of the interview light and relaxed, and ask questions that are completely unrelated to the position (e.g., If money was no concern, what would be your dream vacation?; Setting aside health considerations, what would your favorite ice cream sundae look like?; and What was one of the most memorable things that happened to you?). The purpose of the unusual questions is to create an atmosphere so the candidates become relaxed and the interviewers can observe their personalities and perhaps some attributes

such as compassion and kindness. Many of the attributes needed to be a good caregiver and team member are not easily discerned through the traditional interview process. The group interview provides a better way to glean this information. The effectiveness of the process hinges on the ability of the interviewers to make it fun and playful while observing carefully for “information” about the person. After the interview is finished, the interviewers remain together to discuss their observations and prepare notes about items of interest regarding the positive or negative attributes of the candidates that will help determine who is offered the position.

An unexpected response occurred during a group interview for a cook. One of the candidates responded to the “most memorable thing to happen” question by describing a time he got drunk on pay day and wrapped his car around a tree. Then he went on to explain that he does not drive on pay days anymore. Needless to say, this candidate was not offered the position (Love).



Self-managed work teams are the essence of staff empowerment. In self-managed work teams, individual team members make all decisions relative to their responsibilities. The level of decision-making often includes team member's coordinating the team's work schedule. Team members typically rotate in different roles on the

team. To be successful, work teams need to have fluid communication with management, regular team meetings, and routine interaction between teams and management (Yeatts, et al, 2004). Self-managed work teams truly reflect a major culture shift. This outcome is a result of governing authority and leadership investing energy and effort to overcome the built-in barriers from a traditional work culture in order for self-managed work teams to work.

In assisted living, work teams are typically configured to provide assistance and services for a small group of residents. The size of the assisted living residence will determine the appropriate number of work teams and the staff members included in each work team. A self-managed work team is responsible for the assistance and services needed by its residents. The work teams problem-solve and make decisions on items related to their responsibilities, and are accountable to leadership for outcomes. Work team members help residents with a wide variety of needs, such as laundry, preparing a meal after hours, spending social time together, bathing, light housekeeping, snacks, etc.

Research indicates the use of work teams results in higher performance and reduced

turnover (Yeatts & Cready, 2007). In most cases, properly implemented self-managed work teams can increase quality and productivity 30–40 percent and over 200 percent in better implementations (Chaudron, 2008). Work team members perceive their efforts to be important and meaningful. Building good interpersonal and self-management skills encourages teamwork which in turn increases staff commitment and job satisfaction (Sikorska-Simmons, 2005). Studies conducted in nursing homes that have application in assisted living found that the decisions made by work teams are, at times, more innovative and creative than those made by management because the team members are most familiar with the residents and the work process in comparison to management (Yeatts & Cready, 2007).

PROCESS EXAMPLE

The following are several examples of processes to support PCC work team practices:

- As a work team, create clearly defined work responsibilities and expectations;
- Have team members participate in the interview process to hire new team members; and
- Create rituals and traditions to celebrate the work team's successes and accomplishments.

(Another PCC workforce feature is for staff to consistently work with the same group of residents (known as consistent assignment). Consistent assignments helps staff get to personally know each resident and become knowledgeable about their individual needs, preferences and choices (Hannan, 2005). Staff know, for example, when a resident likes a warm evening shower and cup of tea before going to sleep. In addition to being essential to the provision of good care, consistency provides residents with a sense of trust that is invaluable to their sense of overall well-being. Consistent staff assignments have also been found to significantly impact factors such as staff retention, resident and family satisfaction and clinical outcomes (Ferrell & Dawson, 2007).

Consistent staff assignments have been found to significantly impact factors such as staff retention, resident and family satisfaction and clinical outcomes.

feedback. It likely will take some trial and error efforts until all staff are effectively communicating together. Leadership can help by modeling effective discussion behavior. Each assisted living residence will need to determine what method works best to bring staff together.

PROCESS EXAMPLE

While processes for in-person meetings and discussions are essential for nurturing and supporting staff community, other forms of communication can also be used effectively to support and motivate staff. One organization’s team members strengthen their bonds of community by writing a personal note on birthdays describing why they like working with them.

The workforce transformation process to a PCC culture will encounter challenges. The following describes a workforce challenge experienced by the RidgeOak assisted living community but is one that is commonly experienced. During the transition process some of RidgeOak’s employees quickly embraced the changes, offering support and enthusiasm. Others held back waiting to see whether the PCC changes would be effective. A few employees were never able to make the transition from the old culture to the PCC culture. These individuals eventually left the organization (Walton, 2009). That a community will lose a few employees initially during a transformation process is a given. The opportunity to replace them with stronger, more capable individuals can be a positive outcome.

In summary, achieving PCC outcomes depends on a stable workforce in which everyone (including owners, boards of directors and corporate executives) is oriented, trained and continually supported in PCC practices.

6. Services Element

Services that are person-centered integrates personal preferences, values, lifestyle choices and needs. Successful implementation of PCC, therefore, heavily depends upon effective integration and internalization of the philosophy of optimizing elder well-being — physical, social, emotional, spiritual and intellectual. Helping an assisted living resident maintain as much physical function as possible provides them with more independence. For example, if limbs are not moved, muscle tone breaks down. Physical function is diminished if muscle tone breaks down. Imagine that a well-meaning caregiver always brushes a resident's hair. The resident loses the opportunity to "exercise" their upper arm and shoulder muscles. Over time, the elder begins to lose some physical function. Staff and family members are oriented in PCC to encourage elders to do as much as possible for themselves to retain maximum physical function — an important feature of well-being and self-esteem. Caregivers learn when a little assistance can help someone maintain physical function and thus independence, such as helping squeeze the toothpaste onto a toothbrush or twisting open a tube of lipstick because arthritic fingers are very painful in the morning. The elder completes the rest independently.

The same approach holds for the other dimensions that contribute to well-being (e.g., social, emotional, spiritual and mental/cognitive health). A staff member aware of the emotional benefits of having purpose in daily life will use their knowledge about a resident's life story, interests, talents and capabilities to routinely discover ways to encourage each resident to share their interests and talents with others. For example, a staff member may suggest to a very social resident how a visit from them could really help the new resident feel welcome. As staff



gain practice and expertise, these interactions become more instinctual and spontaneous. One staff member, serving a breakfast table of four men she knew well, noted to one of the men, "I put a lot of brown sugar in your oatmeal, so taste it before you add more sugar." The resident picked up his spoon, smiled kindly at her and said, "You're a good girl" (Baker, 2007).

The relationship-based focus of PCC has recently been found to have an important benefit not previously identified. A study in GREEN HOUSE® homes of the relationships of nursing home direct-care staff, nurses and the models of care found that the high level of familiarity the direct care staff had with elders led to very early identification of changes in health condition, facilitating timely interventions (Bowers, 2010).

The following family member experience is presented to show the opposite of desired PCC outcomes. "They put all their money into the plants and much less into staff training. My mother waited one hour for pain medication. Why couldn't it be that the staff and (residents) take an interest in each other? Why can't they (staff) see the (residents) as real people with pasts they would want to get to know? (Baker, 2007)." The Services structural element provides innumerable opportunities to help optimize resident social, emotional, spiritual and mental/cognitive well-being, happiness and health through personal interactions with services such as: assistance with bathing, dressing, and grooming; serving meals; administering medications; and transportation to an appointment or outing, among many other interactions. The key is understanding that effort and action are needed to make it happen.

PROCESS EXAMPLE

"I" CENTERED SERVICE PLANS

Changing the style of creating service plans to the "I" centered format improves upon the ability of staff to better reflect the emphasis on the "person." Working with the resident and any personal representative they choose, a multidisciplinary team approach is used to create the service plan written from the resident's perspective. Not only does the "I" centered service plan respect the resident's preferences, interests, values, lifestyle choices and needs, but it, as importantly, presents it in a written format to help staff stay focused on the personal nature of providing assistance.

The following are some examples of "I" centered service plan items:

Ambulation — instead of noting "ambulation twice a day," an "I" centered service plan would say, "I need to walk twice a day for 10 minutes of exercise. On sunny days I like to walk outside. GOAL — I want to remain as active and ambulatory as possible."

Incontinence — instead of noting "toilet every two hours during awake time," an "I" centered service plan would say, "I have difficulty with continence and would like reminders to use the toilet after each meal and before I go to bed. GOAL — I want to maintain my dignity about staying continent and not use incontinent products for as long as possible."

Memory Challenges — instead of noting "resident needs cueing and orienting because of memory loss," an "I" centered service plan would say, "I sometimes experience confusion and do not know where I am. This confusion causes me to become frightened. Please approach me gently using a soft voice to reassure me that I am not lost. This calms me and lessens the chance that I might strike out. GOAL — I need help to manage my memory challenges and retain my dignity."

Staff in a PCC culture understand that their job responsibilities involve helping optimize resident’s multi-dimensional well-being. How each staff member goes about achieving this will vary because each staff member has unique personality attributes that interact distinctively with each resident’s unique attributes. Something as simple as a smile or gentle touch can convey compassion engendering emotional happiness.

PROCESS EXAMPLE

In communities that are already operating in an open, trusting PCC culture, one way for administrators/executive directors, managers and supervisors to evaluate whether systems and processes are achieving desired outcomes is to spend two consecutive nights in the assisted living residence and be on the receiving end of assistance. While the director or manager will not actually need assistance with bathing, dressing or grooming, this exercise provides a first-hand opportunity to witness the nature and quality of services. After the two days, the staff would meet together to discuss outcomes. This exercise provides an effective way to meaningfully involve staff in evaluating this structural element. Perhaps several months later another staff member could “move in” to continue the cycle of evaluating operational performance and whether desired outcomes are being achieved as a team.

7. Meaningful Life Element

The humanistic focus of PCC promotes a holistic* outcome to engagement and socialization for elders — meaningful life. The term “meaningful life” express the element’s broader context beyond “activities” to encompass purpose and psychosocial well-being. For the purposes of this paper, meaningful life is defined as: **optimizing residents’ holistic well-being through experiences for elders that affirm their sense of self; promote purpose, enjoyment, and meaning in daily life; and that foster connections with others.**

Jitka Zgola, a well-known activity specialist, describes meaningfulness as: “having purpose; it is done voluntarily; it feels good to the participant; it is socially appropriate; and it imparts a sense of success.” Beth Baker recounts in her book *Old Age in a New Age* (page 144) a Pioneer Network workshop she attended led by Virginia Bell, herself an elder, in which Ms. Bell urged the participants to think of activities in a much more organic, natural way. “Older people and people with dementia need help to make them feel connected, feel loved, feel respected. Whenever we do that, we do an activity.” This seminal phrase, “whenever we do that, we do an activity” is paramount to the understanding that **anyone and everyone is involved in helping elders experience meaningful life and that it is not simply a task relegated to someone hired for activities.** This is a key tenet of achieving PCC outcomes for residents. It realigns the pattern of daily life to dynamically involve everyone in meaningfulness.

* The term “holistic” is used in this paper to mean the consideration of the whole person and situation (e.g., physical, mental, emotional, intellectual, spiritual, environmental).

Employing these features fosters an environment in which personalized interaction, mutual enjoyment, and a sense of belonging and purpose can flourish.

Reflecting back on John Maxwell's five features for successful relationships noted on page 11 (e.g., respect, shared experiences, trust, reciprocity [looking out for one another], and mutual enjoyment), one can understand how the core philosophical value of relationships underpin meaningful life. Employing these relationship features in daily life with elders and

co-workers fosters an environment in which personalized interaction, mutual enjoyment, and a sense of belonging and purpose can flourish.

Opportunities to engage and be stimulated can bubble up spontaneously or as planned events, and can be experienced individually or within a group. Spontaneous activities can be short and as simple as walking past a group of residents and breaking out into singing "You Are My Sunshine" for someone who likes to sing and has an outgoing personality, or looking through a book or photo album together, taking a walk, or sharing a funny comment (Love, 2007; Laurenhue, 2000). Individual spontaneous events themselves may reach a small audience, but when everyone in the assisted living community is invested in the practice, the effect can be transformative.

The activity specialist may be responsible for coordinating and/or scheduling activities, but others in a PCC community are just as likely to do so. A key role of the activity specialist in PCC is to talk with residents, staff and family members to identify ideas and suggestions for group activities and entertainment. This approach is significant because it changes the dynamic from

residents being passively entertained to one in which they are, to various degrees, actively engaged — just as they were prior to moving into the assisted living community. When the "community" of people in the assisted living community are fully involved, even changes to the typical array of planned activities and outings happen. Interesting activities such as cooking, landscaping, scrapbooking and computers are included (Walton, 2009).

In one assisted living community, a new resident declined to participate in most planned activities. During a service plan meeting, the resident's daughter mentioned her mother loved to play Scrabble. Since the daughter did not know others yet in the community to help find a Scrabble-playing partner for her mother, the staff offered to help. They found a partner who made the resident happy to be able to do something she enjoyed, and the daughter pleased to know that her mother's well-being was important to staff (Baker, discussion 2009). In another community, a resident said that she missed playing Gin Rummy. Two other residents and a staff member spoke up saying they loved playing cards and would play with her — and did so.

The notion of whole-person wellness was introduced back in the late 1990s by a forward-thinking retirement community in Harrisonburg, Virginia — Virginia Mennonite. The six dimensions of its wellness model include the following domains: physical, social, intellectual, emotional, spiritual, occupational and environmental (Edelman & Montague, 2008). Wellness also includes kinesthetic and sensory experiences in addition to these six domains. The multi-dimensional wellness needs of people are important to keep in mind, so that interactions and engagement are not overly focused on any single domain, and that over a reasonable time period elders have access to all the wellness domains.

Activity items and materials need to be readily available and not locked away in cabinets. A rainy day, for example, may spur a resident to pull out a puzzle or a deck of cards. It is also beneficial to have activity items that encourage extended family members to visit such as toys and an outdoor swing set for children. One assisted living residence keeps a jar full of dog biscuits on the reception desk; a great way to signal that the residence is pet friendly.

PROCESS EXAMPLE

One effective PCC group engagement tool used widely by PCC supporters is a “Learning Circle.” A Learning Circle provides an open discussion forum that involves each participant, drawing out shy speakers and limiting others who may typically monopolize conversations.

Learning Circles are easy to set up and simple to do. Community members (residents, family members and staff) gather and sit together in a circle — if possible without a table in the middle. Someone volunteers as the facilitator and initiates discussion by asking a question or presenting a topic. Someone else in the circle volunteers to speak first; then going around the circle one by one, everyone gets a chance to talk. Others in the circle are not permitted to talk until it is their turn. The more practice community members get using the Learning Circle³ for group discussions, the easier the conversation flow becomes. This technique may be helpful to use to discuss issues and problems a community may be experiencing.

Since people have different needs for solitude and social interaction, what constitutes meaning and purpose is not the same for everyone. Some people prefer solitary activities such as reading books or listening to music all day. Others derive satisfaction and purpose from helping others. Since PCC is person-centered and based on personal interactions, staff know what each resident prefers.

It is important for well-being to nurture mutually enriching relationships which means that elders are not always on the receiving end of care. A component of meaningful life includes altruism; the unselfish regard for and concern about the welfare of others. Some people have a strong need to be altruistic, so meaningful life includes their active involvement in helping others. Translated to daily life, some elders may be just as likely as staff to volunteer around the “house” by setting the table, fixing flowers, visiting an ill resident, or to lead an exercise program. One PCC outcome is that residents do not feel like “guests” in their assisted living home. A measure of success for this outcome is observing altruistically inclined residents comfortable doing things around their home and helping others.

Volunteer opportunities for residents do not have to be limited to the assisted living residence and could include the community at large such as at a local animal shelter or church-sponsored thrift shop. A volunteer opportunity in the community may become an interesting way for an adult child or grandchild to engage with the resident outside of the assisted living residence.

There is strong connectivity and relatedness among the objectives of Relationships & Community, Service and Meaningful Life. You will know a community has achieved the goals of Meaningful Life when days are filled with the normal sounds of conversation and laughter among residents, staff and visitors.

³ <http://www.culturechangenow.com/pdf/learning-circle.pdf>

8. Environment Element



Thus far, the elements that provide the framework for building a nurturing, empowering organizational and operational culture that optimizes the well-being of its community members in a relationship-based environment have been described. The Environment Element addresses both the physical and emotional

environment. Beyond the bricks and mortar, PCC environments create an emotional atmosphere of home through the integration of design, space, light, colors, sound, furniture, furnishings and outdoor space. “Home” is: privacy; lived space; identity; power/autonomy; connectedness [things, people, activities]; and safety/predictability” (Carboni, 1990). Assisted living providers were pioneers in understanding the importance of the environment and purposefully de-institutionalized assisted living with residential features such as: handrails crafted out of woodwork; front porches with rocking chairs; and areas designed specifically for and include features of home including living rooms, sunrooms, private dining rooms, carpeting and wallpaper. Proponents of PCC strongly feel that using language such as “home-like” is inappropriate. Since the objective is to achieve a home environment, it should in fact be called home (Interviews, 2009).

The sterile, stark physical environments of many institutional LTC settings (i.e., nursing homes) were replaced in assisted living by such groundbreaking changes as: private rooms; elders

encouraged to bring their own furniture and furnishings; refrigerators in common areas for access to food 24 hours a day; laundry areas accessible to everyone; attractive pictures on walls including resident art throughout the assisted living residence; meals served on table linens instead of on bare table tops or trays; and no public address systems providing noise interruptions. These positive changes in design, furniture and furnishings also were beneficial for individuals with dementia as they provided recognizable and familiar context that was orienting and comfortable (Calkins, 2003; Brawley, 1997).

“Privacy” has been a distinctive characteristic of assisted living since its origin. Private living space is the embodiment of the commitment to privacy in both the founding philosophy of assisted living as well as PCC. In PCC environments, an elder only shares their living space at their discretion.

Besides incorporating features of home PCC physical environments support changes in elders’ physical function including sensory losses. Some of these design features include: flat doorway thresholds to help prevent falls; increased lighting throughout the community to support declining eyesight; and lift tracks installed in bedroom ceilings.

Some proponents of PCC are creating smaller, more intimate physical settings that are residential in scale. There are a number of models of the small house concept: Neighborhoods, GREEN HOUSE® homes, Households, Small House and Cottages. Some of these models require new construction (e.g., GREEN HOUSE® homes), while other models can be achieved through renovation, remodeling or retrofitting existing buildings. The smaller residence area is a common feature of these settings ranging in size from the GREEN

The smaller settings offer a better opportunity for getting to know everyone and forming house communities.

HOUSE® model and other small houses with 6 to 12 elders to households accommodating 16 to 24 elders. As well as providing a more intimate home environment, the smaller settings offer a better opportunity for getting to know everyone and forming house communities which is virtually impossible to achieve in large spaces.

The GREEN HOUSE® Project has developed principles and key associated practices that all homes are required to follow in order to ensure consistency. Many adaptations are made for specific needs such as urban environments, special care focused homes and cultural practices. Flexibility is ensured through the principles-based approach that allows many ways of implementing the goals of PCC and meaningful lives. Features of GREEN HOUSE® homes include:

- A hearth communal area and open kitchen area
- Dining area with a single table large enough to seat all elders, staff and two guests
- Private bedrooms with full bathrooms and medicine cabinets
- Ample natural light
- Mechanical lifts installed in the bedroom ceilings
- Secured outdoor space easily accessible from the hearth area and available to elders at all times

There is a growing body of research on small environments (Calkins, 2008; Kane et al, 2007). One study suggests that there are significant improvements in quality of life for elders, no detriment (and perhaps improvements) in quality of care, and potential for improvement in staff satisfaction (Bowers, 2009; Sharkey et al, 2009; Kane et al, 2007).

The Environment Element contributes importantly to PCC by providing a home environment that helps optimize emotional well-being and connectedness to physical features that are familiar and comfortable. Hopefully by this point, readers understand the circular and interconnected nature of all the elements and why it is not possible to fully achieve PCC outcomes without incorporating all of the elements that form the building blocks of PCC.

9. Accountability Element

“Accountability” refers to the responsibility of accounting for one’s actions and outcomes. There are multiple aspects of accountability in assisted living — internal (e.g., consumer, operational and organizational) and external (governmental). This final structural element is the bellwether to test whether or not the other eight structural elements are achieving desired outcomes.

In order to be held accountable, an organization needs to identify desired outcomes and a method of evaluating them. Measuring and tracking performance outcomes are essential to the *internal* evaluation process. Once performance data (e.g., monthly staffing reports to monitor staff stability; weekly/monthly resident fall reports to monitor for resident care and safety; review of residents’ mobility status; resident/family and staff satisfaction survey reports) have been collected, the data needs to be analyzed for findings. Once findings are determined, the

information can be utilized to inform whether operational and organizational processes are achieving the desired results.

All individual steps of the evaluation process are important. For example, simply looking at a monthly staffing report that shows a high rate of staff leaving and determining that staff stability is a problem without going through the steps to analyze the findings might provide an incorrect assessment. Perhaps the staffing report was for the month of August, and every August the assisted living residence loses many part-time staff who are returning to school. A trend analysis of the staffing report would have noted this and the fact that this turnover was expected.

An assisted living residence committed to PCC needs a means to regularly assess and evaluate if operational performance is achieving the desired outcomes.

An assisted living residence committed to PCC needs a means to regularly assess and evaluate whether operational performance, including systems and processes, are achieving the desired outcomes. Collecting operational performance data through internal means is an important step. Equally important is collecting performance data through external means such as from resident, family and

staff satisfaction surveys. These stakeholders are key informants and the findings from the surveys need to be regularly evaluated for internal quality control. It is also very important to share the satisfaction survey findings with all of the stakeholders, and to discuss what actions can be taken to address any problems identified through the surveys. When staff,

residents or family members are candid in filling out a satisfaction survey, they are implicitly trusting managers to use this information to make a difference. This trust can be damaged if managers fail to offer feedback on what they have learned. Assisted living management may get one set of candid satisfaction surveys if they omit the step to share and report back on how problems raised will be addressed, but future respondents may not be as candid and the rate of survey completions may decline. Most assisted living communities will not have the professional capacity to develop its own satisfaction survey tools. There are a number of national companies that provide survey tools at a variety of price points.

There are critics of satisfaction surveys who feel that the purely subjective nature of this measure does not hold to rigorous scientific standards. However, the national companies that create these survey instruments use methods to ensure the psychometric properties of the questions — that the questions measure the concepts intended. It is difficult, if not impossible, to understand operational performance solely in terms of process measures (Edmondson, 2008) such as number of hours staff worked; number of residents cared for; and number of medications administered. Satisfaction surveys ask crucially important questions about quality of life features such as: do staff care about you; are your needs met in a timely fashion; would you describe your daily life as enjoyable.

For companies that operate multiple assisted living communities and that have developed organization-wide operational practices, accountability at the organizational level is critically important so that there is not a disconnect between what corporate staff deem as effective outcomes and practices and desired outcomes and practices at the community level. To understand these dynamics, corporate staff

can benefit from conducting regular surveys completed by the assisted living operational leaders about its organizational practices. As noted earlier, the survey findings need to be shared with the operational leaders including a discussion about what actions can be taken to address problems that surfaced from the survey process.

Assisted living providers are more than familiar with state regulatory accountability. State surveyors generally focus on strictly evaluating a community's compliance with regulations and not with evaluating the aggregate outcomes achieved. For instance, person-centered care implies that residents make decisions for themselves. These decisions may not always be in their best interests. The frequently cited example of a resident with diabetes requesting a piece of cake is a good illustration of the paradox

that might arise if a regulator strictly follows safety language in regulations to the detriment of residents' right to choice and autonomy.

Accountability should not become the tail that wags the dog. In other words, it is important for staff to always ensure that they are meeting all regulatory requirements, but not to be solely focused on this. Both internal and external means of accountability are important: state survey accountability for demonstrating compliance with the state's regulations; and internal accountability to monitor quality performance. Some nursing home implementers of PCC have had the exasperating experience of state surveyors, unknowledgeable about PCC practices, citing them for a deficiency (Stone, Bryant & Barbarotta, 2009). Fortunately this is the exception and not the norm.

Person-Centered Care for Persons With Dementia



According to the Alzheimer's Association, residents with dementia account for more than 50 percent of the assisted living population (Alzheimer's Association, 2006). It, therefore, is important to address PCC as it relates to these individuals. PCC's focus on relationships makes a significant difference when working with residents with dementia

(Sullivan, 2009; Norton et al, 2009; Moyle et al, 2007). Working consistently with the same residents, staff get to know each resident and their needs, preferences and routines. If a resident is not capable of articulating their needs and choices, staff are able to honor lifelong preferences and habits learned through discussions with the resident's family members or other loved ones (Kantor, 2008).

PCC is very effective in reducing behavioral symptoms associated with a dementing disease process (Gitlin et al, 2009; Verity & Kuhn, 2008; Moniz-Cook et al, 2003). Aggressive or resistive behavior is often a defensive reaction taken by a resident when feeling threatened and anxious (Verity & Kuhn, 2008)). In addition to PCC providing improved outcomes for residents, desirable outcomes have also been identified for staff. Staff who perceived themselves to be better trained in dementia care were more likely to utilize PCC skills, report more job satisfaction, and to have reduced incidence of turnover (Zimmerman et al, 2005).

The Alzheimer's Association began a national initiative in 2006 to develop, through a consensus process, recommendations for dementia care practices based on evidence from research and expert practices for assisted living residences and nursing homes. Recognizing that PCC has become the gold standard of quality (IOM, 2001), the recommendations are based on the principles of PCC and echo the information detailed throughout this paper.

The fundamental elements identified for effective PCC dementia care from the Alzheimer's Association's consensus recommendations (Alzheimer's Association, 2006) include:

- People with dementia are able to experience joy, comfort, meaning and growth in their lives.
- For people with dementia, quality of life depends on the quality of the relationships they have with the direct care staff.
- Optimal care occurs within an environment that supports the development of healthy relationships between staff, family and residents.
- Good dementia care involves assessment of a resident's abilities, care planning and provision, strategies for addressing behavioral and communication changes, appropriate staffing patterns, and an environment that fosters community.
- Each person with dementia is unique, having a different constellation of abilities and need for support, which change over time as the disease progresses.

- Staff can determine how best to serve each resident by knowing as much as possible about each resident's life story, preferences and abilities.
- Good dementia care involves using information about a resident to develop "person-centered" strategies, which are designed to ensure that services are tailored to each individual's circumstances.

Assisted living residences that choose to care for individuals with special needs besides dementia, such as those with developmental disabilities, ALS or Parkinson's disease, will also need to ensure that its staff are effectively trained in the sensitivities and skills needed to support these residents' special needs.

Final Person-Centered Care Considerations



Quality assisted living, whether for individuals with dementia or otherwise, requires strong, effective and knowledgeable leaders with a diverse set of operational and management skills and competencies. Standard practices for formally educating, training, mentoring and nurturing assisted living leaders are not fully developed

in this country. Assisted living leaders acquire their skills in a variety of forms including academic training, on-the-job experience, state certification/licensing programs, company training programs, state and national conferences, and individual mentoring. Leaders may lack formal learning opportunities depending on location and setting. Some leaders come to assisted living via nursing home administration or through hotel services. The lack of adequate leadership training and mentoring opportunities leave leaders unprepared and lacking essential skills, which can lead to job dissatisfaction and leaving the profession — all of which impacts upon quality and an organization's ability to achieve and retain PCC outcomes. Research is needed to study how best to effectively educate, train and mentor assisted living leaders.

Because there is such wide variety in assisted living communities ranging from small homes with four to six residents to large ones with over

a hundred residents, it is important to address the framework of PCC relative to this broad variance. The culture of the PCC philosophy, core values, relationships and all of the structural elements are the same in a small home as in a large one; only with some variations for scale. For instance, in small homes, the owner (Senior Management-Owner-Governance Element) may also serve as the administrator (Leadership Element) and provide some ADL support and cooking (Workforce and Services Elements). A small home staff may consist of a couple of workers who handle multiple responsibilities such as cooking, cleaning, direct care, laundry, and outings and work solo as opposed to a large home in which staff responsibilities are more narrow (e.g., housekeepers handle cleaning and laundry, resident assistants provide assistance for ADLs — Services Element) and staff work in teams (Workforce Element). The culture remains the same regardless of size; valuing each individual person and striving to optimize their well-being in a relationship-based home environment.

Lastly, there are several significant factors at work that could have lasting negative effects on assisted living. There is a national labor market crisis affecting the supply of direct-care workers and nurses (IOM, 2008). Poor workforce practices (e.g., inadequate orientation, not part of the decision-making structure, too much work required of too few employees, supervisors who lack people management skills, lack of appreciation and value of work contribution) have contributed to this crisis with results of staff recruitment and retention problems. Two noted workforce experts believe that improving

the jobs for the LTC workforce is a quality issue, an economic issue and a moral imperative (Stone & Dawson, 2008). Secondly, national and state financial policies for long-term care have moved toward supporting home and community-based services and thus an emphasis away from funding residential LTC (e.g., assisted living and nursing homes). This

issue is further compounded by public perception of quality problems in assisted living adding to consumer preference to remain in their own homes and thus utilizing home- and community-based services.

Research indicates that fully implemented PCC provides outstanding quality operations that

have the potential to positively affect the issues noted above. Baby boomers, a generation with a reputation for not accepting the status quo, are increasingly making the decisions about what aging services to utilize for their parents. Their preference is for PCC (Interviews, 2009). The elderly population needing some type of residential care is anticipated to more than double by 2050. Assisted living offers a prime environment to nurture and sustain a quality PCC living community. Where there is drive and motivation, much can be accomplished in relatively short time. After all, assisted living was created and grew to market saturation in less than two decades.

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Attachment A

Interviews (in-person or via telephone) conducted with:

Veena Alfred	Owner/operator of ALs in Maryland, sociologist
Mary Ann Anichini	Former DON, current LTC consultant
Beth Baker	Author of culture change book; AL family member
Sonya Barness	Gerontologist, PCC specialist
Jan Brickley	Consultant pharmacist, NC AL surveyor
Cecilia Burdis	Gerontological researcher
Maggie Calkins	Architect, gerontological researcher
Patti Cantillo-Kodzis	Nurse, training specialist
Paula Carder	Gerontological researcher
Emily Carton	AL administrator, geriatric care manager
Walter Coffey	Co-dir of GA Culture Change Coalition, former AL admin
Mary Tess Crotty	Regional Director, Genesis Eldercare
Bernie Dana	Academic, gerontological researcher, management
Kathleen Ustick	Dementia specialist
Susan Ganson	CARF accreditation specialist, former DON
Heidi Gil	Director LTC Planetree, former AL admin
Susan Gilster	CEO AL-NH-adult day care, nurse, dementia specialist, gerontological researcher
David Green	SAGE, Wellspring Initiative, former NH admin
Jean Harnett	NH and AL administrator
Jeanne Hyde Grubman	Gerontologist, dementia specialist, NH admin
Cindy Heilman	Registered dietician
Eric Haider	PCC specialist, NH admin
Dan Haimowitz	Geriatrician
Sue Hunter	AL administrator
Robert Jenkins	Director – The GREEN HOUSE Project
Bill Keane	Guide – The GREEN HOUSE Project, NH admin, dementia and PCC specialist
Annette Kelly	Gerontological researcher, nurse, former director FL Culture Coalition, former DON
Dan Kuhn	Dementia and PCC specialist
Marla Lahat	CEO – home care agency
Karen Larsen	CEO – CCRC
Anna Liisa	NH admin
Anna Marie Mariani Huehn	AL admin
Kim McRae	AL family member, dementia & PCC specialist
Michele Ochsner	AL family member, researcher
Doug Olsen	Gerontological researcher, leadership/management
Anna Otigara	The GREEN HOUSE Project, nurse, PCC specialist
Leslie Schultz	Director – adult day center
John Shoesmith	Architect, culture change design specialist
Lynn Snow	Gerontological researcher
Mary Tellis-Nayak	PCC specialist, former DON, former director LTC JCAHO
Vivian Tellis-Nayak	Gerontological researcher, sociologist
Jack York	PCC engagement specialist
Sheryl Zimmerman	Gerontological researcher, social worker
Del Zook	AL administrator
Tom Zwicker	NH admin, PCC specialist

Resources

PCC — General

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