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Client-Centered Care Approach to Group Home Care

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Abstract

Client-Centered Approach to Group Home Care

of Mentally Challenged Individuals

by

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MS, United States International University-Africa, 2001

BS, United States International University-Africa, 1999

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Abstract

Scholars since the 19th century have focused on the provision of care in group homes and have demonstrated that structure (that is, the staff, facilities, and equipment), is critical in the delivery of care. The researchers, however, advocate doing *for*, rather than doing *with* the clients the activities that address the clients' welfare. The purpose of this study is to investigate how a client-centered approach would affect the quality of care delivered to the mentally challenged individuals (MCIs) in a group home. The study employed the quality-care framework in which the emphasis is on structure (skills), process (efficiency), and outcome (results). The research questions examined operational values underpinning company sanctioned work processes, how personal values underpin work processes of the direct caregivers, configuration of personal values the caregivers believe should be supported in the group home context, and how critical incidents shaped the value set of direct caregivers in regard to care processes. Using structured questionnaires and observing staff as they delivered care to their clients, data were collected from participants who were direct caregivers (n = 7), a facility administrator, and a nurse. The data were coded, categorized, and analyzed for emergent themes. The results of the analysis indicated that there was discord between staff and the organizational leadership. This discord could be improved through increased interaction between the mentioned stakeholders. The results further depicted that client-centered care may have a positive impact on the health of the MCIs that would enable the MCIs to make notable contributions to social change.

Client-Centered Care Approach

To Mentally Challenged Individuals

by

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Dedication

This study is dedicated to my wife Mary M. Mugo, and our sons Eric W. Mugo, Lee M. Mugo, and Kevin N. Mugo, who have supported me and provided love and inspiration through this life's journey. Thank you so much!

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There have been many people that supported me through this long journey. First I want to extend my appreciation, thanks, and gratitude to Dr. Suzanne Richins for her mentoring, advice, guidance, and belief in my expertise-thank you! I also want to extend my thanks to my committee member, Dr. Ronald Bucci for his feedback and support through the dissertation process, and Dr. Vibha Kumar who ensured that the study adhered to Walden University research standards. I also want to extend my appreciation to the staff members of the group home where the study was done. I cannot forget to thank the many Faculty and students who provided their input throughout the process of researching and writing this dissertation.

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Chapter 1: Introduction to the Study

Negative attitudes towards the mentally challenged existed in the United States both before and after 18th Century (Milne, 2002) and these negative views have led to the stigmatization of mental illness and confinement of the sick in deplorable conditions (Milne, 2002). Institutionalization was deemed as the best option for taking care of the mentally ill individuals: thus, the availability of institutions increased access to mental services (Milne, 2002). Institutionalization, however, experienced underfunding from the government, and the shortage of staff led to the provision of poor living conditions and violation of human rights (Beadle & Mansell 2010). Advocates of the mental health care system reform were based on the assumption that mental patients would get better services within communities. They pushed for deinstitutionalization as the best option for treating the mentally ill (Walker, 2012).

Background

Discrimination of individuals with disabilities in community-based programs, which receive government finances in the United States is prevented by the Rehabilitation Act of 1973 (Walker, 2012). The enactment of the Rehabilitation Act of 1973 was designed to ensure equal rights and equal opportunities for the disabled population in the United States, and the maltreatment of disabled persons led to a wide-scale closure of institutions for the mentally disabled (Milne, 2012). The development of group homes emerged as an alternative living arrangement that promised an independent living environment that was integrated into community life (Walker, 2012). Since that time, group homes evolved from large congregate living arrangements, essentially

functioning as small de-facto institutions, offering highly routinized and de-individualized care to smaller group housing arrangements pledging adherence to a person-centered care model of communal living within the community context (Beadle-Brown & Mansell, 2010; Riley, 2012). The philosophy underpinning de-institutionalization was that mentally challenged persons would be better served by integration into the larger community with support and care options that respected their civil rights and promoted achievement of their potential (Beadle-Brown & Mansell, 2010; Milne, 2002; Riley, 2012). Researchers demonstrated that small group homes had the potential to provide residents with high-quality care outcomes, including behavior improvement and a reduced need for medication with an increased satisfaction among residents and their families (Ashman, Beadle-Brown, Mansell & Ockendon,2005; Beadle-Brown, Felce, Jones, & Lowe, 2000; Kozma & Mansell, 2009).

The findings demonstrated, further, that underperforming group homes were characterized by misalignment of power holder values with the organizational values, a sense of doing for the residents and not with the residents, a sense of staff centeredness, and resistance to organizational instructions (Bardi et al., 2008; Gehman et al., 2013). The situation indicated that client-centeredness to care was critical in reversing the trend in the underperforming group homes (Bigby C., Beadle-Brown, J., Clement, T., Knox, M., & Mansell, J., 2012).

Problem Statement

Although researchers have concentrated on investigating staff efficiency in the delivery of care to the mentally challenged (Walker, 2012), they have not tried to

understand the impact client-centeredness would have on the care provided at the group homes (Bigby et al., 2012). In the literature review, I identified a lack of information on how the client-centeredness process affects the delivery of care and underscored the need to investigate how the client-centered approach to the delivery of care (process) would influence the quality of care in group homes.

Purpose of the Study

The objective of group homes, which rehabilitate mentally challenged individuals, is to help their clients develop skills and access resources needed to increase their capacity to be successful and satisfied in living, working, and learning in social environments of their choice (Psychiatric Rehabilitation Association, 2012). One goal of this study was to understand if emergent value practices used in group homes impacted the quality of client care process. I intended to further explore the potential for process modifications to influence client care outcomes. The influences to outcomes were assessed using Donabedian's model (1980): structure, process, and outcome of quality care. The purpose of the study was to investigate how the client-centered approach practices were applied in a group home that rehabilitated the mentally disabled individuals in order to achieve their set goals.

Quality of Care Framework

Researchers and group home policy advocates promoted the shift from institutional care to client-centered care in group homes, and outcomes research provided compelling evidence that supported the design to maximize independent functioning and provide the greatest benefits for group home residents (Beadle-Brown & Mansell, 2010).

Emergent value practices as defined by Gehman et al. (2012) included repeatedly modifying work processes, which evolved to harmonize with the value hierarchy of the stakeholders. The impact of these modifications on the quality of work processes needed operative investigation.

Although emergent work practices in group homes possess the potential to significantly deviate from evidence-based best practices for client-centered care, Donabedian's (1980) model identified three domains relevant to high-quality client care: structure, process, and outcome. The structure refers to the environment and the resources necessary to provide services. Structure includes facilities, equipment, staff, and monetary resources. The process describes the techniques and practices used to provide care for the client. Outcomes are the end results realized by the recipient. According to Donabedian, good structure is a prerequisite to good process, and good process is a prerequisite to good outcomes. This model is depicted in Figure 1 below.

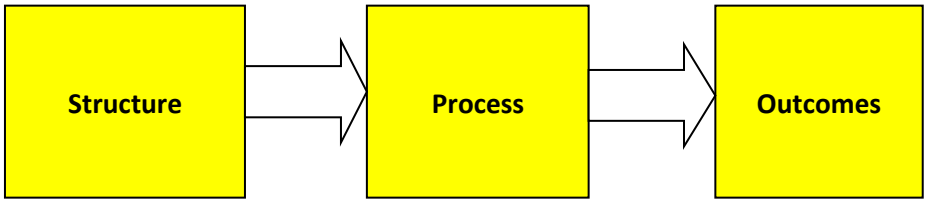


Figure 1. **Donabedian Quality Model (1).**

Since the model's inception, health services researchers have used Donabedian's conceptualization to study the varying contributions of each of these three domains (Larson & Muller, 2002). Accreditation bodies developed quality assessment standards based on each domain to award institutional accreditation to health services organizations (Joint Commission on Accreditation of Health care Organizations, 1986). Recent research

was directed towards refining and specifying the sub-dimensions of the health care process as first conceived by Donabedian and detailing the specific criteria that constitute quality in the medical care sector. To this end, researchers continue to explore the quality dichotomy first posed by Donabedian, the distinction between the quality of technically correct care (structure) and the quality of interpersonal care (process); (Donabedian, 1980).

According to Donabedian, technically correct care (process) is synonymous with evidence-based clinical medicine. High-quality technical care reflects scientific state-of-the-art progress in provider knowledge, skills, available treatment, and technology. This domain is also a flawless operationalization of the clinical process of care (Hagashi,T., Shekelle, P.G., Adams, T.L., Kamberg, C.J., et al. 2005) such that the patient receives maximum benefits while experiencing no medical misadventures. This component of quality is best judged by both an implicit and explicit peer review process that assesses the extent to which care adheres to clinically relevant criteria (Gupta, 2008). Consequently, the pursuit of high-quality technically correct care (process) was operationalized in the health care industry by the adoption of a variety of continuous quality improvement programs, which are routinely evaluated and refined by health service researchers and practitioners (Trivedi et al., 2005).

Donabedian (1980) defined the interpersonal side of care (process) as the social and psychological manner in which care is delivered. This component of quality care includes the extent to which the client is treated with respect and dignity through inclusion in the decision-making process and is afforded comfort and convenience

(Donabedian, 1983). According to Donabedian (1982), the interpersonal aspect of care (process) is the component of care that the client is best able to judge, and consequently features prominently in the client satisfaction initiatives so prevalent in the health care field over the past two decades. This quality domain defines and measures best practices (Enthroven & Vorhaus, 1997). In the most recent literature, researchers have examined the quality of care according to structure, process, and outcome, using either the technical (structure) or interpersonal (process) lens of measuring and judging the level of quality in the medical episode of care.

Significance of the Donabedian Model

Donabedian's (1982) framework was developed at a point when health care quality assessment was heavily reliant on the professional judgment of the care provider and the development of explicit criteria for judging quality was in its infancy. Donabedian's (1980) definition and framework encompassed the three dimensions of care: structure, process, and outcome. The three dimensions are still deemed important in the current age. The differing caregiver judgments regarding what is and is not high-quality created interest in work process, and thus, work process is currently used to assess quality care in the health sector (Donabedian, 1982). Similar to the hospital sector, work process in group homes reflects structural elements that may not benefit the residents (Kozma et al., 2009). The stated situation occurs when the residents are not involved during the implementation of activities, which affects their welfare. The emergent care process in group homes may impact the quality of care in any of Donabedian's three

major domains: structure, process, and outcome, and the role of the work process in the quality care enhancement rationalizes the use of the Donabedian quality framework.

Design of the Study

The methodology for the research is qualitative, which engaged a case study approach of one group home in Massachusetts that embraced a client-centered approach in the delivery of care services. Qualitative study methods have been used extensively in health programs and are good in explaining the views of the affected individuals or groups (Tellis, 1997). In order to get a picture of how issues regarding client-centered care developed, a case study method was used to gather focused data. According to Baxter and Jack (2008), a case study enables researchers to discover issues through diverse views, which enable the concerns in a situation to be understood. Yin (2003) explained further that a case study should be undertaken in an investigation to address the how and why of processes and when the content of the problem aims to understand a particular scenario. The phenomenon would be understood through gathering data from various sources in order to depict an in-depth evaluation of the situation (Creswell, 2007).

In a qualitative enquiry, there is no rule on the size of the sample, but it should be based on what the investigator wants to know, on what is useful and credible, and on whether it can be done within the available resources and time (Patton, 2002). It is, as such, not necessarily representative of the study population and should establish a deep understanding of the study population in relation to the research questions (Marshall, 1996). Large samples would create difficulties in teasing out rich data, and too small

samples cannot achieve data saturation (Onwuegbuzie & Leah, 2007). Onwuegbuzie and Collins (2007) recommended 12 participants sample as a general rule.

The participants in this study were seven caregivers who provided care to the individuals in three eight-hour shifts, one administrative staff member, and one nurse. Due to their different roles in the group home, the participants responded to work processes that related to their roles. A pattern of events consequently emerged and different themes were formed, which informed the conclusions made thereafter. Participants were staff members who had worked for 1 year at the group home. According to Patton (2002), this category of respondents selected would provide rich information on the issues under investigation. Validity and usefulness of the findings would not be influenced by the sample size, but the information gathered from participants and the skills of the investigator in observing and analyzing the events at the group home (Patton, 2002).

Case study methods are used extensively in health programs and provide a good explanation of views of the affected individuals or groups (Tellis, 1997). A case study involves gathering focused data through interviews, observations, records, and reports (Creswell, 2007). The collected information helps the investigator depict how conflicts regarding client-centered care process develop (Donabedian, 1980) and is critical in designing the intervention measures. A case study explores activities in the situation under investigation, and in this study, an investigation was undertaken in a group home that rehabilitated individuals with varying mental challenges and embraced a client-

centered approach to care. The study population included direct caregivers, nurses, and the facility administrator.

Significance

Previous studies (Beadle & Mansell., 2010; Milne, 2012) showed that group homes can only achieve best-quality outcomes when care is provided in a way that empowered the residents and not when the process of care is clinically empowered. According to Donabedian (1980), the administration of medication should be done on time and the right activities (bathing, eating, and toileting) in the group homes should be carried out effectively and efficiently. The activities which were implemented were compared with the organization's operational regulations and procedures.

The process describes the activities performed in the delivery of care that includes a provision of service that adheres to the recommended guidelines (technical quality) and the sharing of information between the caregiver and the residents (interpersonal quality). The outcome describes the effects of care after empowering residents on independent living, and caregivers' work output may serve as a part of the process in group homes (Walker, 2012). Residents play a critical role in their own health care outcomes when they are empowered in the implementation plan of care, set in motion through collaboration with their health care providers (Donabedian, 1980). The significance of the client-centered approach is that the strategy reduces stigma, which allows the mentally challenged individuals to eventually integrate into community (Walker, 2012) and to make their contribution to social change.

Research Questions

The study intended to understand the applied process of care in the rehabilitation of mentally challenged individuals in a group home in Massachusetts that practiced a client-centered approach in the delivery of services to its clients. This was a descriptive study, and the following research questions were developed:

RQ 1: How does the configuration of operational values underpinning company sanctioned work processes facilitate the client-centered care at the group home?

RQ 2: How have the critical incidents shaped the company sanctioned work processes to conform to client-centered care at the group home?

RQ 3: How does the configuration of personal values underpinning work processes of direct caregivers and the facility administrator conform to the client-centered care at the group home?

RQ 4: How have critical incidents shaped the value set of direct caregivers and the facility administrator to conform to the client-centered care at the group home?

Assumptions and Limitations

This case study of a group home focused on client-centered practices in its rehabilitative services to its mentally challenged clients. Assumptions were that I would be facilitated by the organization's management, the caregivers, and the facility administrator to undertake the investigation. The study acted as an evaluation and it was assumed that the management would use the findings to improve their practices. It was also assumed that the participants would be honest and would provide dependable information, which could be used in drawing the research conclusions. Case studies do

not have clear beginnings and end points (Creswell, 2007), and it was assumed that the study would stick to the scheduled time frames set for specific events.

Limitations are occurrences in a study, which are out of the researcher's control (Creswell, 2007). These limitations limit the extent of the study and sometimes affect the end result and conclusions (Patton, 2002). Limited access to only certain people in an organization, certain documents, and certain data present limitations (Patton, 2002). According to Creswell (2007), the findings in this type of study cannot be generalized. Similar group homes would, however, use the study findings to relate to their work practices and use the opportunity to adapt and implement what is appropriate to them; to enhance social change within different communities.

The convenience of interview times between the interviewer and the interviewee in the planned study could vary and thus, be a limiting factor (Patton, 2002). Therefore, an interview schedule that was convenient to the interviewer and interviewee was developed in order to facilitate participation. Situations may also not be favorable for effective observation (Patton, 2002), which is critical for understanding the client-centered care process. I selected times that were convenient for the effective observation of the process. However, the respondents may withhold information that would be important in the investigation (Patton, 2002) and be a limiting factor. The organization leadership encouraged and allayed the perceived fears of the participants.

Scope of the Study

The scope of the study refers to the parameters under which the study was undertaken (Creswell, 2007), and the problem under investigation was within the set

parameters. In the planned study, I investigated only the client-centered practices in the delivery of services in one particular group home that rehabilitated the mentally challenged individuals.

Definition of Terms

Facility administrator: Person, who plans, directs, coordinates, and supervises the delivery of health care in a group home (Walker, 2012).

Health care access: A concept that comprises accessibility, availability, acceptability, affordability, and accommodation, which determine the degree of fit between clients and a health system (Penchanky & Thomas, 1981).

Institution: Defined as any segregated setting where the disabled are not allowed to exercise control over their lives and to make decisions. This limitation can include poorly managed group homes. If caregivers act towards residents in a manner that limits the client's responsibility, caregivers can easily turn the community home into an institutional setting (Mansell & Beadle-Brown, 2010).

Person-centered care: Individuals are supported to make informed decisions about their own lives in order to be successful in the future (Riley, 2011).

Psychiatric rehabilitation services structures: Person-centered, person-directed, and individualized to meet the specific needs of service users. The services focus on helping clients develop skills and to employ resources needed to increase the capacity for success and for satisfaction in the living, working, and learning in social environments of their choice (Psychiatric Rehabilitation Association, 2012).

Summary

I began this chapter with an introduction to the study. In this introduction, I provided an explanation on the negative perception of the mentally challenged individuals that existed in the United States from as far back as the 18th century (Milne, 2002). The introduction was followed by a background that justified the study. The highlights of the background included that mentally challenged individuals were initially discriminated against, and this situation prompted advocates of human rights violations to push for mental health reform in the country (Milne, 2002). The situation required deliberate efforts within legal and political classes, which resulted in the enactment of the Rehabilitation Act in 1973 that protected the welfare of the mentally disabled individuals in the United States (Beadle-Brown & Mansell, 2010).

Mentally challenged individuals were first accommodated in institutions, which due to financial constraints failed to provide proper care (Milne, 2002). Many mentally disabled individuals ended up living in deplorable conditions until the government approved community-based health care (Walker, 2012). The government allocated funds from Medicaid to support community-based facilities that were developed with the aim of treating and integrating the mentally challenged within communities (Burke & Thomson., 2008).

The facilities, which operated as group homes, put emphasis on staff competency and created competition within staff due to increased individual and work values. This culminated in underperformance within group homes due to conflicting interests among caregivers, the clients, and the organization. Although researchers have concentrated on

the effects of staff efficiency to delivery of care, information on the effects of the client-centeredness process to care was lacking (Bigby et al., 2012). The situation depicted a literature gap on the effects of care process in group homes that engage in the client-centeredness care approach and was explained in the problem statement. The investigation was a case study of a group home that engaged in a client-centered approach to the delivery of care to its mentally challenged clients, and as such, the findings of the study cannot be generalized (Creswell, 2007). The findings can, however, be adapted and implemented by similar group homes in order to enhance social change. The quality care framework that applies to the individuals' approach to care delivery and the concept of interpersonal relationships (process) as a prerequisite for optimal outcomes in the delivery of care (Donabedian, 1980) was explained, and a rationale for use of the quality care framework in the study was provided in this chapter.

The purpose of the study was to investigate how client-centeredness was practiced in a group home that embraced the client-centered approach in order to enable their mentally challenged clients realize their goals in life. The significance of the study was that the client-centered approach minimizes stigma and facilitates the integration of the mentally challenged individuals into the community (Walker, 2012). Four research questions that address care process issues in a group home were presented.

The scope of the study was restricted to one particular group home in Massachusetts that engaged in the client-centered approach in rehabilitating its mentally disabled clients. Several realistic assumptions were made. Study limitations were outlined and possible mitigation measures suggested. The definition of terms was provided for

clarity of terms that are used in the study. The Chapter one is followed by a review of the relevant literature in Chapter two. Chapter three follows with a description of the study design, participants, procedures, assessment that was used, and information on how the gathered data were assessed.

Chapter 2: Literature Review

Background

The deinstitutionalization movement that began in the United States in the 1950s resulted in the closure of many large psychiatric institutions where conditions were revealed as routinized and deplorable (Riley, 2012). The philosophy underpinning deinstitutionalization was that the mentally disabled would be better served by integration into the larger community with supports and care options that respected their civil rights and promoted achievement of their potential (Beadle-Brown & Mansell., 2010; Milne, 2002; Riley, 2012). The privately run, state licensed, community-based group homes arose to serve as the housing and care alternative for the deinstitutionalized mentally disabled population with the expectation that these homes would provide more compassionate and less restrictive care (Riley, 2012; Semmelhack, Hazell, & Hoffman, 2008). Conceptually, a group home was meant to be a small supervised congregate living arrangement in which disabled individuals would participate in communal life and community life to the best of their ability (Semmelhack et al.). In reality, deinstitutionalization was not accompanied by either well-conceived or well-funded initiatives to ensure that disabled individuals were provided with the resources and care necessary to achieve the conceptual ideal; instead, early group homes were relatively large and functioned as de facto institutions. These homes continued to provide routinized and de-institutionalized care that restricted resident movement in and out of the surrounding community (Riley, 2012; Semmelhack et al., 2008; Thomson, 2008).

Funding, Regulations, and the Proliferation of Group Homes

The 1999 Supreme Court's Olmstead's decision was a milestone in the mental health disability sector because it recognized the importance of integrating individuals with mental disabilities within the community subject to professional advice of the physician, the affected individual's willingness to this approach of treatment, and the funding agency's financial resources (Thomson & Burke, 2008). Mental health disabilities were included under the Home Community-based services (HCBs) management approach and qualified for funding from both the state and the federal governments, and a 1915c programs waiver gave states an opportunity to assist institutions such as group homes, which offered home-based services (Thomson & Burke, 2008).

There was bipartisan consensus within political parties that serving individuals with mental disabilities at community-based facilities, rather than in institutions, was a good option for the United States (Thomson & Burke, 2008), and as such, political parties advocated for several changes in the implementation of Medicaid with an emphasis on the support of Home Care Based Services (HCBS) through the Deficit Reduction Act (2005). Medicaid was prevented through the introduction of 1915b waiver programs from discriminating institutional long-term care beneficiaries, such as the mentally disabled individuals (Smith & Moore, 2008).

The states were, through the Omnibus Budget Reconciliation Act (1981), allowed to be creative in the Medicaid program, and by including the mentally challenged in the HCBS, were enabled to allocate additional funding to these services (Smith & Moore,

2008); this funding led to an increase in the number of group homes that provided care for the mentally challenged (Riley, 2012; Semmelhack et al., 2008; Thomson, 2008).

Quality of Care in Group Homes for the Intellectually Disabled (ID)

Researchers demonstrated these small group homes have the potential to provide their residents with high-quality care outcomes, including behavioral improvement, a reduced need for medication, and increased satisfaction among residents and their families (Felce et al. 2000; Kozma et al. 2009; Mansell et al., 2005). Researchers further demonstrated that better care outcomes were associated with those homes with staff who actively support resident's achievement; however, some disagreement exists as to the exact care processes that constitute best practices in resident support. Reinders (2010) determined that a high-quality relationship between caregiver and resident was essential in interpreting the client's needs because many intellectually disabled individuals (IDs) are unable to clearly communicate through conventional avenues. Randers's research failed to specify criteria for by which high-quality relationship could be judged.

Dunn, Claire, and Holland (2005) determined that direct caregivers supporting adults with intellectual disabilities were frequently placed in the position of substituting their own interpretation of what was in the best interests of their residents because the residents themselves lacked the mental capacity to make their own decisions. These findings are supported by Walker's (2012) research that established the lack of established guidelines on the delivery of care to the disabled individuals; the caregivers develop their own interpretation of the right ways of delivering care services. The criteria used by the caregivers were a projection of what they personally would consider in their

own interests if they found themselves in a similar situation. Dunn et al. (2005) concluded that support workers relied on their own values and experiences to frame these substitute decisions.

Ideally, all group homes would provide this level of support to their mentally disabled residents, but researchers documented that the quality of the person-centered support process varies across group homes (Kozma et al., 2009) with the staff in the poorer performing homes functioning in ways that reveal a rift between the espoused values of the organization and the realities of a staff centered work culture (Bigby, Knox, Beadle-Brown, Clement, & Mansel, 2009). These findings led to a model that supported independent living with one roommate in a conventional residence within the community (Walker, 2012).

Although this model was associated with outcomes comparable to the outcomes possible in the best of the small group homes, the independent living model does not benefit all mentally disabled individuals (Mansell & Beadle-Brown, 2010). The mentally disabled individuals requiring the highest level of support do not experience good outcomes in an independent supported living arrangement while other disabled individuals cited loneliness, exploitation, and vandalism as drawbacks to supported independent living (Emerson, Robertson, Gregory, Hatton, & Wash, 2001). This experience underscores the importance of interpersonal and technical care as essential to shaping a higher quality experience for the mentally disabled individuals (Riley, 2012). These findings suggest a continued role of the small group home in the support of the mentally disabled.

Little attention was paid to what shapes the caregiver's work-related value set and how that plays out in the process of care (Dunn et al., 2005). One unexplored area that impacts organizational centers is the tension between costs and quality, and how that filters through the system and impacts the lens caregivers use to guide their own conduct with residents (Reinders, 2011). Medicaid funding for HBCS is working on developing quality assurance, but the interpersonal side remains underdeveloped because, unlike hospitals, client satisfaction must be measured with little input from the client (Chi &Pan, 2011). Appropriate leadership is as such critical because it links the employees' values to those of the organization.

Previous researchers focused on establishing the existence of uneven staff performances and progression of staff-centered work practices in poorer performing homes, or on understanding how caregivers interpret their values towards their clients' values (Reinders, 2011). Further research into client-centered home care is necessary to determine how best to improve the support practices of staff and ensure better outcomes for the residents. This investigation is a case study that seeks to understand the relationship between the evolutionary process, and the resulting deficits in the care necessary for the optimal resident outcomes in a group home that embraces client-centered work processes.

Theoretical Foundation

Introduction

The research questions will be presented through the lens of two major theoretical concepts, the Gehman, Trevino, and Gerud's (2013) values work theory and

Donabedian's (1980) conceptualization of quality care in the workplace. A discussion on Gehman et al.'s (2013) theory will be followed with an evaluation of the quality of care literature.

Values work theory is grounded in the value practice perspective: a conceptualization in which workplace procedures are viewed as normatively organized around personal perceptions of those actions an employee or an organization ought to carry out, and the manner in which those actions should be performed (Dewey, 1939; Rouse, 2001; Schatzki, 2002; Gehman, Trevino, and Garud, 2013). In Gehman's theory, value-driven workplace practices emerge through a dynamic interplay in which values embedded in organizational policies, dogma, processes, or procedures are judged as either consistent with, or divergent from, an employee's own standards of right and wrong. Value consistency motivates employees' acceptance of, and compliance with, organizational dictates. A divergence of values leads to a values clash in which opposing employees respond with behaviors more consistent with personal interpretations and values sets. When modified behaviors take root among dissenting employees, a new value-driven work practice emerges and becomes the workplace norm (Gehman, Trevino, and Garud, 2013). A more detailed description of values work theory follows the historic examination of the conceptualization and research surrounding the values in the workplace presented below.

Values in the Workplace

Origins

The application of values theory to understanding workplace behavior has its most direct roots in the work motivation literature that flourished in the wake of the Hawthorne studies of the 1920s and 1930s. The Hawthorne investigators demonstrated that human beings respond differentially to altered conditions in the work environment and that these altered behaviors have implications for work practices (Mayo, 1927). Following the work of previous researchers, organizational researchers sought to develop techniques to encourage high-quality productivity by better aligning the characteristics of the work environment with aspects of motivated behavior (Auster & Freeman, 2012; Nadler & Lawler, 1977; Hackman & Oldham, 1975). Researchers further sought to understand how the interface between the psychological realities of organizational employees and the expectations of the workplace could impact the employee performance and organizational efficiency and effectiveness (Rosseau, 1990; Nadler & Lawler, 1977; Hackman & Oldham, 1975). To these ends, research on the structure and function of human values was adapted and applied in the workplace (Rokeach, 1965; Hofstede; Schein, 1992; Brown, 1995).

Major Values Paradigms

The study of human values is a study of dichotomies in which values are defined as standards of both what is right and what is wrong (Perrewe' & Hochwarter, 2001), are viewed as both universal and situational (Hyde & Weathington, 2006), are characterized as both culturally stable and differing in personal preference ordering (Shwartz & Bilsky,

1987; Rokeach, 1973), and functional at both the individual and communal levels. Each of these dichotomies adapted to an investigation in workplace motivation and behavior (Ravlin, 1995). The structural and functional dichotomies of values research are captured by two complementary paradigms: values as consistent and universally applied perceptions that motivate social cohesion, and values as diverse, situationally applied perceptions with the potential to fuel social discord. A brief description and history of these paradigms is presented here.

Values as Universal and Cohesive

Milton Rokeach's work on the structure and function of values was highly influential and served as the foundation for evaluating the effect of personal values in the workplace (Rokeach, 1965). Rokeach (1973 p.49) defined values as an "enduring belief that a specific mode of conduct or end-state of existence is personally or socially preferable to the opposite or converse mode of conduct or end-state". This definition resonated with the motivational underpinnings inherent in the work satisfaction literature of the time by suggesting that human behavior is motivated by deeply held beliefs about the nature of human interactions. Rokeach divided values into related but conceptually distinct domains: the interpersonal domain that defined those behaviors, which respected one's membership in the human race, and the achievement domain, which defined the facilitated pursuit of one's human potential (Rokeach, 1975; Maslow, 1943).

The interpersonal domain was consistent with MacGregor's (1960) insight that employees will engage in a self-motivated pursuit of excellence when they are treated as capable and worthy contributors to the process of work. The achievement domain was

consistent with the insights of Maslow (1943) and research of Herzberg (1966), which indicated human beings are highly motivated to achieve outcomes that contribute to their personal growth and well-being, and react negatively to barriers to those pursuits. Rokeach built on the early work of Kuckhohn and Strodbeck (1961) who defined values as guides central to human thought, emotion, and behavior. Rokeach focused on values as a lens through which human beings give meaning to the actions in which they and others engage. To that end, Rokeach defined a values topology that has been used repeatedly to recognize and assess values both in and out of the workplace environment (Chatman, 1991; Edwards & Gable, 2009).

Rokeach's topology classified values as either instrumental or end-state. Instrumental values include conduct values; those values that constitute the correct way to interact with others, and competence values, those values that define important proficiencies that contribute to one's growth. End-state values include personal end-state values: the outcomes one desires to achieve in one's life, and social end-state values: the outcomes one desires for social entities in which one is a stakeholder. This topology is used to capture the nature of workplace values for conduct and achievement, and consequently, remained relevant in more recent literature (Barley, Meyer & Gash, 1988; Deter, Schroeder & Muriel, 2000). In conjunction with this topology, Rokeach sought to develop a set of universal values that followed Kuckhohn and Strodbeck's suggestion that people focus on a few entrenched values that they believe in, and respond to a few universal issues that are globally known and have value based solutions. Rokeach's own work reflected his concept of these limited values as biologic imperatives that are

operative across cultures and resulted in the development of his well-used values survey (Rokeach, 1975; Schwartz, 1997).

Schwartz's more recent work echoed Rokeach's emphasis on values as biologically innate by suggesting that values are a distinct component of the human personality (Schwartz, 1994)). Schwartz (1994) further emphasized values as trans-situational and responsive to universal requirements that include social interaction and survival needs (Schwartz, 1994). Schwartz extended the Rokeach perspective by imposing order on values with respect to relative importance and developing a universal values measure that accounted for an ordered system of values priorities (Schwartz, 1999; Schwartz & Bardi, 1997).

Further, the motivational properties of values were deeply embedded in the universal and cohesive values paradigm. Values were viewed as contributing to motivated behavior consistent with the achievement of collectively valued ends while adhering to collectively acceptable deportment (Luna, 2008). Transgressing valued deportment carried with it both an internal sanction in the form of guilt for having betrayed the acceptable code of conduct (Kuckhohn, 1951) and external sanctions in the form of collective condemnation (Etzioni, 1993; James, 1982).

Values as Situational and Divisive

A second stream of values research also had its genesis in Kluckhohn and Strodbeck's (1961) conceptualization of values. In addition to acknowledging the centrality of a limited set of values to the human condition, Kluckhohn and Strodbeck (1961) recognized the potential for values to generate conflict by observing that disparate

groups often hold differing values or differing interpretations of the same value in a given situation. This stream of research was exemplified by Maiesse (2003) who noted that value conflict occurs when groups or individuals apply different standards of right and wrong to the way they interpret or respond to issues. The values at the heart of the conflict may, in fact, be shared and stable, but differing interpretations fuel an unwillingness to negotiate or compromise, consistent with values' role as moral parameters (Maiesse, 2003).

Values and their corresponding interpretations are embedded in the practices, thinking and language of groups and often serve as unifying elements of group membership (Kluckhohn & Strodbeck, 1961). The differing value interpretations of others are consequently, experienced as incompatible, inferior, strange or wrong (Maiesse, 2003). Misunderstandings over words or actions predicted on differing sets of norms, meanings, and expectations are a common feature of value conflicts (Maiesse, 2003). Value-based clashes lead to intergroup mistrust and suspicion which, in turn, leads to strained and hostile communications and negative stereotyping of other individuals or groups (Maiesse, 2003).Although a shared value system allows individuals to perceive the environment in similar ways, make accurate predictions regarding behavior of others, and otherwise coordinate group actions and achieve group goals (Kluckhohn, 1951); researchers demonstrated that individuals, even within the same group, may differ in value priorities relative to specific issues or situations (Schwartz, 1992; Williams, 1979). Schwartz' (1992, 1999) research into a universal value set presented compelling evidence that preference ordering among universal values is not stable, as originally conceived.

Priority-based conflict occurs when individuals seek to achieve personal value end-points without regard for the potentially opposing value structure of those that they impact (Schwartz, 1992).

This paradigm also emphasizes the motivational properties of values conflict. When interpretations of right and wrong differ, the discord motivates behavior directed toward either achieving value dominance or discrediting the worth of the opposing side (Kluckhohn & Strodbeck, 1961; Schwartz, 1992; Maiesse, 2003; Bain, Kashima, and Haslam, 2006). Organizational research consequently examined values as motivating both harmonious and discordant behavior in the workplace (Luna, 2008).

Value Levels

In addition to the intrapersonal level, values were examined at a variety of communal levels, including intergroup, organizational, social, and cultural (Hofstede, 1984; Schein, 1992; Brown, 1995). The two major paradigms of shared values as a cohesive influence, and divergent values as a divisive influence are evident across and between all levels of values research (Hofstede, Nevijen, Ohavy & Sanders, 1990; House, Hanges, Javidan, Dorfman, & Gupta, 2004). The dynamics most reflective of Gehman et al.'s (2013) work value theory, and most germane to this investigation, are those that occur when individual level values converge with organizational level values (O'Reilly, Chatman, Caldwell, 1991; Kristof-Brown, Zimmerman, Johnson, 2005, Sims & Kroeck, 1994). A description of this interplay and analysis of recent research characterizing the beneficial and detrimental outcomes experienced by both the individual and the organization follows.

Personal Values

Value Congruence: Implications for the Individual

Organizational research on value congruence in the workplace centered on the beneficial impact of value concordance on employee job-related motivation, satisfaction, commitment, and well-being (Ostroff ET al.2005; O' Reilly & Kristof-Brown, 2001; Finegan, 2000). A 2007 study by Arnaud and Schminke examined the effect of the congruence between personal ethics and organizational ethics on employee work attitudes. The researchers measured three levels of organizational and employee moral development, ranked from the least mature (motivated by self-interest) to the most evolved (motivated to apply moral principles consistently across differing contexts), and examined the influence of congruence on employees' level of job satisfaction, and turnover intention. The researchers found that congruence was positively associated with job commitment across all levels of moral development, while job satisfaction was positively associated only at the intermediate level of moral development (motivated by a caring interpersonal exchange). Researchers also identified that congruence was negatively associated with turnover intention at the level of caring interpersonal exchange and consistent application of moral principles. The researchers concluded that an interpersonally caring ethical organization engenders positive work attitudes across employees at all stages of moral development, including employees with a self-centered moral orientation.

In a 2010 investigation, Posner sought to determine if the positive associations between value congruence and job commitment found in research from the 1980s and

1990s were still applicable in the more tenuous job climate of the 21st Century. Posner surveyed a representative sample of managerial personnel across the service and manufacturing sectors, and measured the associations between employees' perceived level of personal-organizational value congruency and their perceived levels of job commitment, work motivation, work stress, and job anxiety. Consistent with earlier investigations, employees with high levels of perceived value congruence reported higher levels of commitment and motivation than did employees with low levels of perceived value congruence. Moreover, a high level of perceived value congruence was associated with lower levels of stress and job anxiety than was a low level of perceived value congruence. Additionally, Posner found that employees who indicated a high level of congruence were significantly more likely to view their employing organizations as an ethical organization. Posner concluded that value congruence forges strong bonds between managers and their employers and continues to foster work satisfaction even in the current less stable employment environment.

Andrew, Baker, and Hunt (2010) conducted a study of service industry employees in the United States to test whether moral intensity moderates the relationship between congruent personal and corporate ethical values (CEV) and employees' organizational commitment and job satisfaction. Moral intensity was operationalized as a measure of personal sensitivity to ethical issues. Consistent with other research in this area, the greater the employee's perceived overlap with the organization's ethical values, the higher the level of organizational commitment and job satisfaction. The researchers further found that the greater the employee's level of moral intensity, the stronger the

relationship between perceived congruence and commitment and satisfaction outcomes. The researchers concluded that the positive outcomes associated with superior person-organization fit can vary according to employees' responsiveness to perceived value congruence.

Sledge and Miles (2012) investigated how differing cultural interpretations of specified values influenced workplace behaviors. The study was conducted with 50 participants in each of the three countries: the United States, Costa Rica, and China. The investigators used semi-structured interviews and questionnaires to cross-culturally compare how employees defined, and ranked the importance each of the 10 common values from the Jurkiew and Giacalone values framework. The researchers also recorded work behaviors in all three countries to determine how the sample employees exemplified the 10 values by their behavior in the workplace. The researchers found that value interpretations varied by country, and that productivity in one cultural setting did not automatically translate to another setting. The researchers recommended continuous communication between organizations and employees from different cultural backgrounds to further, a mutual understanding of workplace values in order to enhance productivity.

Amos and Weathington (2008) examined the effects that value congruence had on employees work outcomes. The 151 participants responded to a two-part questionnaire. In part 1, participants indicated which values, from a list of values provided by the researchers existed in their organization. In part 2, participants indicated the extent to which they thought each of the values on the list should appropriately exist in their

organization. Participants also indicated their current level of job satisfaction, organizational commitment, and intent to leave the organization. Consistent with previous research, the greater the overlap between perceived appropriate values, the greater the participants' level of job satisfaction, and organizational commitment, and the lower level of turnover intent. The study findings underscored the importance of perceived congruence between employees' values, and organizational values for achieving positive person job-related outcomes.

Value Discord

Implications for the Individual

Gaudine and Thorne (2012) measured the level of ethical conflict nurses perceived relative to their employing hospital and investigated the impact of this discord on turnover intention, absenteeism, and actual turnover. Perceived value conflict was evaluated in three domains: conflict with nurses' professional patient care values, conflict with nurses' professional ethical expectations for administrative inclusion, and regard, and conflict over nurses' professional expectations for fairness, respect, and consideration in staffing policies. Respondents assessed the extent to which their employing organization demonstrated congruence with expectations for ethical treatment in each of the 3 domains. Researchers found that values conflict in all three domains was associated with nurse stress, while ethical conflict over patient care values fueled both absenteeism, and turnover. Values conflict in the staffing policies domain was associated with intent to leave the organization. Researchers concluded that nurse's values relative to what constitutes high-quality care was a major source of values conflict in the clinical setting.

Finegan (1994) investigated the relationship between personal value rankings and moral judgments of ethically questionable behavior in the workplace. The participants were asked to rank their personal values using Rokeach's value survey and to rate 5 scenarios that described ethically questionable behavior in organizations on a scale from 1 (not at all immoral) to 7 (very immoral). Subjects were then, asked to rate their intention to intervene in each of the given scenarios. The researcher found that different value orderings influenced the extent to which the ethically questionable behaviors were perceived as problematic. Two terminal or end-state values were associated with judgments of immorality, with individuals ranking either a "world of beauty" or "natural security" as highly important end-states more likely to judge the behaviors as more immoral. In addition; the researchers found that individuals who ranked highly the personal conduct values of ambition, independence, or responsibility were likely to judge the behaviors as less immoral.

In terms of intention to intervene, those individuals who ranked the terminal or end-state values of " a world of peace" or a "world of beauty" highly were more likely to indicate their willingness to intervene. Those individuals who gave a high ranking to a "comfortable life" were least likely to indicate a personal willingness to intervene. With respect to instrumental values, the researcher found that the personal conduct value of ambition was the sole predictor of intention to rectify the behaviors (Finegan, 1994).

Finegan (1994) concluded that individuals perceive ethical issues in the workplace differently depending on their value preference orderings. Further, individuals, who emphasized values related to a harmonious code ethical conduct or social terminal end-

states suggesting a secure and harmonious social order, were most likely to judge the questionable actions of others harshly. One implication to be drawn is that these individuals viewed the unscrupulous acts of others as threatening a larger moral and social fabric with potential to impact many individuals within a shared environment. Of equal interest was that of these grouping of individuals, those most likely to act on their judgment where those who placed the greatest value on maintaining the social fabric, leaving open the possibility that those individuals who place an emphasis on a harmonious moral code are not comfortable within the potential for personal conflict inherent in confronting the offending behavior. Only those valuing personal ambition over interpersonal harmony were motivated to face such a confrontation for seeming personal gain. Consistent with the interpretation of personal gain, the findings that, individuals seeking the valued personal conduct and end-state outcomes of independence, responsibility, and a comfortable life were least likely to judge behaviors potentially motivated by such considerations as immoral. According to Finegan, the greater organizational implications of these findings were that the greater the discrepancy between the individual's personal preference ordering and value implied in a workplace ethical dilemma, the greater the potential for a personal negative judgment and perceived corrective behavior. Discrepancies with an interpersonal code of values are implicated primarily in negative judgments while threats to one's personal utility or the greater good appear to be associated with the willingness to act.

Organizational Values

Value Congruence: Implications for the Organization

Ilangovan and Durgadoss (2009) organized the implications inherent in the literature on organizational value congruence and sought to develop recommendations for corporate managers. Their review of 13 key articles centered on the potential for congruence or conflict between a manager's personal values set and corporate value set they are expected to foster and uphold. Significant findings from the literature were that 8 of the 13 key studies provided evidence of congruence between manager's personal values and the corporate values embodied in mission and value statements. Further, the authors noted that organizations characterized by socially undesirable congruent managerial values were most likely to run afoul of the law or social mores and fail over time. Organizations in the studies where the manager's personal values clashed with the corporate values were marked by turnover and upheaval. The authors concluded that organizations derive the most benefit when they practice socially desirable values and employ managers whose personal values coincide.

Othman and Rahman (2009) published a literature review and a case study examining both the potential for, and the mechanisms associated with, institutionalized ethics in corporate governance. The argument for institutionalized corporate ethics was buttressed by evidence that the corporate pursuit of maximum wealth for corporate stakeholders has resulted in a series of corporate scandals and failed companies that made corporations unattractive as sustainable investments. An institutionalized approach to ethical organizational governance, designed to weigh organizational outcomes against

social responsibility, is offered as a possible mechanism for enhancing the corporate image and encouraging stakeholder investments based on an expectation of defensible, rather than maximal growth in wealth and assets.

The case study (Creswell, 2007) organization was a best case scenario ranked highly in ethical corporate governance by a shareholder's watchdog organization. The goal of the case study was to determine what structures this exemplar organization used to institutionalize ethical corporate decision-making and behaviors. Face-to-face interviews were conducted with the key personnel and triangulated using public documents and corporate websites. The findings were organized into themes that highlighted the extent to which corporate decisions were scrutinized for ethical or lack of ethical content. The study reviewed the presence of an active internal audit to recommend cases for ethics review; a system of appointing board members with respected and principled backgrounds, the existence of a corporate code of ethics and a corporate ethics hotline; in-house ethics training for the employees; a leadership dedicated to instilling and modeling a corporate culture of ethical behavior and decision-making, and visible enforcement policy in which remedial actions were taken when fraud or unethical conduct was uncovered. The authors concluded corporate ethics like the enforcement of product quality, lends itself to adopting standards and guidelines which are supported by formal structures, are reinforced through corporate culture, and are consistently and visibly enforced. The study, further, showed the potential for a self-regulating culture that would support and provide moral guidance to strengthen good performance within the organization.

Chi and Pan (2011) examined whether transformational leadership was positively associated with employee task performance and whether that association was operationalized through employee's perceptions of a valued job and a caring organization. Previous studies found leaders with transformational leadership qualities to possess critical values, such as charisma, inspiration, caring, and creativity. Transformational leadership has also been found to link employees' values to those of the organization.

One hundred managers and 500 employees participated in the study where the managers were asked to indicate in a questionnaire their assessment on the employees' task performance; while the employees were asked to assess the extent to which they perceived the organization was responsive to their personal and professional needs, and valued their work and contributions. Employees also assessed their manager's leadership to capture perceptions of transformational leadership. The researchers demonstrated that transformational leadership was independently associated with high-quality task performance, and that the influence of the transformational leadership style mediated perceptions of the organization as caring and appreciative of their work. The researchers found that when transformational managers showed support for the employees, the employees tended to perform their job better because their needs were met, and felt confident in their abilities to do their jobs. Researchers concluded that managers valued employees' role in the organization, and that employees saw the concern of the organization through the managers' support to them. This finding concurred with the previous research findings that transformational leadership is inspirational, caring, and

facilitates the agreement between organizational and individual values, that is necessary for the organization's success (Chin & Pan, 2011).

Value Discord

Implications for the Organization

Yaniv and Farksa (2005) examined whether the congruence between operational corporate values, and value-laden promises engendered by the corporate public image: Its brand influenced employee responses to the corporate product and ultimately customer's trust that the corporation would deliver the virtues promised in branding activities. The researchers gathered data from two employees and two customers from 43 stores, using two different close-ended questionnaires. One questionnaire measured employees' perceived congruence with organization's values. The second questionnaire measured the extent to which employees and customers agreed that the store's performance was consistent with the qualities the corporation associated with its brand. Researchers found that the less the congruence between employees' values and organization's values the less likely the employees were to associate with, and uphold the veracity of, the values linked to their corporate brand. A second major finding was that brand perception by employees impacted the customers' perceptions of brand verity. Customers were most likely to perceive corporate branding as accurate if employees did not manifest discordance with corporate brand claims. The implications for organizations are that value discord with employees can translate into a value disconnect with potential consumers of their products.

Geare, Edgar, and McAndrew (2009) examined managers and non-manager workers' beliefs and values, and their relationship to the perceived presence of a unified organizational value system. The researchers gathered data on managers and employees' perceptions of whether the organizational value system was shared by all employees throughout the organization. The researchers also examined the extent to which practicing high commitment management techniques (HCM) was associated with greater perceptions of shared values by both workers and manager. Researchers found that the gap between the managers' and employees' perception on organizational values and commitment was significantly large with the managers focusing more on the organizational commitment than did the workers. They found, further, that managers and workers who practiced HCM practices were more likely to exhibit high levels of organizational commitment critical in enabling the organization realize its goals and aspirations.

Carney (2005) examined conflicting clinical and organizational values in acute care hospitals by collecting qualitative data on perceived ethical values and beliefs from clinical and non-clinical managers. Participants were asked to respond to queries regarding the ethical values and beliefs they perceived as widely held throughout their organization and; how they perceived ethical values and beliefs were exhibited by the organization. Carney found that although clinical and non-clinical managers perceived values and beliefs similarly, neither the clinical nor the non-clinical managers perceived the other holding the same value set; Carney interpreted these findings as reflecting a lack of trust between the organizational managers responsible for the efficiency and

effectiveness of the organization, and the clinical managers responsible for producing and delivering health care. The findings further suggested that shared values alone do not bridge biases toward members of an outside group who are viewed as fundamentally different. It was further established that not all the values perceived by the two groups were ethical and as such, could serve as latent conflict points which could emerge and impact organizational operations.

Frick (2008) investigated how school principals experienced and resolved ethical dilemmas generated by a clash between their personal standards for what is right and wrong and the dictates for school policies or administrative expectations of obedience to authority. The focus of the ethical dilemmas centered on honoring the professional imperative of doing what was best for the student. Frick conducted a phenomenological investigation of 11 school principals using open-ended interviews and scripted ethical dilemmas. Themes that emerged from the investigation indicated that in general the participants agreed with following the policies and procedures operational in their school district, however, all participants related with instances when following the policies or rules of higher administration would have led to actions that were not in the best interests of students. Study participants resolved the resulting ethical conflict in differing ways. Those that chose to follow school policies used rationalization to ease their sense of guilt for transgressing their personal code of conduct, while others adjusted the interpretation of the existing policies to allow minor deviations that better served the students. Still others chose to transgress existing policy and do what they judged to be right for the student and weathered both the legal and professional ramifications. Frick concluded that

the ethical guideline of doing what is best for the student is filtered through the moral standards of the administrator. A strict adherence to policy that conflicts with the individual's internal code leads to personal conflict and feeling of guilt, while transgressing policy leads to professional conflict and the potential for personal loss. Table 1 gives the summary of the recent values research in the literature review.

Table 1.

Summary of the recent values research in the literature review

Research focus	Key findings	Citations
Organization's leadership and employees' value congruence	Outcomes for the employees were desire to do more; commitment to the organization; reduced stress, and anxiety.	Ambrose; Arnaud, and Schminke (2007). Posner (2010). Andrew; Baker, and Hunt (2010). Sledge and Miles (2012). Amos and Weathington (2008).
Organizational leadership and employees' values discord	Employees' apathy, stress, and desire to leave the organization.	Gaudine and Thorne (2012); Finegan (1994)
Organization leadership and management staff value congruence	Congruent on socially desirable values that lead to prosperity and undesirable values that lead to scandal	Ilangovan and Durgadoss (2009). Othman and Rahman (2009). Chi and Pan (2011).
Organizational leadership and care providers value congruence	Adherence to protocol, commitment to difficult tasks and increased productivity	Ilangovan and Durgadoss (2009); Othman and Rahman (2009). Chi and Pan (2011)

Organization's and employees' values discord	Lower productivity, resistant behavior, perception of the organization as untrustworthy, high staff turnover and apathy	Yaniv and Farka (2005); Geare, Edgar and McAndrew (2009); Carney (2005); Frick (2008).

Study Conceptual Framework

Gehman et al. (2013) modeled the dynamics through which value driven work processes are molded and changed through precipitating events at individual and collective level value interpretations, concerns, resistance activities, and accommodations. Gehman et al. (2013) term the resulting work practices and routines, which emerge from the interactive processes "*values practices"*. According to Gehman et al. (2013), values practices are the culminating adaptation of translating normative work policies and standards of what is considered honorable, proper, good, and appropriate into the daily practices that survive the contested realities of the organizational stakeholders.

Gehman et al.'s (2013) investigation into the values practices that emerged from the implementation of a student honor code at a major research university revealed that a top-down administrative decree was not sufficient for a standardized adoption of either the value-driven policy, or the administrative interpretation of the form and function of that policy, throughout the organization. Instead, the implications of the honor code reverberated throughout the organization and its stakeholders causing the employees to shoulder new responsibilities and modify older and equally valued work practices to

accommodate the new edict. This ripple effect led to value clashes and flash points where differing stakeholder groups protested the new value order and cited perceived flaws in both the code and the interpretation.

In tracing the evolution of the honor code, Gehman et al. (2013) determined that the genesis of the code came, not from administrative insight or stewardship, but from precipitating events, both inside and outside the organization, which brought perceived ethical violations among student test takers to the attention of concerned stakeholders. These precipitating events encompassed alumnae's unease with a lack of student understanding of, or interest in personal integrity; concerns with high profile cheating scandals occurring at other universities; a professor's decision to take action on a cheating incident among his students and the resulting student outcry regarding the manner in which the incident was handled, and finally a student appeal regarding academic integrity that proved difficult to resolve due to lack of standard policy on academic integrity. Each of these four precipitating events drew a group of concerned stakeholders pushing for reform in the student integrity policies of the university. Gehman et al. (2013) termed these unconnected pockets of concerns *entanglements*. Each group became advocates for a set of specific values practices they perceived best addressed the concerns generated by their discrete precipitating incident.

The researchers further found that the next major phase in the emergence of values practices was what they termed *knotting.* Knotting occurred when the distinct entanglements coalesced around their common goal of reform and the general principles associated with that reform, without reaching consensus on the work practices most

conducive to achieving mutually acceptable package. The responsibility for the policy fell to administrators/managers who were not part of the initial entanglements, and were inspired to develop an administratively sound honor's policy which they naively assumed everyone would accept. Once the policy was put in place, initiating stakeholders raised objections to elements of the policy perceived as inadequate relative to their initial concerns. Each round of opposition precipitated adjustments to the policy, which in turn, triggered opposition among other stakeholders who experienced the adjusted policy as a violation of the values inherent in already established work processes. Affected stakeholders with adequate power were able to force additional adjustments to the policy, while stakeholders who lacked power countered with reactance, in which the offending elements of the policy were either ignored or locally modified to bring work routines in line with the locally held value hierarchy. These reactive routines triggered managerial responses to limit reactionary behaviors and enforce final dictates, which, in turn, generated latent reactance which simmered beneath the surface of organizational routines until an opportunity arose again to oppose or locally modify dictates. As a result, at any given point in time, the work practices observed in an organization are likely to be an amalgam of corporate and stakeholder values, carried out either formally as a result of local reactance. Variations emerge as value practices that survive until the next round of accommodation or reactance. According to Gehman et al. (2013), the on-going process of reactance and accommodation never ends, because, key stakeholders eventually leave and new hirers bring in their own experiences and work values.

This model resonates with the interpretation of the findings of Bigby et al. (2012) regarding staff work practices in group homes. Client advocates pressed for work practices they perceived would maximize client independence: corporate and organizational management drafted policies to accommodate the stakeholder vision with ethics to comply, and staff resisted arguing that senior management did not understand the complexity of client care. The work routines dictated by policy were ignored by the staff so that valued work routines could continue. Although this post hoc application of Gehman's dynamics to Bigby's findings is reasonable, the actual process of values practices has not been investigated in the group home setting. The application of this model has the potential to reveal the flashpoints, reactance, and accommodation patterns that interfere, with group homes transitioning from institutional care facilities to client-centered supports for maximum client functioning (Kozma; Mansell& Beadle-Brown, 2009). This pattern is fundamental to understanding how to break the sub-optimal cycle of policy implementation and adaptation to develop effective organizational change strategies that reconcile clashes among stakeholder values and value hierarchies.

Quality of Care Framework

Researchers and group home policy advocates promote the shift from institutional care to client-centered care because outcomes research has provided compelling evidence that supports designed to maximize independent functioning provide the greatest benefits for group home residents (Beadle-Brown, Mansell; 2010). Emergent value practices as defined by Gehman et al. (2012) are repeatedly modified work processes, which evolve to harmonize with the value hierarchy of the operative stakeholders. The impact of these

modifications on the quality of work outcomes has yet to be investigated, but emergent work practices in group homes have the potential to significantly deviate from evidence-based best practices for client-centered care.

Donabedian's (1980) model identified three domains relevant to high-quality patient/client care: structure, process, and outcome. Structure refers to the environment and the resources necessary to provide services. Structure includes facilities, equipment, staff, and monetary resources. Process describes the techniques and practices used to provide care for the patient. Outcomes are the benefits realized by the recipient. According to Donabedian, good structure is a prerequisite to good process, and good process is a prerequisite to good outcomes. This model is depicted in Figure 2.

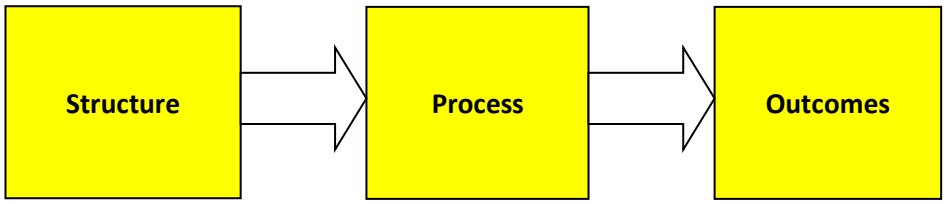


***Figure 2*. Donabedian Quality Model (2).**

Since the model's inception, health services researchers have used Donabedian's conceptualization to study the varying contributions of each of these three domains (Larson & Muller, 2002) and accrediting bodies developed quality assessment standards based on each domain to award institutional accreditation to health services organizations (JCAHCO, 1986). Recent research was directed toward refining and specifying the sub-dimensions of the health care process as first conceived by Donabedian and detailing the specific criteria that constitute quality in the medical care sector. To this end, researchers continued to explore the quality dichotomy first posed by Donabedian, the distinction

between the quality of technically correct care and the quality of interpersonal care (Donabedian, 1980).

According to Donabedian, technically correct care is synonymous with evidence-based clinical medicine. High-quality technical care reflects the scientific-state-of-the-art in provider knowledge and skills and available treatment and technology. This domain is also a flawless operationalization of the clinical process of care (Hagashi, et al. 2005) such that the patient receives maximum benefits while experiencing no medical misadventures. This component of quality is best judged by both an implicit and explicit peer review process that assesses the extent to which care adheres to clinically relevant criteria (Gupta, 2008). Consequently, the pursuit of high-quality technically correct care has been operationalized in the health care industry by the adoption of a variety of continuous quality improvement programs, which are routinely evaluated and refined by health service researchers and practitioners (Trivedi et al.2005).

Donabedian defined the interpersonal side of care as the social and psychological manner in which care is delivered. This component of quality care includes the extent to which the client is treated with respect and dignity; is included in the decision-making and is afforded comfort and convenience (Donabedian, 1983). According to Donabedian, the interpersonal component of care that the client is best able to judge, and consequently features prominently in the client satisfaction initiatives so prevalent in the health care field over the past two decades (Donabedian, 1982 & Smith, 1995). Researchers and practitioners continue to investigate this quality domain to define and measure best practices (Enthroven & Vorhaus, 1997). Authors continue to examine the quality of care

according to structure, process, and outcome, using either the technical or interpersonal lens of measuring and judging the level of quality in the medical episode of care. A review of this literature follows.

Rashid and Jusoff (2009) explored the business concept of service quality as a mechanism for differentiating among health service organizations and determining any given organization's competitive advantage in the health care sector. The authors relied on the conventional distinction between technical service and interpersonal service quality termed functional service quality in this investigation. The researchers used the (Berry, Parasuraman, Zeithaml; 1985) conceptual model of service quality as a framework for investigating how health care consumers judge hospital quality, and factor that judgment into their choice of hospital for treatment and care. The service quality model conceptualizes the consumer quality judgment as an evaluation of the difference between the services the consumer expects based on their past experiences, their current needs, and the recommendations of others, and the service actually experienced. The framework suggests that organizations monitor the match between consumer expectations and actual customer experience by measuring the differences between consumers' expectations and the service quality specifications of the organization, service quality specifications and the actual service delivered, and service delivery and what was communicated to the consumer regarding service delivery.

Researchers conceptualized the measurable service dimensions and influencing factors extant in the health services quality literature over the past three decades to develop a comprehensive health services quality assessment model based on the

Parmsuran et al. (1985) framework. Although the comprehensive model demonstrated a potential applicability for the business service quality framework in health care, the author recognized three major categories of concerns unique to the health care sector that mitigated a seamless transfer of the strict business framework. The authors termed these categories: *service elusiveness*, which included a set of issues related to the consumer's inability to judge the technical process of care; *employee diversity*, which included concerns regarding the need for discretion and professional judgment by health care providers that cannot be codified by the organization, and *interrelatedness* refers to those issues which arise from the fact that the health care consumer is actually a component of the output of a health care organization, not an uninvolved patron.

This outcome offers little new insight into either defining or measuring the quality of health care services or the services of any sector in which professionals' work with clients constitutes the primary exchange and output of an organization (Smith, 1995). Donabedian drew almost identical conclusions regarding health care quality assurance in 1985. This scholarship is consistent with previous attempts to cast human service industries in a strict business mold, and underscores the tension inherent between the business management, and the human service organizations (Waters, 2001).

Andel, Davidow, Hollander, and Moreno (2012) examined the relationship between quality of care and the cost of care in the medical care sector by reviewing prior research on the drivers of health care cost. The reviewers found that morbidity and mortality from medical errors and facility acquired infections were among the most costly components of care and using Donabedian's observation that the highest quality care

should be less wasteful and therefore, less expensive (Donabedian, 1980).They labeled these findings as evidence of lack of consistently high-quality care across the United States hospital sector. The authors also noted that lack of sufficient incentives for hospitals to better manage quality was at least partially responsible for this system-wide failure. Kumaraswamy (2012) examined service quality as a component of quality care. He focused on service quality factors that influenced the patients' perception of care. Service quality is giving patients what they want (patient quality) and what they need (professional quality) while using the least resources without error, delays and waste (Overtreit, 1992). This care requires services to be rationalized (structure) and delivered in an efficient and effective manner (process). Although different models were used to guide the delivery of quality care, the researcher found Service Performance Model (SERPERF) performed best in assessing client perceptions of health providers' attitudes, facilities, design and equipment. The researcher, who based his findings on the analysis of primary data collected through the use of structured questionnaires, established that service delivery had shifted from the original medical service to an emphasis on customer service, and that service providers' attitude was critical in the service quality. The researcher's findings resonated with the previous research findings that the important service quality factors (SQF) were the physician's, support staff's behavior, facilities' design, and performance. These factors are critical in both corporate and non-corporate health institutions

Sayal, Amarasinghe, Robotham, Coope, Ashworth, Day, Tylee, and Simonoff (2012) used Delphi consultation process, which measures the degree of consensus among

experts on a particular issue, to develop quality care standards for children and adolescents with challenges in mental health. Although previous studies identified and recommended individualized care, quality care standards for children and adolescents with mental challenges have not been established. The participants, mental health experts, and the experienced parents of the affected children, identified areas of concern and reached consensus on their importance. They based quality standards on accessibility (structure) and delivery (process). There was a unanimous agreement that communication between children, and the health care staff was critical, and that the health care staff should establish good relationships with the children (interpersonal process). Participants also agreed that providers should also avoid being judgmental when discussing the children with their parents. This research underscored the importance of attitude as a critical measurement in the delivery of quality mental health service delivery and demonstrated the feasibility of developing standards of care for the mentally ill.

Gupta (2008) investigated quality components which could be used to evaluate, monitor, and improve delivery of quality care in health institutions. According to Gupta, although several researchers previously identified aspects of care with patients, few had involved health care providers as consumers. The researcher conducted interviews with a purposeful sample of 15 participants, which included physicians, surgeons, dentists, and hospital administrators, to identify those aspects of care which health care providers deemed crucial, in the delivery of high-quality care. A structured questionnaire was used to identify critical aspects. There was consensus on the need for appropriate equipment, and facilities (structure), reliable laboratory samples' analysis, a caring manner towards

patients, and professional collaboration (technical and interpersonal process) as key factors in the realization of appropriate results (outcomes). These factors resonate with Donabedian's (1980) conceptual framework of the assessment of delivery of quality health care, and as such support use of the model in the study.

Lee (2012) investigated the extent to which one or more of seven leading health care quality assurance programs were being used in hospitals in South Korea. Further, the investigator was interested in determining whether the choice of quality control program was related to hospital size, hospital classification as secondary or tertiary cares center, or the extent to which administrative and clinical personnel were familiar with other available quality assurance programs. The goal of the investigation was to determine if hospitals with the different service delivery goals, as dictated by size and the level of care provided impacted the choice of the quality assurance program. The researcher found that large tertiary care hospitals were more likely to use at least one of the leading quality assurance programs than were secondary care hospitals with fewer than 700 beds. Lee also found that the rank order of quality assurance programs did not differ between tertiary and secondary hospitals, with Deming's Quality Control (QC) program being the most frequently used, followed by Total Quality Management (TQM), which was then followed by Six Sigma. The remaining four programs were used much less frequently by those using quality assurance tools and Lee noted that the choices made by South Korean hospitals were consistent with the choices made hospitals internationally certified by quality awards. The author suggested that the findings indicate that South Korean hospitals using quality assurance programs are competitive globally with respect to

quality management techniques and further suggested that global competition for medical tourism and standardized quality awards is leading to somewhat homogenous approach to managing quality care. These findings again illustrate the recurring theme in the literature; hospitals engage in quality assurance and improvement for fiscal reasons in a globally competitive marketplace. The table 2 below gives a summary of the recent quality literature review.

Table 2.

Summary on Recent Quality Literature Review

Focus	Key findings	Outcomes	Citations
Technical care	Appropriate equipment and facilities enabled physicians to give correct diagnosis.	Quality care and patient satisfaction achieved.	Gupta, H.D. (2008)
Interpersonal care	Caring attitude towards patients and staff collaboration was crucial in the delivery of quality care	Quality care delivered with patients' satisfaction.	
Interpersonal care	Health care staff should establish good relationships Staff attitude is a measure of quality Sayal, K. et al. (2012) with the clients.	Mental health service, and can be used to develop standards of care for the mentally ill.	
Quality Assessment	Quality programs engaged strategies to improve health care delivery.	Quality awards and high ranking.	Lee, D. (2012)

Technical care	Staff competence, and facilities designs Improved service delivery.	Reduction in wastes, health costs, and influenced patients' choice of hospitals.	Andel, C. et al. (2012)
Interpersonal care	There is a shift from medical service to customer service, and health providers' attitude is critical.	Enhancement of the patients' satisfaction, and choice of health facility.	Kumaraswamy, S. (2012)
Technical care	Human services should be dealt with as business ventures, and as such the evident constraints are customers' inability to judge technical processes, and employee diversity giving different professional views	Customer guidance will be critical.	Rashid & Jusoff (2009)

Summary and Rationale for Using Donabedian's Quality Assessment Model in the Investigation

Critical findings on quality care echo the earlier conceptualizations of Donabedian (1980). Quality assessment continues to target structure, process, and outcomes as the core domains of quality management, but the emphasis shifted from Donabedian's focus on the delivery of high-quality care as a service primary benefiting a patient, to an entrepreneurial perspective in which the pursuit of high-quality care serves the financial goals of the health care organization and provides a competitive edge in a more global marketplace. In the United States health care sector, government policy ties Medicare reimbursement to continued quality improvement and an on-going push to reduce

wasteful outcomes. That push focused attention on eliminating medical errors that may lead to costly patient complications and on reducing avoidable and costly readmissions (Andel, et al. 2012). This phenomenon represents the current embodiment of Donabedian's observation that the highest quality care provides the greatest benefit to the patient for the least cost (Donabedian, 1980) and dictates that care be technically correct as defined by evidence-based science as well as resource efficient. This edit encompasses the need for proper structural resource support for the delivery of high-quality outcomes and the need for diverse technically competent health care professionals to carry out the care process (Rashid & Jusoff, 2009). The quasi-market health care system, coupled with insurer's prospectively determined reimbursement rates, accentuates health service organization's need to attract patients and retain their loyalty to ensure financial solvency. This latter phenomenon resulted on increasing attention to the factors which define client satisfaction. Current studies reinforce Donabedian's observations that patients cannot adequately judge the technical side of care, but rather judge interpersonal quality by the extent to which their personal expectations for courtesy, comfort, and inclusion in the decision-making components of care are met (Donabedian, 1983; Kumaraswamy, 2012).

This literature review also highlights the current emphasis on developing or adopting detailed quality guidelines that adequately and explicitly capture the factors that comprise quality care. These guidelines are designed to permit unambiguous assessments of the level of quality inherent in the work processes directed toward technical service delivery, client satisfaction, and patient care outcomes (Kumaraswamy, 2012). An

overarching conclusion drawn from the health sector quality care literature is that unequivocally defining and operationalizing the level of care quality of which with best benefits and satisfies the patient, is the most likely to occur when the pursuit of high-quality care becomes a strategy for reaching financial goals. It is interesting to note that none of the recent research in the area of quality care actually cited Donabedian's seminal work or used his classical model although the latest techniques in quality care can be readily cast in the language and format of Donabedian's definition of quality care and his model for quality assessment. This disconnect between the roots of quality assessment in health care appears to reflect the lack of detailed specificity inherent in Donabedian's work.

Donabedian's framework was developed at a point when health care quality assessment was still heavily reliant on the professional judgment of the care provider and the development of explicit criteria for judging quality was still in its infancy (Donabedian, 1982).Donabedian's definition and framework, consequently, encompasses all dimensions of quality care that are still deemed important in the current age but is better suited to identifying and classifying differing caregiver judgments regarding what is and is not a high-quality work process than are the more prescriptive frameworks currently being used to assess quality of care in the health sector. Further, Donabedian's definition and the model of quality care both predate the development of prospective payment systems in the health care and assume that quality of care is a caregiver pursuit, while financial gain or organizational viability is an administrator's pursuit. Donabedian's sole acknowledgment of the relationship between the delivery of care and

the cost of care was his observation that high care is parsimonious (Donabedian, 1980), and provides no guidance on how to reconcile differing value preference tradeoffs for achieving parsimony. This view contrasts sharply with the well-aligned dictates of the quality assessment models currently embraced by the health care sector.

The climate for quality assessment in group homes resembles the quality assessment climate in the health sector when Donabedian was developing his conceptualizations of quality care. Group homes do not compete for clients in a global economy, nor is their funding tied to prospective payment systems that encourage high-quality client outcomes as a strategy of maximizing financial goals (Beadle-Brown, 2010 & Mansell). Few, if any, guidelines exist that explicitly and unambiguously define and enforce work processes that maximize client-centered care. Defining and measuring the quality of care in group homes remains an underdeveloped subject, if not totally undeveloped area of concern as evidenced by an almost complete lack of quality assessment literature in the area. The single exception to be found was Sayal et al. (2012) who demonstrated that standards of care could be developed for the mentally challenged, thus emphasizing the extent to which standards have yet to actually be developed and incorporated into this sector of care.

When discussing Gehman et al.'s (2012) framework, the care climate in group homes leaves work process open to modifications based on the differing values and value preference orderings of caregivers and administrators, and provides a rich environment for the clashes and conflicts inherent in emergent value practices. To judge the extent to which emergent value practices impact the quality of care delivered to the group home

residents, Donabedian's definition of high-quality care as being technically correct, interpersonally satisfying and inclusive of the client, and providing the greatest benefit for the least amount of resources provides an appropriate mechanism for categorizing and understanding the emergent value practices on client care in the group home sector. Just as in the hospital sector, the work processes in group homes reflect the structural elements available for the provision of care and produce outcomes that may or may not benefit the resident (Beadle-Brown, Kozma, & Mansell; 2009). Emergent care processes in group homes may, therefore, impact the quality of care in any of the Donabedian's three major domains: structure, process, or the outcome of the care delivered. I will consequently attempt to sort and organize identified quality impacts in accordance with Donabedian's quality assessment model to determine quality-based linkages and patterns among emergent care practices in the group homes under investigation.

Key Literature Review

According to Dunn, Claire, and Holland (2010), decisions made on behalf of individuals with mental disabilities must be in accordance with their interests. It is, however, not easy to determine the values of decisions made on behalf of the individuals with mental disabilities, and caregivers are not informed on the legal and ethical implications of the day to day support that they give to the mentally challenged individuals. Dunn et al. (2010) found from analysis of 21 interviews conducted with caregivers from two group homes, one a for-profit, and the other for-charity, both housing individuals with intellectual disabilities; that although there were legal guidelines on the provision of care, caregivers provided care on the basis of their values, and

experience, and this contradicted the organization's procedures, and as a consequence, caused conflict of interest between caregivers and the organization.

Wagget (2012) noted that The United Kingdom (UK) government advocated for moving individuals with intellectual disabilities from institutions, and empowering them, through skills development, which should make them live independently (Department of Health, 2009). The focus here was to develop personal-centered approaches, which integrate individuals with intellectual disabilities (IDs) within communities. Wagget observed the World Health Organization's (WHO's) definition of the learning disability, as an incomplete development of mind, which translated into a type of behavior that could be related to social and emotional factors.

There are, however, individuals who require 24-hour care in group homes and these individuals must have at one time experienced prejudice, abuse, and neglect. Their feeling of despair and anger is thus understandable. Through their relationship with the residents, the caregivers, continue to hear the residents' histories, and begin to act as if they were their own experiences, and the author describes the caregivers as getting possessed by "ghosts". This situation might create emotional issues within the staff, and result in blaming, and looking for faults among each other, and could end up in involving the organization. The direct care staff attitude, is, however, critical in the service delivery of quality care, and is, as such imperative for the staff to have a positive attitude, and minimize conflict among themselves. Although care should focus on emotional support, the poor working conditions for the direct care staff, and prejudices from the community against the residents do not facilitate this aspect of care (Wagget, 2012).

Garcia et al. (2012) investigated how families and staff members viewed the effects of environmental factors on behaviors of individuals with mental disabilities in group homes. Although studies on the appropriate designs of the group home facilities have been done, information from staff and family members on environmental aspects that affect the residents' behavior is lacking (Garcia et al. 2012). The aforementioned information is critical in justifying institutionalization of the residents. The staff members involved in the study were those who participated in the personal care of the clients, and in the housekeeping; while family members were those who had visited their relatives in the group homes at least once in the last four months. The study was done with a population sample of 15 groups from three cities in Canada. The groups were asked to list factors that they thought to be important in influencing behaviors of individuals with severe mental challenges in group homes. They were asked to compare and contrast behavior that negatively affected behavior, and quality of life of the residents, and those that improved behavior, and quality of life. The respondents identified facilities' designs, and staff attitude as critical in influencing the behavior of individuals with mental challenges. The residents were found to prefer privacy, reduced noise, and support from staff, and family members similar to the one they received at their homes.

John Snowdon (2010) reviewed the literature on quality service to individuals with mental health problems in group homes, and shared his findings with the Residential Care Task Force of the International Psychogeriatric Association (IPA). The presentation provoked discussions which were based on the participants' opinions, and experience based on observations, which helped the author to refine his recommendations on the

health service delivery in group homes. The author recommended that quality care requires adequate funding, caring attitude, education and teamwork among all the supportive staff. Teamwork should include linkages where, organizations that provide service in group homes review their care processes and delivery of services. It was, however, noted that the suggested approaches depended on specific operational areas; depending on circumstances and needs.

Dening and Milne (2009) observed that although the quality of medication and the treatment of mental health conditions was good, not much information on social aspect for enhancing quality health care was available. Quality of care varied in different group homes, and the authors attributed this to levels of staff training, and support from the health specialists. Investment in staff training and improvement of work environment were critical in the provision of quality care. They found that collaboration with other care providers and the development of standards that enhance good work practices would require further investigation because of their potential in the delivery of quality service care. A combination of measures that should include the perspectives of the administrative staff, caregivers, and the residents should improve quality service delivery (Sloane et al. 2005). The authors found that there is no consensus on quality care concept, and that quality of life (QoL) in group homes is determined by the existence of health problems, and subjective well-being, and an assessment should be used to check whether the needs of the clients have been met. The residents' perspectives and the appropriate interventions are critical in the improvement of quality service care.

Christina (2012) focused on the prevalence of loneliness in group homes; the groups at risk of experiencing loneliness, and the interventions which have demonstrated reduction of loneliness in group homes. She defined loneliness as being influenced by the amount of resources and social environmental factors and the client's character. In her review of the existing literature, she found that, researchers had identified four aspects, which defined loneliness with interpersonal relationship, housing facilities, resident's personal character, and finally neighborhood aspects.

Although emotional support to residents is critical; the quality of support in reducing loneliness of residents in group homes is more important than the quantity (Christinina, 2012). The quality of support can be enhanced through creating friendship with the residents in person, phone, or through the internet and the interaction among the clients, caregivers, and other staff should be encouraged. Some residents prefer keeping to themselves, while others like interacting with other inmates. The residents should, however, be involved in neighborhood activities, in order to make them a part of the community and consequently reduce loneliness. The facilities design should also be responsive to the residents' needs and desires.

Domen, Kef, Schuengel, and Worm (2010) used the attachment theory to discuss giving quality care to the intellectually challenged individual by the direct care staff. They observed that the role of caregivers is critical in the quality service delivery (Hall &Hall, IDs; 2002), and understanding and appreciating these professionals would improve the quality of delivered care. Care for the intellectually disabled individuals (IDs) should focus on the relationship between the caregiver and the client. This includes

the behavior towards the clients and the continuous interaction (Reinders, 2009). The attachment to the client determines the service and care provided to the IDs.

The authors found that this type of care was lacking, and long-term care organizations were not concerned. Investigating organizations, and/or understanding the quality of care in groups at specific times is critical, though, whatever the situation, different clients will receive different levels of care from the caregivers. The attachment theory, however, emphasizes on optimizing the willingness of the direct care staff in the service delivery of quality care.

Caregivers should focus on enabling their clients to live in ways that are acceptable in the society (Wolfensberger, 1972). The authors found that attachment to IDs from parents, family friends, close friends, and mentors was limited. For the IDs, the attachment was more with direct care staff, and although group homes might invest in giving comprehensive training to direct care staff in quality service delivery; high workload, limited individualized support, and high staff turnover were a bottleneck. The attachment theory, however, puts emphasis on focusing attention on individual clients in order to ensure quality care delivery (Reinders, 2009). In order for attention on individual clients to be applicable, focus should be on specific situations and standards.

Bigby and Clement (2009) examined what is known about work practices that influenced the direct care staff approaches to work in different settings. The authors found during their literature review that although inclusion of mentally disabled individuals into the community had been at the center of the intellectual disabilities

policies, the concept had not been well defined, and there were as such disagreements among those who worked in this sector.

Bigby and Clement (2009) conducted an ethnographic study where they collected data from a group home in a Community Inclusion Program. The group home housed 5 adults with severe mental disabilities whom the Program intended to integrate into the community setting in a Metropolitan area in Australia. The program recruited a Community Inclusion Officer (CIO) whose role was to ensure that direct caregivers integrated individuals with intellectual disabilities into the community (Warren, 2005 p.1).

Care practices adopted by the direct care staff and the residents behavior change were critical in ensuring inclusion of individuals with IDs into the community (Jones, et al., 1999; Mansell, 2005). Appropriate service delivery approaches enhance integration of individuals with IDs into the community and can be achieved through the staff ratio to the residents, staff qualifications and experience, knowledge and attitude; job satisfaction, role clarity, and autonomy of managers for organizing care. The researchers were also required to give their support in this initiative.

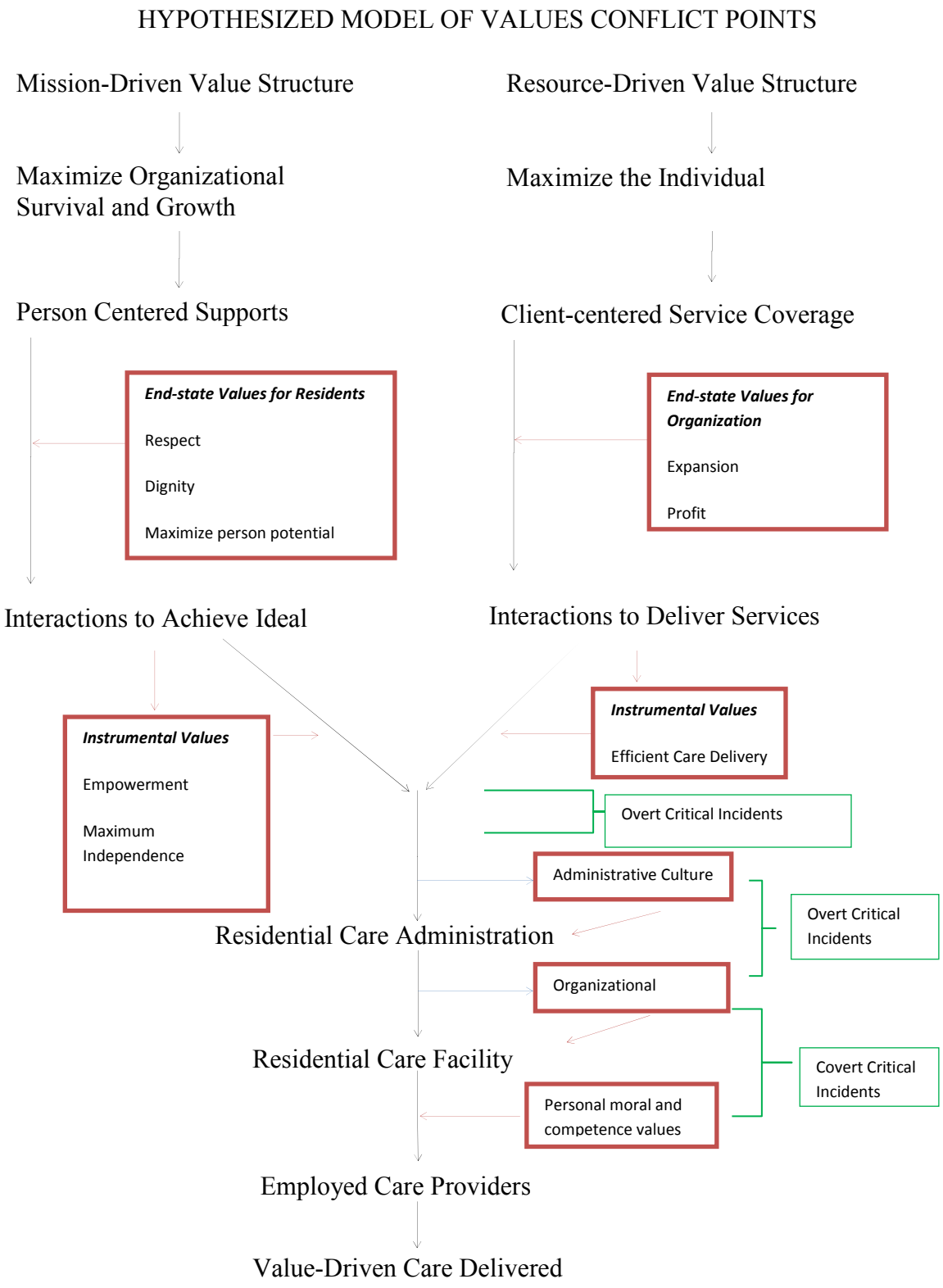
The staff did not support the idea that individuals with severe intellectual disabilities (IDs) would fit in a community participation program, and lack of support is a reflection of the society's perception of the IDs (O'Brien et al.2005). The staff viewed this activity as a future strategy for integrating individuals with IDS into the community, and reverted to their old work practices (Fournies, 1988). Family members of the

individuals with IDs, had also their doubts on the integration strategy and did not as such challenge the caregivers views, and practice.

Worden and Challis (2008) examined the contents included in a planning tool to establish whether they included the minimum standards as were outlined by the British government. The investigation was a follow up of previous studies on the assessment of care, and planning in group homes (Worden et al. 2006). The researchers aimed at identifying which staff members were involved in the care planning in group homes, type of documentation, and whether processes of care were included in the documentation.

According to the government, minimum care included individualized care that recognized strengths and preferences of the residents, who were noted to have complex and social needs (Department of health, 2006a) and records should be kept for accountability and follow-up. The researchers found that out of 255 questionnaires which were sent out, in Manchester and Cheshire in (2001/2); 182 were completed, and returned (71% response).They scrutinized the forms and found out the responses were categorized into problem-based aspects, the identified problem areas, the prescribed standard of care, and the daily care. They found that although the researchers were expected to involve the residents in the daily activities; only 16% of the homes involved them, and homes differed in what they included in their planning tools. The response from homes was interpreted to be due to varying definitions of quality care, and researchers, further, found out that professionalism was critical in the delivery of quality care. Figure 3 depicts a model of values conflict points.

Figure 3. **Model of Values Conflict Points**



The model has two branches, which lead to a common meeting point. The first branch focuses on the mission values, while the second focuses on the resources values. The mission values are derived from the Department of Mental Health; while resources are allocated from the Medicaid State funding. The mission branch depicts how individual values can be enhanced through maximizing empowerment and an individual's independence that resonates well with Rokeach's (1973) classification of values, which is consistent with Donabedian's conceptualization of the process. The situation can be realized through interaction between facility administrator, individual, and caregiver in order to ensure person-centered supports. This focus will, as a result, maximize the residents' potential to do things for themselves and consequently earn respect and dignity.

The other branch focuses on how efficient care delivery can be achieved through maximizing organizational resources and growth that focus on client-centered coverage and interaction between the caregiver and the administration. The scenario is in line with Auster and Freeman's (2013) findings that resources support the organization's value system, and Rokeach's (1973) topology that extends classification of values. The situation will as a result expand services, increase organizational potential, and profit.

The two branches meet at the level of Residential Care Administrator whose role is critical in the work process at the facility. One must encourage person-centered support within the existing resources in the organization. The mission statement must reflect this balance where person-centered support is maintained within the confines of available resources and suggest processes that are consistent with the idealized blend. Critical

incidents occur when work processes are challenged on a specific point by stakeholders with an interpretation stemming from a different value set or hierarchy relative to that single point in the overall process. This interpretation is not necessarily wrong relative to the point of challenge, but it does require accommodation. It is through this on-going process of challenge and accommodation that the work processes begin to drift from the processes that are congruent with the idealized values set, to processes that represent accommodated values drift. The operational values are the modified value set as represented in the work processes that emerged from the challenge. The administration will pass down those modified process that are germane to the facility, and the facility will be faced with absorbing a work requirement that has drifted from the idealized. The care facility must then accommodate their work process to the modified value set. Within the facility, this process is repeated with challenges that happen at the point of needing to adopt a modified work process from above or from internal challenges from other stakeholders that hold a different value set or hierarchy around a specific point of operations. Adoption of different work processes leads to more accommodation and more values drift, and more modification in the work process. These are the overt critical incidents that Gehman charts. The end result is a drift of operational values from the idealized values with a resulting set of work processes that likewise drift from the ideal approach to accommodate the point specific challenges. Once this filters down to the caregivers, they have no choice but to yield to the discordant demands of the work environment; however the discordant demands may crash with their personal and competence value hierarchy as they would like to pursue them in the work environment.

They respond by changing their value system within the context of the work environment to deal with the incongruence. This change is not the official organizational accommodation; it is a personal accommodation and consequently a "covert" critical incident which leads to their own modification of the work processes that have not been sanctioned by the organization (Rokeach, 1973).

Research Questions

The conceptual model suggests that interaction among administrators, caregivers, residents, and efficient use of resources are critical in the client-centered care.

RQ. 1 How does the configuration of operational values underpinning company sanctioned work processes facilitate the client-centered care at the group home?

RQ. 2 How have the critical incidents shaped the company sanctioned work processes to conform to client-centered care at the group home?

RQ. 3 How does the configuration of personal values underpinning work processes of direct caregivers and the facility administrator conform to the client-centered care at the group home?

RQ. 4 How have critical incidents shaped the value set of direct caregivers and the facility administrator to conform to the client-centered care at the group home?

Table 3 gives a list of the research questions, the variables, Chapter 2 headings, subheadings and the summary.

Table 3.

List of research questions, the variables, Chapter 2 headings, subheadings, and summary

Research questions	Variables	Chapter 2 headings, subheadings	Summary
RQ1 How does the configuration of operational values underpinning company sanctioned work processes facilitate the client-centered care at the group home?	Value congruence/value discord	Values in the workplace. -Origins -major value paradigms -values as universal and cohesive -values as situational and divisive -values level.	The corporate values must be congruent with the values espoused in the organization's mission statement. This is critical in the implementation of client-centeredness in the delivery of services (process).

RQ 2 RQ. How have the critical incidents shaped the company sanctioned work processes to conform to client-centered care at the group home?	Quality assessment,	Quality framework	Quality assessment that is implemented by established quality assessment bodies' put emphasis on technical and interpersonal care (process) that is critical in the client-centered approach.
RQ 3 How does the configuration of personal values underpinning work processes of direct caregivers, and the facility administrator conform to the client-centered care at the group home?	Personal values v/s organizational values	Personal values -Values congruence: Implication for individual -Values discord: Implications for the individual Organizational Values -values congruence: Implicational for the organization Values discord: Implications for the organization	Personal values and organizational must be congruent in order to enhance client-centeredness in the delivery of care.

RQ. 4 How have critical incidents shaped the value set of direct caregivers, and the, facility administrator to conform to the client-centered care at the group home?	Quality assessment	Quality framework	Quality assessment that is implemented by established quality assessment bodies' puts emphasis on, technical and interpersonal care (process) which is critical in the client-centered approach.

Summary

Group homes were developed in the United States in the 1950s to alleviate the inhumane conditions that were experienced by the mentally disabled individuals in the large psychiatric institutions (Vladeck, 2003). The philosophy behind the development of group homes was to integrate the mentally challenged individuals within communities and to empower them to participate in communal activities (Vladeck, 2003). This initiative was supported by politicians who enacted several legislations in support of the community-based health care services (Rilley, 2011) and their financing (Thomson, 2008).

Group homes are owned and operated by organizations, groups, or individuals (Walker, 2012), and the operational staff include direct care staff supervised by

residential care administrators who are responsible to the organizational management. Good outcomes will be realized, when, there is the client-centered type of care, and in order to achieve the intended goal, there must be a congruence of values among the organization, the caregiver, and the residents (Schwartz, 1994). Conflict of interest might negate the effort to attain the expected outcomes.

Chapter 3: Research Method

Introduction

Methodology is a general research strategy that outlines the way in which a study is conducted and identifies the methods to be used (Creswell, 2009). The methods define processes of data collection, how data are analyzed (Miles & Huberman, 1994), and the processes to be followed in a particular procedure in order to achieve the desired results. In this study, I explored the practiced institutional work processes in relation to the stated organizational approaches in an institution that focused on client-centered strategies of delivering care to its mentally challenged individuals and was as such a qualitative inquiry (Creswell, 2007) in which a case study approach was used.

Literature on the Methodology and Methods

Literature on methodology and methods should focus on the requirement of the intended study (Patton, 2002). This research was a case study in which I explored issues or problems with participants who were within a similar context. The study resonated with Maxwell (2013) who argued that a case study is not a methodology but a choice of what was to be studied. This argument resonated, further, with Riley (2011) who asserted that the client-centered care process is focused on supporting individuals to make informed decisions and manage their own lives. A case study was selected from other methods because it allowed me to observe and record emotional expressions, and data were gathered through interviews, observations, and from reports (Creswell, 2007). This method was ideal for the situation under investigation because critical care issues which reflected on client-centered care outcomes were understood and recommendations made.

Planned Study

In the group home, individuals are supported in their daily activities by direct care staff, the management, and the facility administrators. The focus in this study was to investigate how individuals are individually supported in order to realize their goals and aspirations in life through the person-centered approach to care. In person-centered care, individuals are supported to make informed decisions about their own lives in order to be successful (Riley, 2011). The study may answer the how and why questions that identify patterns of behavior of the participants (Creswell, 2009) and thus, address the client-centered care processes, on the other hand a qualitative inquiry that focused on measuring the attitudes of the individuals was preferred to a quantitative inquiry.

Design of the Study

The study was conducted in a group home in Massachusetts that embraces a client-centered approach in its delivery of care services. The study population included the seven caregivers, one nurse, and the group home administrator. In order to obtain a picture of how issues regarding client-centered care develop, a qualitative case study was used to gather focused data. According to Baxter and Jack (2008,), the use of a qualitative study enables researchers to unearth issues through diverse lenses that enable the concerns in a situation to be understood. The purpose of this study was to investigate how client-centered approach practices are applied in a group home that rehabilitates mentally disabled individuals in order to achieve their set goals.

One goal of this study, consequently, was to understand if emergent value practices in group homes impacted the quality of client care process and to explore the

potential for process modifications to influence client outcomes. In-depth information was gathered from different sources. I cross-checked the respondents' responses with the clients' behavior to meet the member checking requirement for accuracy.

Study Participants and Sampling

In a qualitative inquiry, there is no rule on the size of the sample, but it should be based on what the researcher wants to know, on what is useful and credible, and on whether it can be done within the available resources and time (Patton, 2002). It is, as such, not necessarily representative of the general population but should establish a deep understanding of the study population in relation to the research questions (Marshall, 1996). Large samples would, however, create difficulties in teasing out rich data, and too small samples cannot achieve data saturation (Onwuegbuzie & Leah, 2007). Onwuegbuzie and Collins (2007) recommended 12 participants sample as a general rule.

The participants in this study were seven caregivers who provided care to the individuals in three 8-hour shifts, one nurse, and one administrative staff. Due to their different roles in the group home, the participants responded to work processes that related to their roles. A pattern of events consequently emerged and different themes were formed, which informed the conclusions made thereafter. The validity and usefulness of the findings are not influenced by the sample size, but the information gathered from the participants and the skills of the researcher in observing and analyzing the events. The table 4 below describes the different sampling strategies that can be used when collecting data.

Table 4.

Sampling strategies

Sample classification	Focus
Purposeful sample	Select rich information from individuals, depending on the type of questions asked.
Intensity sampling	Individuals who have lived in the research site, for at least one year, will have a better understanding of the processes
Criterion sampling	Identify individuals who have similar exposure, and experience in certain issues
Typical case sampling	Point out what is normal, typical or average.

The participants in this study were the facility administrator, the nurse, and seven caregivers who work at the facility. In order to gather adequate information on the client-centered care processes at the group home, all the participants were respondents and no sampling was done.

Ethical Considerations

Participants provide personal information (Creswell, 2007) in which they expose their private life details and spend time on the study and as such, there are critical ethical considerations that must be addressed. Participants in this study were respected by ensuring use of appropriate language and names, as outlined in the *Publication Manual of*

the American Association (APA, 2001) guidelines, and I avoided stereotyping maintained confidentiality.

Human Subjects' Protection

Research regulations require the evaluation of research proposals that involve human subjects (Miles & Huberman, 1994). In this study, I considered issues such as protecting research human subjects and others from risks that have the potential to affect their health and other benefits. Therefore, I focused on the importance of the knowledge gained through the study. It is also a requirement to indicate the contribution the study would have on a particular research field and the adequacy of the proposed protection of human-beings (Patton, 2002). In this study, I implemented the proposed plans and protected human subjects from research risks in regard to the study and the plans and protection aspects will be used during the evaluation stage. Data safety and monitoring plans were evaluated (Patton, 2002) in order to ensure that the collected information is not accessed by unauthorized persons, and I ensured that the respondents were protected.

Definition of Human Subjects

Human subjects are living individuals, about whom a researcher conducting an investigation would obtain data through intervention, or interaction with the individual (Maxwell, 2013). Intervention includes physical procedures such as one-on-one interviews, completing questionnaires, group discussions by which data is gathered or observing the participants' behavior in their environment, while interaction takes place when there is communication or interpersonal contact between the investigator, and the subject/subjects (Maxwell, 2013).

Research Questions

Research questions focused on the situation under study and were framed in a way that pointed the investigator to the information that enabled understanding of the area of concern (Maxwell, 2013). The questions were exploratory where the investigator tried to understand a situation in which much was not known (Creswell, 20077). This approach facilitated the investigator to identify themes that helped in the understanding of particular processes. The study intended to understand the processes of delivery of care provided to the mentally challenged individuals in a group home in Massachusetts, the USA, that practices client-centered approach to its clients, and the following research questions were developed for the study.

RQ. 1 How does the configuration of operational values underpinning company sanctioned work processes at the group home compare to the idealized value set and hierarchy espoused values by the company administration?

RQ. 2 How have the critical incidents shaped the company sanctioned work processes at the level of the group home?

RQ. 3 How does the configuration of personal values underpinning work processes of direct caregivers compare to the configuration of personal values the caregivers believe should be supported in the group home context?

RQ. 4 How have critical incidents shaped the value set of direct caregivers in regard to care processes in the group home?

Role as a Researcher

In this qualitative study, the researcher conducted interviews, observed, collected data, and did not use questionnaires which have been developed by other researchers. According to Creswell (2007), the use of previously developed questionnaires would affect research processes, procedures, and findings. The researcher avoided bias due to prejudice and personal beliefs. Bias would influence research procedures, processes, and consequently compromise research findings (Abusabha & Woelfel, 2003). In order to stay professional, the researcher stuck to good conduct and behavior during interviews. The researcher avoided (a) commitment or disagreement with participants (b) remained active listener, and keen observer, (c) recorded only the expressed opinions of the participants (d) drew conclusions inductively from observations (e) summarized findings, identified patterns, and collaborated all information to form accurate representations of participant views. Trochim and Donnelly (2008) and Frank (2000) supported the aforementioned precautions as critical in carrying out a study effectively and efficiently.

Data Collection

Data is critical in studies because it is through collecting and analyzing data that the investigator is able to address the research questions (Creswell, 2007). Several intertwined activities that include research subjects, gaining access to research sites, reporting, purposeful sampling, collecting and recording information, exploring issues, and storing data are carried out during data collection process in a case study (Creswell, 2007). The approach is critical because activities form a circle that starts with the individual, or site, and should end up with the storage of data (Creswell, 2007). After

identifying the participants, a researcher makes arrangement for interacting, and develops a relationship with them in order to facilitate the collection of quality data, and takes a purposeful sample, collects data, and records; cross-checks field information, and stores data (Creswell, 2007, p.118).

In the client-centered care process study, the nurse, caregivers, and the facility administrator were the respondents and their views guided investigations into the care processes within the group home. The researcher physically collected data from the aforementioned group home, and in order, to effectively collect data, the researcher developed and used questionnaires, and observed participants as they carried out care practices. The data collection plan is outlined in table 5 below.

Table 5.

Data Collection

Planned Step no.	Activity Plan
1	Identification of the research site
2	Submitting requests and specifying the intended purpose of collecting data
3	Review responses given and plan data collection
4	Gathering data
5	Recording information
6	Clarifying field issues
7	Data storage and analysis

Interview Data

Interviews are carried out among individuals, or groups, in order to understand a particular phenomenon, and are as such tools of collecting information, or data (Yin,

2003). They are undertaken with the aim of collecting primary data, and can be structured (with questions focused on issues in a particular situation), unstructured (questions without a particular order of providing answers), and the semi-structured which are aimed at collecting information or data, through open-ended questions and gives room for probing. Creswell (2007) argues that the quality of data using interviews will depend greatly on the way questions are framed, and also on the interviewer's skills and experience in recording, and interpreting information from the interview. Interview questions will be framed in reference to the setting, or individuals, and will depict diversity, and minimize making personalized conclusions (Maxwell, 2013). They should help the researcher to focus on specific beliefs, actions, and events that can be observed (Maxwell, 2013 p.79), and according to Marshall and Rossman (1999), a site-specific study is "defined by and intimately linked to that place" (p.68). The stated situation applies in the proposed case study of a group home in which six individuals with varying mental disabilities live together, and in which client-centered approaches to care are practiced.

The kind of questions and the way they are asked may influence views, and responses from the respondents (Trochim & Donnelly, 2008). An interview protocol would as such guide the researcher not only on the questions to ask, but, also on appropriate conduct during the data collecting process, and Creswell (2007, p.136) designed a sample protocol, to be used for this purpose as follows:

Interview Protocol Study*:* Client-centered Care Approach.

Time of Interview:

***Date*:**

Place:

Interviewer:

Interviewee:

Description of the study: The study is a qualitative case study of a group home that practices client-centered approach to the delivery of services to its clients in Massachusetts, USA.

Questions asked to address the research questions:

Finally, the individual should be thanked for participating in the interview, and be assured of his/her confidentiality of the responses.

Interview Questions

The interview questions will be mitigated through consulting an experienced researcher (Maxwell, 2013) on the appropriateness of the interview questions; because appropriateness of interview questions is critical, since, wrongly asked questions could yield inappropriate answers (Patton, 2002), which could give wrong conclusions. The interview questions will be in sets of three questionnaires and each questionnaire will be completed in the presence of the researcher by specific respondents who include the facility administrator, the caregiver, and the nurse.

Survey Questionnaire for a client-centered care study to be filled by the Caregiver

Hello,

Thank you for allowing me to communicate with you. I recognize and appreciate the role you play at the group home. I sincerely request you to fill in information on the questions that are specific to your role at the group home as indicated on the questionnaire.

Please answer the questions as honestly as possible. Truthful responses would provide strong bases for suggesting critical improvements in the group home care. I assure you that all responses will be held strictly confidential, and I appreciate your time and generosity.

God bless you.

Please provide correct information to the following questions.

1. How have your personal views on care in group home been influenced by the espoused care practices?

2. How have your views in group home care been influenced by the practiced home care approaches at the group home?

3. How have your personal views on care in group home been influenced by the stipulated organization's home care guidelines?

4. In your opinion, how have care award schemes influenced client-centeredness to the delivery of care in the group home?

5. How in your own views would the clients describe the client-centered care at the group home?

6. How would you describe the relationship between the clients and the staff at the group home?

7. In your view, what are the merits and demerits of client-centered care in the group home?

Thank you.

Survey Questionnaire for a client-centered care study to be filled by the Facility Administrator

Hello,

Thank you for allowing me to communicate with you. I recognize and appreciate the role you play at the group home. I sincerely request you to fill in information on the questions that are specific to your role at the group home as indicated on the questionnaire.

Please answer the questions as honestly as possible. Truthful responses would provide strong bases for suggesting critical improvements in the group home care. I assure you that all responses will be held strictly confidential, and I appreciate your time and generosity.

God bless you.

Please provide correct information to the following questions.

1. Describe in your own words, the practiced client-centered care practices in contrast to the espoused client-centered care guidelines by the organization?

2. Describe the practiced client-centered home care in relation to the organization's mission statement?

3. How have your personal views on care been influenced by the stipulated organization's stipulated care practices?

4. How have care award schemes influenced client-centeredness to delivery of care in group homes?

5. How in your views would the clients describe the client-centered care at the group home?

6. How in your own words, explain the relationship between the clients and the staff at the group home?

7. In your view, what are the merits and demerits of client-centered care in the group home?

Survey Questionnaire for a client-centered care study to be filled by the Nurse

Hello,

Thank you for allowing me to communicate with you. I recognize and appreciate the role you play at the group home. I sincerely request you to fill in information on the questions that are specific to your role at the group home as indicated on the questionnaire.

Please answer the questions as honestly as possible. Truthful responses would provide strong bases for suggesting critical improvements in the group home care. I assure you that all responses will be held strictly confidential, and I appreciate your time and generosity.

God bless you.

Please provide correct information to the following questions.

1. How have your personal views on home care been influenced by the espoused home care care practices?

2. How have your personal views on care been influenced by the stipulated organization's practices?

3. How do the practiced care practices relate to the Organization's Mission Statement?

4. How have care award schemes influenced client-centeredness to the delivery of care in group homes?

5. In your view, what are the merits and demerits of client-centered care in the group home?

Observation

Observation as a tool of research provides access to the phenomenon under the study, and instead of depending on what individuals say when asked how they perform certain activities, the researcher observes and records the respondent's behavior (Creswell, 2009). This observation avoids problems, which might arise in interviews, or a questionnaire, where, respondents give reports or views which are desirable, or socially acceptable. Observation can take different forms, which range from formal, and unstructured approaches to standardized procedures, and can yield associated types of data, both quantitative and qualitative (Creswell, 2009). Observation is applicable in a wide range of social behavior that may be of interest to a researcher, and should be recorded to allow for further analysis, or comparisons (Miles & Huberman, 1994). Although observation complements other research approaches in enhancing triangulation, observer bias could undermine reliability, and cause validity issues on the data collected (Creswell, 2009).

Participants in the proposed study include caregivers, the nurse, and the facility administrator who will be observed as they interact in their daily activities, and the investigator will assume the role of a participant (Creswell, 2007). When in a participant role, the investigator will be regarded as a part of the organization, and participants will act naturally in their roles and activities, and enable the investigator gather as much information as possible (Creswell, 2007).

Data Analysis

In qualitative study, data analysis was divided into preparing and organizing data that include transcripts, or information in photographs (Creswell, 2007, p. 148). Data was coded and put into themes, and then represented in graphs or tables for discussion. Early data analysis, gave the researcher an opportunity to go back to the study site, and filled in gaps in the already gathered information in order to answer research questions (Miles & Huberman, 1994). The analysis was critical especially where different events took place, and required changes in the study approach. It also facilitated generation of interim reports, which were important during continuous evaluation of the study (Miles & Huberman, 1994), and interweaving data gathering, and analysis was a good study strategy in the case study.

Data collected in the client-centered care group home was of a descriptive nature because it explained how certain work processes were practiced in the targeted group home. Data was compared and contrasted with the organization's espoused values and it identified areas of conflict. Data was collected in one week and continuously analyzed to

allow the researcher explore various situations, and be able to link up the practiced procedures.

Table 6.

Steps in Analyzing Data

Outline ideas on what to include in the data analysis		Write notes beside the field notes
Take notes		Should reflect on what is observed on the site
Field notes summary		A summary of what is done
Identify codes		Constitute them into themes
Relate themes		Build into categories
Relate categories		Build them into logical conclusions
Relate categories to the analytic Conceptual Framework		Contextualize in the framework in the Literature Review.
Display data		Show the picture of the Conceptual Framework.

Use of Computer in Data Analysis

Although computers improved effective analysis of text and image data, the process used is the same as that used in manual coding (Creswell, 2007, p.164). The investigator selects data and image segments, and assigns codes, and examines stored data, to identify data with similar codes, and gives a code label, and all codes are grouped manually into categories (Creswell, 2007). This process is undertaken by the researcher

but not the computer program. The computer, however, plays the role of storing data, and facilitates easy access to codes provided by the researcher. Although the computer might not be appropriate for studies with small databases, they are useful in storing data in an organized manner that facilitates easy access (Creswell, 2007 p.165), and scrutiny of data that allows for quick conclusions. There are a number of programs that are used in the qualitative data analysis, and *NVivo* will be used in this study because it has features that help manage and analyze qualitative data (Creswell, 2007).

In the process of reviewing data collected through questionnaires, during observations, and through program's documents; certain patterns emerged which were coded, and grouped into themes, and categories which provided explanations and meaning (Sadana, 2009). Researchers argued that the process of coding and categorizing information and data in qualitative studies was interactive, and involved multiple sources of information, and data (Baun and Clarke, 2006; Sadana, 2009; Creswell, 2007). Statements from raw data that captured client-centered care in this study were filtered into codes, themes, and categories. The emerging approaches to delivery of care were constantly compared, and contrasted, and coded further into categories that focused on the client-centeredness to care. There were, however, discrepancies in the coded and categorized data, which after careful evaluation were discarded, because the data lacked important information about client-centeredness practices in the delivery of care. Researchers in qualitative investigation used theme and category interchangeably (Sadana, 2009). There were, however, no conflicting issues within qualitative research on the definition, and analytic function of a theme, and there was a consensus that the term

identified the essence of a unit of data (Sadana, 2009). Themes in this study captured important information about data in relation to the research question, and represented some level of patterned response, or, meaning within the data set. This argument was supported by Baun and Clarke (2006, p.82) in their assertion, that themes captured information that related to the research questions.

Validation and Reliability

Validity and reliability of researched information is critical in authenticating the findings of the study and in qualitative study it takes different perspectives (Creswell, 2007), depending on the researcher. Lincoln and Guba's (1985) views on validity and reliability are explained by Creswell (2007, p.203) as findings in a study, which are credible, and dependable. This perspective is convincing because credibility and dependability ensure applicability, which is the main focus in studies. Other researchers such as Angen (2000) argued that in order to ensure validity and reliability; issues in the study should be specific, and ethical. Angen brought in an ethical dimension, which is critical in research, especially when dealing with human beings as research subjects. According to Angen, as explained by Creswell, 2007, p.204; validation should be an issue of trustworthiness, or genuineness of the researcher, in explaining the research findings. Group home clients will not be respondents in this study, and their exclusion might create difficulties in acquiring primary information on their individual perception of the client-centered care at the facility. Information will be gathered from the facility administrator, the caregivers, and the nurse. In order to collect objective information, the researcher will remain faithful and avoid bias in order to gather data that would be

compared and contrasted with the organization's stipulated standards and guidelines of client-centered care.

Qualitative researchers spend much time with participants, in order to build trust, understand the existing cultures, and correct any misinformation that might have arisen during interaction between the researcher and the respondents (Creswell, 2007 p. 2007). This consequently gives the researcher deep understanding of the perspectives on the issues being studied (Creswell, 2007) and allows for probing participants on how and why they do certain activities. This strategy can be improved by identifying specific threats and developing mitigation measures. The mentally challenged will not be participants in the study, and the researcher will as such cross-check responses provided by the study participants to ensure that the answers given in the questionnaires are supported by the organization's documented standards and guidelines. The table 7 below gives a validity matrix of the client-centered care.

Table 7.

Validity matrix for the client-centered care (adapted from Maxwell, 2013 p.130)

1. What do I need to know?	*2.Why do I need to know this*	*3.What kind of data will answer the questions*	*4.Analysis* Plans	*5.Validity threats*	*6.Possible strategies for dealing with validity threats*	*7.Rationale for strategies*

RQ 1: How does the configuration of operational values underpinning company Although the organization has its stated values, the attitudes of the Structured responses from caregivers and facility administrator on their work values and Coding and categorizing data sanctioned work processes at the group home relate to the idealized value set and hierarchy espoused values by the company administration?	Caregivers and the administrator are not known.	attitudes		Organizational confidentiality issues	Use of open-ended questions to minimize confidentiality fears	To facilitate participant to provide as much information as possible.

RQ. 2 How have the critical incidents shaped the To understand what might have i) Responses from the facility administratActivity reports company sanctioned work processes at the level of the group home?	influenced changes in the delivery of care	or ii) Facility administrative reports	Data confidentiality issues	Assure that data with help on improvemEncourage participants' involvement ent of services

RQ. 3 How does the configuration of personal values underpinning work processes of direct caregivers relate to the Effects of an individual's work values and attitudes in the group home are not known. configuration of personal values the caregivers believe should be supported in the group home context?	Number of confrontational work related incidences among the group home Community.	Facility management reports.	Organizational confidentiality concerns.	Open-ended interview questionnaires	Reduces the interviewees fears of organizational victimization

RQ. 4 How have critical incidents shaped the value set of direct caregivers Incidences that might influence direct care staff in regard to care processes in the group home?	work related number of corrective work related practices are not known.	Management reports	Office confidentiality issues	Open-ended interview protocol with the interviewee	To protect staff from victimization for giving information about the organization

Qualitative inquiry was identified as the appropriate approach for the proposed client-based care processes in a group home that accommodates the mentally challenged individuals, and will be a case study that will be carried out in a group home in Massachusetts, USA. The study participants are six persons served, seven caregivers, and one administrator. Data will be collected by the investigator through observation, interviews, and NVivo computer program will be used for analyzing data. Validity and reliability will be ensured through cross-checking observed and interview data with the existing management records.

Summary

Research methodology explained the study design, participants, role of the researcher, engaged approach, research questions, validity and reliability, and ethical issues of concern. The study design is a qualitative inquiry that is rationalized for the

proposed study, and intends to understand the client-centered work processes in a group home in Massachusetts, USA; that accommodates six individuals with varying mental challenges, seven caregivers, and one administrator. There are five research questions to be addressed, through one-on-interviews, observation of activities, and management records. Nvivo computer program will be used for data analysis, and the researcher will be engaged in the data collection processes.

Chapter 4: Results

Introduction

I begin this chapter with an introduction that explains the rationale for the study, provide the study findings, and conclude with a summary. The setting under which the study was undertaken is explained and a description of the study informants is provided. Authenticity in collection of data is explained and evidence of trustworthiness is provided. Data collection processes and analysis are also explained. This study is descriptive and is a client-centered approach on the delivery of care to mentally challenged individuals in a group home in Massachusetts. The purpose of the study was to assess the effectiveness of the client-centered practices in the delivery of care. The study employed the Donabedian conceptual framework (1980) that underlined the structure (staff) as a prerequisite to process (skills utilization) and process as a prerequisite to outcome (results). The outcome (results) were expected to comply with the organization's mission statement, putting emphasis on empowering the mentally challenged individuals through skills training, and engaging them in the decision-making process on issues which were critical in achieving their objectives in life. The goal of the study was to gain an understanding of how direct caregivers, administrators, and nurses deliver care to the mentally challenged individuals. The goal of this study resonated with the assertion by Lincoln and Guba (1985) that the intent of qualitative research is to understand a particular social situation. The understanding of the delivery of care process in this study was achieved through reviewing the organization's documents on care delivery practices, observing participants as they delivered care to their clients, and

analyzing responses that addressed four research questions. The research questions were as follows:

RQ 1. How does the configuration of operational values underpinning company sanctioned work processes facilitate the client-centered care at the group home?

RQ 2. How have the critical incidents shaped the company sanctioned work processes to conform to client-centered care at the group home?

RQ 3. How does the configuration of personal values underpinning work processes of direct caregivers and the facility administrator conform to the client-centered care at the group home?

RQ 4. How have critical incidents shaped the value set of direct caregivers and the facility administrator to conform to the client-centered care at the group home?

In order to tease out focused answers to the research questions, two sets of questionnaires were constructed. One set contained issues which were to be addressed by the facility administrator, while issues in the other set of questionnaires were to be addressed by the direct caregivers, and the nurse. Questions in both sets of questionnaires focused on investigating how direct caregivers, the facility administrator, and the nurse perceived client-centeredness in the delivery of care at their facility. The use of questionnaires has been supported by researchers as a good tool of collecting data, and Maxwell, (2013), and Ackroyd (1981) argued that use of questionnaires in qualitative studies had limited influence on trustworthiness and reliability of the results. Taylor and Bogdan (1998) stated that questionnaires are useful in collecting large amounts of data from several participants within a short period, and are relatively cost effective. The

assertion by Taylor and Bogdan (1998) was found to be true because data in this study were collected from seven direct caregivers, one administrator, and one nurse within 4 days at a relatively low cost. The search for information in this study began with scrutinizing related literature on the delivery of care in group homes and then identifying the gap in the existing literature. Maxwell supported this approach and stated that related literature gives a researcher an opportunity to identify a gap in the existing literature, and a gap that advocated for further studies in a particular subject area. The literature review in this study provided a framework on which to compare and contrast results. Table 8 below is on the use of literature and the existing criteria.

Table 8.

Use of literature and the existing criteria

Use of Literature	Criteria
Literature was used in a way that it framed the problem that the study aimed to investigate	Literature was existing in the intended area of study
Literature was presented as review of literature in Chapter two	Literature review was acceptable to the participants, and the community partner in this study
Literature was used in the end of the study as the basis for comparing, and contrasting results.	Literature was used to relate the identified codes, themes, and categories.

Participants' perception was established through analyzing responses to questionnaires and was instrumental in understanding how participants viewed the delivery of client-centered care in the group home. Furthermore, the findings justified the

use of questionnaires as an important tool in this study. Participants provided their individual consent to complete questionnaires and to be observed as they delivered care to their clients at the group home during office hours.

The nurse took about 25 minutes to prepare and administer medication to each of the six individuals, and direct care staff took about 10 minutes to demonstrate skills in utensils and floor cleaning processes to each individual. Observation provided me an opportunity to see and relate issues under investigation. Observation was a critical tool in understanding the processes practiced by participants as they delivered care. Creswell (2007) argued that interview questions are important in answering the concerns of the research questions. The concerns in this study were addressed through the use of several open-ended questions provided in two sets of questionnaires that gave participants an opportunity to respond. Participants provided varying responses that reflected an individual's understanding of the questions asked. I remained focused and objective when analyzing data, and this strategy resonated with Popper's (2004) assertion that researchers should avoid subjectivity when coding open-ended questions in a qualitative study. Design of interview questions was also critical in ensuring a focused understanding of the questions by the respondents, and in order to minimize misunderstanding of the questions, I carried out a pre-testing where participants were asked to give feedback on their understanding of the questions asked. The participants' feedback on the questions provided an indication of the level of clarity on the issues covered under investigation, and questions were reframed where discrepancies were found to exist. Adjustment was necessary for the ease of the participants' understanding.

Questions in the two questionnaires were designed to enable participants to respond effectively to the four research questions. I was a participant; therefore, the respondents viewed me as one of them and were relaxed and attentive when participating in the research activities. Creswell (2007) argued that a researcher who was a participant should ensure that he or she did not introduce bias or influence the participants' views. I ensured that I abided with the instructions given by the organization's representative during vetting process and remained professional during the investigation. I did not influence, or introduce bias in the study, and responses from participants should be perceived as honest and trustworthy.

Findings

Through examining documented care procedures and guidelines, observing participants as they delivered care to their clients at the facility, and reviewing participants' responses in the structured questionnaires, I was able to capture and outline the participants' perception on the client-centeredness approach to the delivery of care at the group home under investigation. Participants were asked to give individual consent, before participating in the study which was conducted during office hours. Participants agreed to complete structured questionnaires and to be observed as they delivered care to their clients at the group home. Giving individual consent showed willingness and commitment to participate in the study, and participants' responses should be considered genuine and honest.

Setting

Research settings were interpreted as physical, social, and cultural sites where an investigation was carried out (Patton, 2002). The researcher in this study did not manipulate conditions of the study, but laid focus on activities that located him in the study context. This approach was supported by Maxwell (2013) who asserted that a qualitative researcher should focus on studying a phenomenon in its natural environment. In a qualitative study, investigation is conducted in order to get the meaning of a particular phenomenon, and as such, participants in this study remained in their natural environment (Creswell, 2009). In this study, participants delivered care activities as a routine and this scenario facilitated the researcher to tease out client-centered care issues as they unfolded.

The study was carried out in a group home in Massachusetts, the USA, that accommodated six mentally challenged individuals. The individuals included four males and two females of different age groups, ranging from 30 to 65 years. Care was provided by seven direct caregivers, a nurse, and a facility administrator. Participants, who were skilled in different health care delivery areas, were asked to give consent to participate in the study during office hours, and to give their views on the level of the practiced client-centered care at the group home under study. They also gave consent to be observed as they delivered care to their clients.

Demographics

Participants who were direct caregivers, administrator, and the nurse, had more than two years' experience in the rehabilitation of the mentally challenged individuals

and were exposed to client-centered care practices within this particular facility for more than one year. The time that participants had been at the facility gave them an experience that enabled them to explain their perception of client-centered care. The seven caregivers, who were the participants in the study were both male, and females of ages ranging between 25 and 60 years, and had attained different levels of education. The difference in age and education facilitated participants to offer varying perceptions, which were useful during data analysis. The aspect of age and education gave participants experience, and knowledge that was crucial during analysis of the gathered data and information, and this aspect resonated with Popper's (2004) argument that age and education were critical in understanding and interpreting research questions. The participants delivered care to six mentally challenged individuals who included four males and two females of different age groups from different ethnic backgrounds (European, African, and Caucasian), and had lived in the facility for over three years. Although the mentally challenged individuals who received care were verbal, they could not be recruited as informants in this study, because they were considered a vulnerable group whose rights had to be protected. The table 9 below lists the study participants by job, gender, age, years of service, and level of education.

Table 9.

Study participants by job, gender, age, years of service, level of education

Job	**Gender**	**Age Range**	**Years of Service at the Facility**	**Level of Education**
Administrator	Female	30-40	3	Degree
Nurse	Female	28-35	4	Degree
Caregivers	Males and Females	25-60	3	G.E.D

Authenticity in Data Collection

This study involved collecting information and data through use of structured questionnaires, observing participants as they delivered care, and examining documents on procedures and guidelines on client-centered care practices. Participants included the facility administrator, nurse, and direct caregivers. Questions in the questionnaires were a reflection of the participants' areas of responsibility and participants' perception as such was critical. According to Creswell (2007), a case study focused on an issue that was explored within one or more cases in one setting. The different staff members who were participants in this study had worked for over two years in this facility and the mentally challenged individuals had lived at the facility for over three years. The researcher went through a vetting process by the organization's representative in order to ensure that the collected data was not misrepresented. In order to collect authentic information from participants, the researcher listened and answered questions which participants asked

concerning the research process. He was also respectful to participants, non-judgmental, and was present during the research activities. The researcher was skilled in identifying areas of deception when analyzing information given in the questionnaires. A participant might have been thinking outside the full context of the situation under study, and, in this case a participant would introduce arguments that reflect on staff centeredness in the delivery of care and the researcher was keen to detect such anomalies, and remained objective. The aforementioned qualities of the researcher were critical in ensuring collection of the right information and data. Authentic data enabled the researcher to undertake objective analysis and provide the right results (Creswell, 2007).

Evidence of Trustworthiness

Triangulation involved cross-checking information from several sources and was a critical process in ensuring trustworthiness and reliability of the collected data (Creswell, 2007). Triangulation in this study was done by using information gathered through the use of questionnaires, program documents, and the observation. In order to ensure reliability in the study, the researcher who was a key instrument of data collection built a picture, and analyzed words, and reports of the detailed views of the participants. The study was conducted in a natural setting which was critical in this study. The natural setting facilitated research activities to be carried out as a normal routine, that was not intimidating (Creswell, 2009). The study was undertaken at the group home during office hours and the research time was agreed between the researcher and the participants. Participants gave consent to participate in the study and ensured that they understood the research activities, through asking for clarifications during the research process. The

commitment of the participants to this study was a reflection of their attitude towards this study, and their responses would be perceived to be genuine.

The use of questionnaires was supported by Popper (2004), who asserted that questionnaires used in qualitative studies did not influence participants' perceptions. The researcher, who was a participant observer remained impartial by ensuring that participants provided their personal views on the questions asked without his influence. This conduct of the researcher was supported by (Maxwell, 2013), who argued that a participant observer must act professionally, and should not influence respondents' responses. The recorded observation of participants as they delivered care; information from program documents, and responses from questionnaires were triangulated to authenticate the gathered data.

Data Collection Process

Data collection in this case study involved gathering data from various sources and this approach resonated with Patton (2012), who asserted that there were six sources of information that included existing documents, archived documents, completed questionnaires, observations, and artifacts as critical during data collection process. Data in this study was collected in a group home in Massachusetts, the USA that practiced client-centered approach in the delivery of care to its mentally challenged clients. The study involved review of documented program's procedures and guidelines on delivery of care, observation of client-centered care processes, and completion of structured questionnaires by staff. Permission to collect data was sought from the organization's representative. The purpose and procedure of the study were explained, and then,

participants were asked whether they were willing to participate in the study and were asked to take one day (24-hours) to consider their decisions as to whether they would give individual consents to participate in the study. They were also asked to give consents to be observed as they delivered care to their clients. It was after giving their consents that the study process began. Maxwell (2013) argued that before participants gave consent of their intent to participate in a study, they should be informed, and as a consequence, be accountable for their responses. Structured questionnaires with open-ended questions gave participants an opportunity to express their personal views. Questionnaires were completed by participants at the facility during office hours, and the situation facilitated participants to operate within their environment. Through use of an observational protocol, the researcher was able to take field notes as participants continued to deliver care to their clients. The table 10 below lists the program documents and reports.

Table 10.

Program documents and reports

Document	Report
Critical needs Assessment, which, was undertaken 72 hours after an individual was referred to the rehabilitation group home.	Confidentiality of the individual's assessment report was written and maintained in accordance with State, and Federal laws. Maintained in accordance with State and Federal laws
Individual Action Plan (IAP). Individual goals, objectives, and intervention measures were outlined.	Individual client's service notes, which reflected rehabilitation activities undertaken were written each time a rehabilitation intervention was carried out.
Countable substance book	Recording of used controlled medications was done on daily basis.
Medication sheets	Reports on used medications were done on daily basis.
Communication log	Communication on issues regarding client-centered care was done during work shifts.

Codes, Themes, and Categories

The focus in the analysis of this study was to develop a storyline and as such became a process of going through textual data from questionnaires, observations, and program documents in a systematic manner (Taylor & Bogdan, 1998). Information was analyzed and ideas and concepts coded. Similar codes were linked in order to fit data into themes and categories. Codes helped to summarize what was happening in the data,

through linking the collected data and interpreting codes, and the linkage became the basis for analysis.

Coding is a process of sorting and organizing data, and codes were labels that were assigned to information gathered during observations, program documents, and responses given by participants in the questionnaires (Miles & Huberman, 1994). Codes served to label, compile, and organize data, and were used to categorize concepts into themes without affecting the context (Miles & Huberman, 1994). A theme statement was used to interpret information (Creswell, 2009), and the researcher in this study ensured that the statements were clear, and provided the reader with a summary of interpretation.

Codes and themes in this study were important in answering the four research questions because they gave a pattern of how client-centered care was perceived and practiced by the participants at the group home. Three codes were pre-determined from the conceptual framework (Creswell, 2009), and another two codes were identified later. The later codes were identified during observations of participants as they delivered care to their clients, and from program documents along with participants' responses to the questionnaires. As a rule, codes should fit into data; not data to fit into codes (Creswell, 2009). Codes in this study were developed from the gathered data and information, and codes that addressed similar issues were grouped into the same themes. The table 11 below outlines the themes identified from the categories.

Table 11.

Pre-determined codes, themes, and categories

Code	Theme	Category
A	Efficiency: Issues included documented procedures, and guidelines on delivery of care; staff members' skills, and attitudes.	Structure
B	Delivery of care: Issues included work practices, and interpersonal skills among care providers.	Process
C	Resultant care: Issues included adherence to documented care standards and organization's mission statement.	Outcome

Creswell (2007) asserted that themes in a case study were developed from categories, and argued further, that themes should be more than the identified categories. This argument was affirmed in this study, where issues on client-centered care emanated from predetermined codes, themes, and categories; while new issues were identified during the study. Themes represented meaning derived from data that was related to the research questions and were established from the frequency of patterns of the gathered information, and data (Creswell, 2007). In this study, three categories were predetermined, which included structure, process, and outcome, and three themes were consequently predetermined. The predetermined themes included efficiency that was influenced by the care provider's level of skills and attitudes; delivery of care that was influenced by care providers' interpersonal relationships, and resultant care that was

guided by procedures, stipulated guidelines, and the mission statement. Other themes were identified during the study included: quality care that focused on adherence to documented standards; Values congruence that addressed care providers' values agreement with organization's values; Value discord, which focused on care providers' values disagreement with those of the organization, and finally administrative issues, which addressed organizational strategies in actualizing mission statement. Based on the aforementioned themes; a pattern emerged, that depicted the participants' perception of the client-centered approach to delivery of care to the mentally challenged individuals in the group home under the study. The table 12 below depicts the pre-determined codes, identified codes, themes, and categories.

Table 12.

Pre-determined codes, identified codes, themes, and categories

Code	Theme	Category
A	Efficiency: that was influenced by care providers' skills and attitudes towards delivery of care.	Structure
B	Interpersonal relationships: relationship among care providers that enhanced delivery of quality care.	Process
C	Resultant care: care that was enhanced by stipulated procedures, and guidelines.	Outcome
D	Quality of resultant care: care that was enhanced by care standards.	Outcome

E	Agreement of personal values, with Organizational values (Congruence)	Structure
F	Disagreement of personal values with Organizational values (Values discord)	Structure
G	Administrative issues, which focused on actualization of mission statement.	Process

Data Analysis

The data that was collected from the completed questionnaires, documented procedures, and guidelines on the care delivery practices, and observation of participants as they delivered care to the clients were reviewed and analyzed. Gathered information that related to efficiency due to staff attitudes, and skills; organization's leadership and staff's values agreement (values congruence), and staff and organization's leadership values disagreement (values discord) was grouped into one category (structure); information on interpersonal relationships and administrative strategies which enhanced work practices into another category (process), and the final category was on the received care and its quality (outcome). Information and data were categorized as the study continued and this approach was critical in ensuring that information was grouped in the right codes, themes, and categories (Creswell, 2007). According to Creswell (2009, p.185), there were eight critical steps in qualitative data analysis; that included: raw data (transcripts and field notes), organizing, and preparing data for analysis, reading all data, coding data, putting codes into themes, interrelating themes, interpreting meaning of

themes, and putting themes into categories. Information and data was coded in this study and were classified into the identified themes and categories. Analysis continued until saturation was achieved, that meant there were no new themes identified. Creswell and Clark (2010), outlined 7 steps that would be helpful in the process of identifying themes, coding, categorizing, and analyzing data. The steps were as listed below:

1. Examining data, transcripts, and writing notes.
2. Identifying codes, themes, and categorizing information, and data.
3. Cross-checking related codes to ensure that they agreed.
4. Gathering, and grouping similar codes to develop themes.
5. Linking, and interrelating themes.
6. Developing a case study through the description of themes.
7. Cross-checking areas of concern by analyzing the collected data.

The steps outlined by Creswell and Clark (2010) were followed in this study through the administration of questionnaires, examination of existing documents, documentation of issues noted during observations, and validating of data. Data from documents, completed questionnaires and the observations made; were used to cross-examine information and this process is referred to as triangulation (Creswell, 2003). Documented data stipulated organization's procedures and guidelines on client-centered care, and observations focused on the care delivery processes. Codes, themes, and categories were developed after reviewing the collected data, and the review was done three to four times to ensure that data was classified in the right themes, codes, and in the relevant categories (Miles & Huberman, 1994).

Interpretation of the collected data depicted existing issues, which compromised quality of the delivered care at the group home (Donabedian, 1980), and the findings were within the three identified categories: structure (attitudes), process (interrelationships among care providers), and outcome (delivered care). The three aspects: structure, process, and outcome, which were identified during interpretation resonated with Creswell (2007), who argued that interpretation of data in a case study should focus on one, or, many aspects. The table 13 below depicts the codes, the themes, and the categories.

Table 13.

Codes, Themes, and Categories

Code no.	Theme	Category
A	Evidence of influence from organizational values	Organizational values (structure)
B	Evidence of effects as a result of staff satisfaction	Staff attitudes, skills, and efficiency (Structure)
C	Evidence of influence from personal values on delivery of care	Staff values (Structure)
D	Evidence of activities which had influenced delivery of care	Work practices (Process)
E	Impact from result-based award initiatives	Quality of delivered care (Outcome)

Research Questions

In order to answer the research questions, participants were asked to respond to open-ended questions, which were in two sets of structured questionnaires. One set had six questions, which were answered by the administrator and the other set had five questions, which were addressed by the nurse, and the seven direct caregivers. The questions in the two sets focused on client-centered issues, and this approach enabled the researcher to tease out views on client-centered care from individuals whose experience in client-centered care practices, level of education, roles, and responsibilities at the group home were different.

Survey Questionnaire for a client-centered care study to be filled by the direct caregiver/nurse.

1. How have your personal views on care in group home been influenced by the espoused care practices?
2. How have your views in group home care been influenced by the practiced home care approaches at the group home?
3. How have your personal views on care in group home been influenced by the stipulated organization's home care guidelines?
4. In your opinion, how have the evidence-based client-centered care award schemes influenced the quality of care delivered at the group home?
5. In your view, what are the merits and demerits of client-centered care in the group home?

Survey Questionnaire for a client-centered care study to be filled by the Facility Administrator.

1. Describe in your own words, the practiced client-centered care practices in contrast to the espoused client-centered care guidelines by the organization?

2. Describe the practiced client-centered home care in relation to the organization's mission statement?

3. How have your personal views on care been influenced by the stipulated organization's care practices?

4. How have evidence-based care award schemes influenced the delivery of care at the group home?

5. In your view, what are the merits and demerits of client-centered care in the group home?

6. What would you as an administrator describe as the challenges in implementing client-centered care in your facility?

The table 14 below depicts the direct caregiver and nurse responses to the questionnaire.

Table 14.

Direct caregiver/nurse responses to the questionnaire

Questions in the questionnaire	Response
1. How have your personal views on care in group home been influenced by the espoused care practices?	6 out of the 8 participants perceived the espoused care practices as being different from their personal views on client-centered care approaches
2. How have your views in group home care been influenced by the practiced home care approaches at the group home?	7 out of 8 participants perceived the practiced home care approaches as having improved their work practices
3. How have your personal views on care been influenced by the stipulated organization's stipulated care practices?	6 out of 8 participants perceived having been positively influenced by the organization's stipulated care practices. They perceived the stipulated care practices as acting as reminders during delivery of care practices
4. In your opinion, how have care award schemes that emphasize on evidence-based care influenced delivery of client-centered care at the group home?	6 out of 8 participants perceived the award schemes that focus on evidence-based care as having improved the level of efficiency in the delivery care at the group home
5. In your view, what is the merit, and demerit of client-centered care in the group home?	7 out of the 8 participants perceived client-centered care as empowering the clients to do things for themselves, and 6 out 8 perceived client-centered care as taking a lot of time, and sometimes frustrating to the care providers.

The table 15 below lists the facility administrator's responses to the structured questionnaire.

Table 15.

The facility Administrator's responses to structured questionnaire

Questions in the questionnaire	Response
1. How have your personal views on care in group home been influenced by the espoused care practices?	The Administrator perceived guidelines as being different from her perception of client-centered approach.
2. How have your views in group home care been influenced by the practiced home care approaches at the group home?	The Administrator perceived the practiced home care approaches as having influenced her positively
3. How have your personal views on care been influenced by the stipulated organization's stipulated care practices?	The administrator felt that some of the stipulated guidelines were not practicable.
4. In your opinion, how have care award schemes that emphasize on evidence-based care influenced delivery of client-centered The administrator felt that award schemes that focused on evidence-based care had improved quality of the delivered care care at the group home?	
5. In your view, what is the merit and demerit of client-centered care in the group home?	The administrator perceived client-centered approach as having empowered the clients, while the care providers felt frustrated by clients who wanted things to be done for them
6. What would you as an administrator identify as a challenge in implementing client-centered care in your facility?	The administrator identified the unwillingness by clients to learn as challenging.

Table 16.

Research Questions, Questionnaire question, Responses, and themes

Research Question	Questionnaire question	Response	Theme
RQ 1. How does the configuration of operational values underpinning company sanctioned work processes facilitate the client-centered care at the group home?	How would you describe client-centered care practices in contrast to the espoused client-centered care guidelines by the organizational management? (administrator)	The facility administrator perceived guidelines as conflicting with her perception of client-centered approach. The same views were shared by the direct caregivers and the nurses.	Disagreement on values between staff, and the organization. (Values discord)
RQ 2. How have the critical incidents shaped the company sanctioned work processes to conform to client-centered care at the group home?	How have award programs influenced your personal views on client-centered care?	8 out of 9 respondents perceived the award programs as an encouragement to practicing client-centered care. The programs improved the quality of the delivered care.	Quality improvement

RQ 3. How does the configuration of personal values underpinning work processes of direct caregivers and the facility administrator conform to the client-centered care at the group home?	How have your personal views on care been influenced by the stipulated organizational care practices at the group home?	7 out of 9 respondents perceived organizational care practices as agreeing with their personal values.	Value congruence
RQ 4. How have critical incidents shaped the value set of direct caregivers and the facility administrator to conform to the client-centered care at the group home?	How have the International Awards on quality influenced client -centered care?	8 out of 9 respondents perceived award schemes as having had positive influence on their perceptions of client-centeredness to the delivery of care.	Care providers were empowered to enhance efficiency which translated into an improvement in the quality of the delivered care. (Empowerment).

Summary of the findings

The client-centered approach to the delivery of care focused on enabling the mentally challenged individuals to gain skills, which facilitated them to act independently in order to realize their goals in life (Bigby et al. 2012). Agreement on organization's leadership and individual staff members' values was critical in enabling individuals learn and be skilled to do things for themselves (Rokeach, 1973). Disagreement on values, however, negated the effort to empowering the mentally challenged individuals (Riley, 2012). The findings in this study showed that staff members did not perceive the

stipulated organization's procedures and guidelines in the client-centeredness as critical in the delivery of care to the mentally challenged individuals. They, however, felt that organization's management practices should be regularly reviewed, and updated as the delivery of care continued in order to effectively address emerging challenges in the delivery of health care. These findings agreed with Walker (2012) who argued, that processes in health care delivery were dynamic, and should be assessed and adjusted at all times.

Chapter 5: Discussion, Conclusion, and Recommendations

Introduction

This chapter is a summary of the study and it captures the purpose, design of the study, results, research findings, dissemination of information and data, recommendation for action, implications for social change, recommendation for future research, reflection of the researcher, conclusion of the study, and summary. Although previous researchers studied quality care in group homes (Riley, 2012), there was a lack of information on the client-centered approach (process) to care of the mentally challenged individuals (Bigby et al., 2012). According to Creswell (2009), a study is done in order to address a knowledge gap in the existing literature, and the purpose of this study was to understand how client-centered care was practiced in a group home in Massachusetts that accommodated the mentally challenged individuals. In the study, I employed a qualitative approach of enquiry and focused on collecting data from direct care staff, the facility administrator, and the nurse who administered medications to the mentally challenged individuals. The aforementioned participants were both males and females of different age groups, with different levels of education, and from different ethnic backgrounds. Age, level of education, and different ethnic backgrounds were found to have an influence on an individual's perception to client-centered care (Riley, 2012), and diversity in the choice of participants was critical in this study. Diversity in recruitment of participants provided an

Purpose of the Study

Group homes were started in the early 1990s to rehabilitate mentally challenged individuals who were previously confined to mental hospitals (Milne, 2012), and the group homes' principle objective was to develop the individuals' skills as a way of empowering them to integrate into communities and make their contribution to society. Group homes also assisted the mentally challenged individuals to access resources needed to increase their capacity to gain skills, work, and learn in the social environments of their choice (Psychiatric Rehabilitation Association, 2012). One goal of this study was to understand if emergent value practices in group homes impacted the quality of the client care process. In this study, I intended to further explore the potential for process modifications to influence client care outcomes. The influences to outcomes were assessed using Donabedian's model of quality care (1980) in which structure (staff skills, efficiency, and attitudes) was a prerequisite to process (interrelationships among care providers) and process a prerequisite to outcome (realized results). The purpose of the study was to investigate how client-centered approach practices were applied in a group home in Massachusetts that rehabilitated the mentally challenged individuals' in order to achieve their set goals.

Study Design

The variables in this study were operational values underpinning company sanctioned work processes, the effect of critical incidents on the company sanctioned work processes, how personal values underpin the work processes of direct caregivers, configuration of personal values caregivers believed should be supported in the group

home context, and how critical incidents shaped the value set of direct care in regard to care processes. Research questions were developed based on the study's variables in order to investigate care processes, which were practiced by care providers at the group home under investigation. According to Donabedian (1980), a structure that included staff skills and attitudes had an impact on the process that included the delivery of care practices and relationships among care providers; the final outcome was the realized results. In order to gather information and data that assisted in answering the research questions, two different questionnaires were developed to be addressed separately by the facility administrator, the caregiver, and the nurse. The facility administrator, seven caregivers, and the nurse comprised the recruited participants in this study. Participants gave consent to participate in the study during office hours, and this gesture indicated commitment and accountability on the information and data provided. The questionnaires were critical in enabling participants to provide personal views on how they perceived the delivery of care at the group home under study. Information was gathered from the use of questionnaires, documented procedures, and guidelines as well as an observation of participants as they delivered care; these enabled me to review and carry out an objective analysis.

Research Plan

I used four research questions to discover existing issues on the delivery of care at the group home under study. Structured questionnaires were used to guide participants to provide focused responses, and an observation protocol was developed to guide me to identify client-centered issues as care was delivered. Participants were asked to give

individual consents before participating in the study during office hours. Individual consent depicted staffs' commitment to the delivery of client-centered care at the group home, and the responses provided should be considered genuine and honest. Using responses from participants, documented care procedures and guidelines, and observation of participants as they delivered care, I was able to analyze issues on the client-centered care practices. The table 17 below lists the research questions, responses, and the identified issues.

Table 17.

Research Questions, Responses, and Identified Issues

RQ 1. How does the configuration of operational values underpinning organization's sanctioned work processes facilitate the client-centered care The facility administrator perceived guidelines as conflicting with her perception of client-centered approach. The same views were shared by the caregivers and the nurse. at the group home?	The response indicated disagreement on values between care providers, and the organization (Values discord).

RQ 2. How have the critical incidents shaped the organization's sanctioned work processes to conform to client-centered care at the group home?	The majority of the participants perceived award programs as an encouragement to practicing client-centered care. Award programs created competition among organizations that provided care.	Competition for recognition encouraged efficiency, that had positive impact on the quality of the delivered care (Quality improvement)
RQ 3. How does the configuration of personal values underpinning work processes of direct caregivers, nurse, and the facility administrator conform to the client-centered care at the group home?	The majority of the participants perceived their personal values to be in agreement with the organization's values on client-centered care practices.	Agreement between staff and organization's values would have a positive impact on the delivery of care (value congruence).
RQ 4. How have critical incidents shaped the value set of direct caregivers, nurse, and the facility administrator to conform to the client-centered care at the group home?	Majority of the participants perceived award schemes as having influenced their views positively on client-centered care.	Positive influence on care providers' values on client-centered care enhanced quality of the delivered care (Quality improvement)

The table 18 below lists the questions asked to direct caregivers and the nurse.

Table 18.

Questions to direct caregivers, and the nurse

Question	Response
1. How have your personal views on care been influenced by the stipulated organizational care practices at the group home?	Most of the caregivers and the nurse felt that their personal views had been positively influenced by the stipulated organizational care practices at the group home
2. How would you, in your own words explain client-centered care practices in the group home?	Majority of the participants explained client-centered care as care practices where individuals did activities with care providers instead of care providers doing activities for the individuals
3. How have the Award Schemes on evidence-based care influenced client-centered care practices?	Award schemes had created competition among care providers, that consequently improved quality of the delivered care
4. How have award schemes influenced your personal views on client-centered care?	Majority felt that award schemes created recognition which they wished to be associated with

The table 19 below lists the questions asked to the facility administrator.

Table 19.

Questions to the Facility Administrator

Question	Response
1. How would you describe client-centered care practices in contrast to the espoused client-centered care guidelines by the organizational management?	The administrator felt that care was not delivered according to the instruction given by the organization's management.

2. How would you describe practiced care practices in relation to the kind of care stated in the organization's mission statement?	The administrator felt that three-quarters of the care providers provided care as outlined in the Mission Statement
3. How have your personal views on care been The administrator felt that her personal views influenced by the stipulated organizational care practices at the group home?	were influenced by the stipulated organizational practices
4. How have the Award Schemes on evidence-based client-centered care approach influenced client-care practices?	The administrator felt that award schemes had significant influence on the client-care practices
5. How have award care schemes influenced your personal views on client-centered care?	The administrator felt that the award schemes had influenced her personal views on the client-centered care practices
6. How would you in your own words explain client-centered care practices in the group home?	The administrator described client-centered care as doing activities with the mentally challenged individuals instead of doing for them.

Results

Research Question (RQ 1) focused on establishing how the organization's work values facilitated client-centered care practices at the group home. Participants who included the facility administrator, direct caregivers, and the nurse perceived documented guidelines that focused on implementing the organization's values as conflicting with their personal views on the client-centeredness to care. The guidelines were perceived negatively by the staff, and as a consequence caused a conflict of interest that compromised delivery of care at the group home.

Research Question (RQ 2) aimed at obtaining views of the participants on how award schemes, which put emphasis on evidence-based care practices had impacted delivery of quality client-centered care at the group home. The researcher explained about evidence-based quality award schemes as initiatives that focused on enhancing staff skills and attitudes, and utilization of skills by staff in order to achieve quality care. Evidence-based care criteria were based on the effects of the client-centered care practices in the delivery of care. Health care organizations competed among themselves for recognition in offering quality care, and in gaining prominence within the human services sector (Riley, 2012). Rationale for this approach was outlined in Donabedian (1981) quality care framework. Donabedian (1981) quality framework is a concept that is administered by professional health care organizations in order to improve delivery of quality health care. Most participants perceived evidence-based quality care award schemes as having positive impact on the enhancement of delivery of quality care.

Research Question 3 (RQ 3) targeted personal views of direct caregivers, and facility administrator in regard to client-centeredness to care. Over 75% of the participants perceived client-centered care approach as having improved the quality care at the group home. Participants argued further that, individuals were given an opportunity to suggest the kind of care that benefited them. The window opened an avenue for individuals to suggest their preferred care, and this gesture was empowering to the mentally challenged individuals.

Research Question 4 (RQ 4) focused at the administrator's, and caregivers' views on the award schemes. Over 80% perceived award schemes as an encouragement to staff.

Award schemes had a positive impact on the delivery of quality of care, in which the staff was involved. The staff argued that after contributing to the winning of an award, the organization's leadership would have rationale for improving their welfare (Gehman et al. 2013), and benefits would motivate staff to improve their efficiency in the delivery of care at the facility.

Concluding View on the Results

Over 75% of the participants perceived client-centered care as a good approach and their perception resonated with Walker (2012), who found client-centered care to be empowering individuals to realize their objectives in life. Responses from interview questions, observations, and the documented procedures, and guidelines provided answers to the research questions. The findings were triangulated by linking the results of the study to the ideas from the literature review in chapter two, and the implications for social change.

Value Discord

The findings indicated that the organization's values and personal values of direct caregivers, administrator, and the nurse did not agree. The organization's mission was to empower its clients to be independent and to realize their dreams through skills' enhancement. Some participants perceived the mentally challenged individuals as unwilling to learn and not interested in doing things for themselves. Although staff supported empowerment of the mentally challenged as critical in integrating individuals into the society, and consequently enabling individuals to contribute to social change, participants felt that the concept of doing things with the clients created challenges,

which required review and adjustment The organization leadership, however, maintained that its goal was to rehabilitate the mentally challenged individuals in order to enable them integrate, and contribute to social change through doing things with them, and not for them. The different views caused disagreement (discord in values), that made the organization leadership, and the care providers to pull in different directions, and this situation had the potential to negatively affect the quality of the care delivered at the facility (Walker, 2012).

Quality Improvement

The findings were that over 80% of the participants perceived quality award schemes as being instrumental to making the evidence-based client-centered approach a good choice in the delivery of quality care to the mentally challenged individuals at the group home. The award schemes specified standards, which were internationally recognized, and organizations which conformed to the set standards enjoyed international status, and this achievement was critical to an organization's advancement in the health care service industry (Bigby et al.2012). The standards were based on the staff efficiency (structure), interpersonal relationships (process), and achieved result (outcome). The approach resonated with Donabedian's (1980) conceptual framework on quality care that, advocated structure as a prerequisite to process, and process a prerequisite to outcome.

Value Congruence

The findings in the study were that over 75% of the participants agreed with the organization's practices in the client-centered approach to the delivery of care to the mentally challenged individuals. The participants perceived client-centered practices as

empowering the clients to understand and participate in carrying out personal, or group activities. This approach enabled clients to integrate into the community and make their contributions to positive social change. Practices were, however, adjusted as delivery of care continued, and the change caused a deviation from the organization's stipulated guidelines (Rokeach, 2012). Although an organization's guidelines should be objectively developed, they might miss the providers' values, and preferences, and consequently cause conflict during implementation (Gehman et al. 2012). In order to minimize the aforementioned conflict, developing guidelines with care providers instead of developing for them created ownership, and enhanced sustainability that was crucial to positive social change.

Empowerment

The findings were that 7 out of 9 participants perceived client-centered approach in the delivery of care as empowering the mentally challenged individuals. Direct caregivers imparted skills to the mentally challenged individuals through doing things with them, rather than doing for them. This approach resonated with Gehman et al. (2012) assertion that by encouraging individuals to participate in carrying out activities, the situation gave individuals an opportunity to understand and acquire skills, and as a consequence became empowered. The focus of client-centered approach to delivery of care was to coach individuals to do things for themselves, and to discourage other people from doing things for the individuals. This approach was found to empower the mentally challenged individuals to be independent.

Evidence from Observation

Participants were observed after giving their consents to be observed as they delivered care to the mentally challenged individuals. The researcher used a protocol that guided focused observation on the client-centered care practices. Observations were rated on a scale of 1 to 3 in which 1= disagree, 2= agree to some extent, and 3= agree. Although the language used by care providers had elements of enhancing achievement of client-centered care, providers did not take adequate time to explain issues, which advocated for client-centered care practices. Care providers were noted to interact with their clients, but coordination of activities lacked among care providers. Existence of the observed issues was noted to compromise the quality of the delivered care. Table 20 below depicts the ratings of the observed client-centered care practices.

Table 20.

Ratings (on a scale of 1-3) of the observed client-centered care practices Where 1= disagree 2 = agree to some extent 3 = agree

Observed care practices	Rating
The language used by direct care Staff/nurse to individual clients was appropriate in achieving the Client-centered care	2
Direct care staff/nurse took adequate time to explain different issues to individual clients	1
Direct care staff/nurse adhered to their work time Schedules	3
Direct care staff/nurse interacted with individual clients with respect	2
Direct care staff and nurse coordinated their roles in the delivery of care in a professional manner.	1

Findings

Majority of the participants perceived client-centered care as a good approach to delivery of care, and the finding resonated with Walker (2012), who asserted that client-centered care empowered individuals to realize their targets in life. Data, and information gathered from documented procedures and guidelines; through use of questionnaires; during observations; were triangulated by linking the findings of the study to the ideas from the literature review in chapter two, and the implications for social change. Participants' responses to questionnaires, observations by the researcher on the delivery of care; documented procedures, and guidelines provided answers to the research questions. The findings enabled the researcher to understand and draw conclusions on the delivery of client-centered care at the group home under the study. The figure 21 below shows the research questions, the responses, and the findings.

Table 21.

Research Questions, Responses, and Findings

Research Question	Questions in the Questionnaire	Response	Findings
RQ 1. How does the configuration of operational values underpinning company sanctioned work processes facilitate the client-centered care at the group home?	How would you describe client-centered care practices in contrast to the espoused client-centered care guidelines by the organizational management?	The facility administrator perceived guidelines as conflicting with her perception of client-centered approach. The same views were shared by the caregivers and the nurse	The facility administrator perceived guidelines as conflicting with her perception of client-centered approach. The same views were shared by the caregivers and the nurse
RQ 2. How have the critical incidents shaped the company sanctioned work processes to conform to client-centered care at the group home?	How have award programs on the evidence-based care influenced your personal views on client-centered care?	Eight out of the nine participants perceived the award programs as an encouragement to practicing client-centered care.	Care providers were motivated to win the awards, and therefore provided care as stipulated. This situation consequently enhanced quality care at the group home

RQ 3. How does the configuration of personal values underpinning work processes of direct caregivers, nurse, and the facility administrator conform to the client-centered How have your personal views on care been influenced by the stipulated organizational care practices at the group home? Care approach at the group home?		Seven out of the nine participants felt that their personal views had been positively influenced by the client-centered approach	Most care providers were influenced by client-centered care approach, and the situation encouraged care providers to engage client-centered care practices during delivery of care.
RQ 4. How have critical incidents shaped the value set of direct caregivers and the facility administrator to conform to the client-centered care at the group home?	How have the evidence-based quality awards influenced client-centered care?	Eight out of the nine participants perceived award schemes as having contributed significantly to the effective delivery of quality care at the group home	Award schemes changed personal views of the providers positively and inspired providers to make significant contributions to the quality of the delivered care.

Interpretation of the Research Findings

The first research question focused on finding out how Organization's work values had facilitated client-centered care practices at the group home. The Organization's values were outlined in the procedures, and guidelines, which were to be followed by care providers. Values were critical to the organization's existence and as a

consequence needed to be understood by care providers in order to enhance the purpose of the organization. Participants who included facility administrator, seven caregivers, and a nurse had personal perceptions on the delivery of care to the individuals in the group home, which differed from the organization's documented procedures and guidelines. This situation had potential to cause conflict in the delivery of client-centered care at the group home and to consequently compromise the quality of care. Agreement between organization's leadership values and care providers' values was crucial in ensuring delivery of quality care, and the situation could be improved through building interactive relationships.

The second research question aimed at getting views of participants on how incidents, such as award schemes had impacted client-centeredness to delivery of care. The investigator explained to participants about quality award schemes and the conditions for winning awards. The award-winning criteria was set by the health care professional groups and most participants perceived award schemes as having potential to enhance client-centered care practices. Participants argued that award schemes motivated care providers to seek recognition within health care delivery services, and increased efforts by providers to provide superior care and an enhanced quality of care.

The third research question targeted the personal views of caregivers and facility administrator in regard to the client-centeredness to care. The majority of the participants perceived client-centered approach as good. They argued that individuals were provided with an opportunity to suggest the kind of care they preferred. The opportunity was

critical because individuals who were at different levels of disability would advocate for preferences, which suited them.

The fourth research question focused on the administrator's, and caregivers' views of the award schemes. The majority of the participants perceived award schemes as an encouragement to staff. Award scheme's implementation depicted scrutiny on delivery of care in which staff members were involved and would provide a window for staff to make bargains with the organization's leadership on the improvement of their terms, and conditions of work.

Dissemination of Information and Data

Dissemination was carried out after the researcher collected and analyzed information, and gathered data from the documented care procedures, completed survey questionnaires, and the observation made. Dissemination in the study results assumed the traditional theory of communication, in which there was the sender of information (researcher), and receivers of information (participants). In this theory, participants received, processed information, and then gave feedback (Riley, 2012). The exercise was, however, challenging because, participants possessed different levels of education, and knowledge, and as a result, they provided varying arguments on the study findings. Attitudes, and experience of individual participants were also different, and the researcher had a challenge in moderating the responses provided.

Implications for Social Change

Social change refers to significant changes, which have profound social consequences in terms of altering norms, cultural value patterns, and improving

community's health status (Fetter, 2002). According to Gehman et al. (2013), the changes made in transforming the society to a better life should be made in a participatory manner. Involving participants in planning and in implementing activities facilitated participants to feel part and parcel of a process, and consequently to own the process. The concept of ownership is critical for sustainability of future activities, and this study was keen to isolate and to understand sustainability issues. The goal in health care delivery was to ensure equitable coverage for all efforts to reform the system to realize better coverage (Mansell, 2012). In client-centered care, individuals participated in the delivery of care process (Bigby, 2012), and the care process encouraged individuals to make decisions on realistic practices which would be engaged in the delivery of care. This opportunity was empowering and facilitated individuals to realize their dreams, and consequently make significant contribution within the society. The methodology of this study was interactive and it provided participants with an opportunity to give their views freely. The interactive approach facilitated individuals to share ideas and to carry out member checking in order to authenticate findings (Creswell, 2009). The process enabled the researcher who was a participant to tease out important social implications in the client-centeredness approach to care. Participants described clients as having felt appreciated and challenged to do things for themselves which enabled them to integrate within the community and to make their contribution. Participants stated, further, that the individuals' guardians and friends appreciated the client-centered care approach and perceived the practice as having made health care improvements that benefited individuals.

Table 22.

Research Questions, Responses, and Impact on Social Change

Research Question	Response	Impact on Social Change
RQ 1. How does the configuration of operational values underpinning organization's sanctioned work processes facilitate the client-centered care at the group home?	The facility administrator perceived guidelines as conflicting with her perception of client-centered approach. The same views were shared by the caregivers and the nurses.	The providers' perception on guidelines was critical in the delivery of care. In a situation where discord in organization and provider values was envisaged, a conflict of interest was likely to occur that would have ramifications to social change
RQ 2. How have the critical incidents shaped the organization's sanctioned work processes to conform to client-centered care at the group home?	Majority of the participants perceived the award programs as an encouragement to practicing client-centered care.	The programs created competition for recognition among care providers, and this situation had potential to improve quality of the delivered care. Individuals' receiving quality care would empower individuals to contribute to positive social change.
RQ 3. How does the configuration of personal values underpinning work processes of direct caregivers, nurse, and the facility administrator conform to the client-centered care at the group home?	Majority of the participants perceived that their personal values agreed with the organization's values on the client-centered care approach.	When organization's values agree with staff values, the two are encouraged to work together, and their joint effort had the potential to realize results which have notable social change. (Value congruence)

RQ 4. How have critical incidents shaped the value set of direct caregivers, nurse, and the facility administrator to conform to the client-centered care at the group home?	Majority of the participants perceived awards scheme as having had a positive contribution to the delivery of quality care.	Award schemes are administered by professionals who set standards for delivery of care, and the winner should excel in their performance. Winning the award, created competition that enhanced quality care improvement, and an impact on social change.

Recommendations for Action

This study is referred to as a single instrumental case study because it focused on a specific concern (Stake, 1995). The researcher selected the setting within which the study was undertaken. Data was, however, collected extensively from observations, questionnaires, documents, records, and the researcher made a conclusion that client-centered approach had a positive impact on the beneficiaries. The conclusion views were made from the participants' personal views on client-centered practices in a group home where the study was undertaken. Researchers are reluctant to generalize findings based on these kinds of findings (Creswell, 2007), and recommendations are made to carry out further studies in order to justify the findings in this study.

Client-centered care was found to have a positive impact on the lives of the mentally disabled individuals in the group home and this finding was established from the responses provided by the participants on the research questions. Over seventy-five percent of the participants supported client-centered care. The participants provided their views through the structured questionnaires. Participants completed questionnaires after giving consent to participate in the study and the findings should be considered authentic.

Further evidence on the support of the client-centered care approach was established during observations where participants were observed as they carried out their activities. A recommendation would be made that both public and private organizations should practice client-centered approach in the delivery of health care services. Operational guidelines should be developed preferably with the stakeholders in the service industry. Research established that a delivery system that was developed in a participatory manner had the potential to create sustainability in community programs (Riley, 2012). Implementation of client-centered care that is developed in a participatory manner would be embraced by staff and the mentally disabled. The staff would, however, require orientation to the client-centered care approach in order for them to understand their roles and responsibilities.

Strengths of the Study

The purpose of this study was to investigate how client-centered care was practiced in a group home in Massachusetts, USA. Group homes were found to make significant contribution to the rehabilitation of the mentally challenged individuals (Riley, 2012) and client-centered care found to empower individuals to do things for themselves (Mansel, 2010). The importance of client-centeredness in the delivery of care created the necessity to investigate how care was delivered (process). The group home under the study had established procedures and guidelines on client-centered care processes and the existing procedures and guidelines laid a background that was essential to care providers and the participants. The available information on client-centered care enabled participants to evaluate the approach and develop arguments for or against client-

centered care approach to delivery of health care. Participants had worked in the group home for over one year, and their stay made them knowledgeable about the clients' wants and needs. Knowledge about clients, was as such instrumental in understanding the clients' preferences and was crucial in facilitating adaptation to specific care processes.

Limitations

The study was done in one facility in Massachusetts, USA that practiced client-centered approach in its delivery of care. The procedures and guidelines at the facility were specific and were based on the organization's purpose and mission. The organization's purpose and mission might be different from other group home care providers because of varying values and considerations, and social economic status of individual organizations. The findings in this type of study would therefore not be generalized, and this view resonates with Creswell (2007), who argued that findings of a study in a specific environment would not be generalized, but could be used to rationalize the need for further studies on similar situations. Participants had varying levels of education that ranged from GED to degree, and as such participants understood the study issues in different ways. Understanding issues differently made participants describe care processes in ways that they understood research questions and teased out issues objectively. Analysis of responses from participants was challenging to the researcher.

Recommendation for Further Study

The study was a qualitative case study in a group home in Massachusetts, USA that practiced client-centered care in its delivery services. According to Creswell (2007), this type of study involves a specific issue that is within a restricted setting. The results

cannot as such be generalized (Creswell, 2007). The findings in this study depicted positive impact on the health of the individuals at the group home and the outcome was attributed to client-centered care practices in the delivery of care. Improved health enabled the mentally challenged individuals to realize their potential through acquiring skills (empowerment), and facilitated the integration of the rehabilitated individuals into the community (Walker, 2012). Acquisition of skills enabled individuals to make significance contribution in the society, and as a consequence impacted social change in a positive manner. The study found, further, that there were pockets of value disagreements between staff and the organizational leadership. This disagreement had a negative impact on the quality of care delivered at the group home and a further investigation into sources of disagreement would be desirable in order to explore the root causes, and engage early corrective measures. The study findings depicted quality delivery of care through client-centered approach, but since the results were confined to one case, they would not be generalized. Further study that compared and contrasted practiced client-centered care should be undertaken. In a further study, the researcher would identify salient issues, which impede client-centered practices. The investigation would quantify issues in the delivery of care, and allow for generalization of the results (Creswell, 2007). Intervention measures would be outlined, and be implemented in order to rectify the identified negative issues, which negate the client-centered care effort.

Reflection of the Researcher

The emphasizes in this research was to understand meaning and significance of client-centered care practices in a group home that rehabilitated mentally challenged

individuals (Marshall et al.1991, p.74), and this situation involved acknowledging the difficulties in representing complex social reality with a few sets of data (Covaleski and Dirsmith, 1990, p.544), and also attempting to analyze data from several sources. The researcher focused on the value of inquiry, which was achieved through answers to questions which stressed on the participants' understanding of the delivery of the client-centered care at the group home under the study (Denzin and Lincoln, 2003, p.13). The researcher acknowledged that social systems were socially constructed, and would be changed by activities of individuals working within a specific environment (Ryan et al.2002, p.126). The researcher saw himself as an instrument of the research, and acknowledged that interpersonal relationships emerged which were complex, and deeply rooted in the participants (Darlington and Scott, 2002, p.46), and were critical in each individual's perception of the merits, and demerits of the client-centered care practices.

Discussion

Researchers in qualitative studies state research questions, and not objectives (Creswell, 2009). The answers to research questions were goals, which the study aimed to achieve, and as such, the answers took a central position (Creswell, 2009) in the study. Questions were constructed in a way that led the researcher to gather information that helped in understanding the situation under investigation (Maxwell, 2013). Questions were written clearly and accurately in order to facilitate participants' understanding of the information sought by the researcher. There were four research questions, and six sub-section questions in one questionnaire, and five questions in another questionnaire. The questionnaire with six questions was completed by the facility administrator, and the

other with five questions completed by direct caregivers and the nurse. The two questionnaires were used to gather data, and information, that was used to answer the research questions (Creswell, 2007). The questionnaires focused on staff perceptions on client-centered care. Roles and responsibilities of different staff members gave the researcher an opportunity to gather diverse views on client-centeredness to delivery of care at the group home. Participants were also observed as they delivered care to their clients, and the information gathered expanded the researcher's understanding of the care practices at the facility under the study. The researcher's review of documents on client-centered care at the facility, and information gathered during observation, and from completed questionnaires enlightened the researcher, further, on the care practices.

Conclusion

The approach taken in carrying out this study was all inclusive in order to capture perceptions on client-centered care of the care providers. The participants who included the facility administrator, seven caregivers, and the nurse had specific roles in the delivery of care to the mentally challenged individuals. The participants understood that the role of the group home was to rehabilitate the mentally challenged individuals' through empowering them in order to effectively integrate into communities, and make a contribution to social change. Activities were done with them and not for them and this approach enabled the mentally challenged individuals to gain skills, which were crucial to their empowerment. The participants demonstrated their commitment to this study by voluntarily signing consents before completing questionnaires and being observed as they delivered care to their clients at the group home. The participants participated during the

dissemination of the findings and agreed with the suggestions and recommendations made by the researcher.

Summary

The purpose of this study was to investigate care processes in a group home in Massachusetts, the USA that practiced client-centered care in the delivery of health care services to its mentally challenged clients. Although there were pockets of disagreement between the organization's leadership and care providers, the majority of the participants perceived client-centered care as an approach that empowered individuals to do things for themselves. The participants' perception resonated with Bigby et al. (2012) who asserted that the mentally challenged individuals who were facilitated to do things for themselves were enabled to be independent, and consequently made contributions that had long-term impact on social change. The findings in this study were found in one particular group home, and as such the results would not be generalized (Creswell, 2009). The findings would, however, be used when carrying out further studies, which would quantify issues experienced in the delivery of client-centered care.

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Appendix A: Observation Protocol

1. **Observer:** Researcher

2. **Participants observed:**

Nurse/ Direct Care Staff

3. **Background**

Observation will be done on the direct care staff and the nurse when delivering care to the clients.

4. **Focus**

The intended purpose of this observation will be to observe how client-centered care is practiced by the direct care staff and the nurse at the group home.

5. **Ratings (on a scale of 1-3) of the observed client-centered care practices**

Where 1= Not at all 2 = to some extent 3 = True

Observed care practices	**Rating**
The language used by direct care Staff/nurse to individual clients was appropriate in achieving the Client-centered care	
Direct care staff/nurse took adequate time to explain different issues to individual clients	
Direct care staff/nurse adhered to their work time Schedules	
Direct care staff/nurse interacted with individual clients with respect	
Direct care staff and nurse coordinated their roles in the delivery of care in a professional manner.	

Walden University's approval number for this study is 07-28-15-0294102 and it expires July 27, 2016.