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Feature Article

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

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ABSTRACT

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

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Introduction

The culture change movement within nursing home care has built momentum. Culture change envisions person-centered care (PCC) as better addressing nursing home quality of care and resident quality of life than the traditional medical model.[1] A key component of person-centered care is resident choice in daily life (e.g., self-made decisions regarding meals, grooming, entertainment, and sleep schedule). Some research evidence suggests that the resident choice process (more specifically than culture change) is tied to quality of life[2] and quality of care outcomes.[3] In additional studies, residents have indicated their own desire for such choice.[4]

To date, evidence suggests that U.S. nursing homes have not fully realized resident choice in daily life. Two studies have documented the extent of staff realizing everyday resident choice.[5,6] The results are discouraging; structured observations found staff not offering residents morning care choices a majority of the time. Given these findings, the question arises: What are the challenges to achieving the resident choice care process?

Limited nursing home-based research addresses this question. A few U.S. studies examine barriers and facilitators to culture change generally but not resident choice specifically.[7–10] Qualitative investigations more relevant to resident choice and to challenges in realizing it have been conducted outside the U.S. Two international studies centered on daily life choices but were circumscribed to highly specific choice domains; one focused exclusively on resident hip protector use,[11] while another focused on length of time spent in bed at night.[12] Another U.K. study most closely matched the topic of staff promotion of resident choice in daily life but within the context of interactions between service providers and individuals with intellectual disabilities.[13] Thus, qualitative research on U.S. nursing homes has

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yet to explore resident choice broadly and comprehensively across an unlimited set of domains of daily living.

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

Our research question was grounded in work that applies[14] self-determination theory (SDT) to the nursing home setting. SDT asserts the universal importance of autonomy for human beings. Kasser and Ryan (1999)[15] empirically tested aspects of SDT in nursing homes, establishing the important role that staff "support" of resident autonomy played in achieving resident-related reduced levels of depression and heightened levels of well-being, vitality, and life satisfaction. We assert that one aspect of staff supporting autonomy is helping residents experience choice in daily living. This paper thus sought to build upon SDT's pre-existing conceptual foundation by asking the following research question: "What do staff see as facilitators or barriers to their ability to support resident choice in daily life?" No *a priori* hypotheses were established given the exploratory nature of our inquiry.

Design and methods

Study design

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

Participants

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

No exclusion criteria were employed; eligible participants consisted of all CLC staff members (i.e., nursing staff, rehabilitation therapists, social workers, psychologists, physicians, chaplains, activities staff, housekeeping staff, and administrative staff). Senior leaders (i.e., CLC Associate Chief Nurse, CLC Medical Director, service line chiefs, and Medical Center Director) were also eligible. We thus triangulated our data sources across two sites, across multiple disciplines, and across hierarchical levels related to job position to ensure the richness and depth of the data.[16]

Interviews

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

Data analysis

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

We employed inductive thematic analysis of the interview data for our exploration of staff experiences with resident choice. Data analysis began with the first author repeatedly reviewing the staff interview data to identify inductively emergent codes and to assess connections amongst the codes to identify themes.[17] During this process, the first author developed a preliminary codebook with code labels and definitions as recommended by DeCuir, Marshall, and McCulloch (2011).[18] To ensure methodological rigor, the codebook was refined iteratively with repeat transcript coding by and consultative discussions with the senior author. The constant comparative method also guided analytic efforts. Prior data were constantly re-analyzed in light of codes that emerged in later analysis; thus, interviews coded earlier in the process were re-coded later on as the codebook developed into its final form.

Results

Twenty-six senior leaders, clinicians, and front-line staff members were interviewed for the parent study. (See Table 2 for "Staff Sample Characteristics"). Two main thematic categories emerged from the resident choice sub-analysis: 1) tensions in

Table 1
Sample interview questions related to resident choice.

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