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Direct Care Staffs' Experiences and Perceptions of Person-Centered Care Training

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This is to certify that the doctoral dissertation by

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Abstract

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MSN, Walden University, 2012

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Dissertation Submitted in Partial Fulfillment

of the Requirements for the Degree of

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Abstract

Many long-term care (LTC) facilities within the United States have replaced the institutional model of care with one that accepts person-centered care (PCC) as the guiding standard of practice. Quality training ensures that direct care staff have the skills and the knowledge in the delivery of quality PCC. However, many nurses and nursing assistants have expressed the desire for further training in PCC practices to effectively deliver quality care. The purpose of this study was to explore the types and length of training and education provided based on the perceptions and experiences of direct care staff related to their implementation of PCC practices. The theoretical framework for this study consisted of Rogers' PCC approach theory and philosophy. A qualitative interpretative phenomenological design was used to examine the perceptions of training and education of 20 certified nursing assistants using semistructured interviews. Once the interviews were conducted and transcribed, the data were coded into superordinate themes that stemmed from participant responses. Themes of PCC practices, teaching modalities, learner type, length, and introduction of training were identified as a result of the data analysis. The data also revealed that it is important for LTC facilities to be aware of how they are providing PCC education and training to their staff so that they may provide their residents with quality individualized care that emphasizes the whole person. Study findings may inform LTC administrators, leaders, and managers on the deliverance of effective training and educational practices when implementing PCC models within their facilities. The results may also spur national LTC organizations to refocus their core beliefs, values, and culture towards a culture that considers the whole person.

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Chapter 1: Introduction to the Study

Introduction

An estimated 12 million Americans required long-term care (LTC) in 2007, and by 2050, the number of individuals using LTC services will likely double from the 13 million people using services in 2000 to 27 million people (Centers for Disease Control and Prevention [CDC], 2013). The Social Security Act, Sections 1819 and 1919, requires facilities to comply with federal requirements regarding residents' quality of care and quality of life (Centers for Medicare and Medicaid Services [CMS], 2015). As of November 2016, the CMS has put into effect its Mega-Rule update, also known as the Final Rule. The Final Rule will be implemented in three phases. The first phase went into effect on November 28, 2016, the second phase is set for November 28, 2017, and the third phase is set for November 28, 2019 (CMS, 2015). The purpose of the Final Rule is to improve care, with the main goal of furthering CMS's mission of improving PCC in LTC facilities (CMS, 2015). These regulations are based on the values of both freedom and respect for the older adult population's personal right to take risks or make their own choices (CMS, 2015).

The concept of PCC as a care delivery approach has evolved since the 1950's works of Carl Rogers, which focused on individual personal experience as the standard for living and therapeutic effect (Fazio et al., 2018). Since then, there have been many other conceptualizations of PCC. During the last decade, a series of new models have transformed the industry's understanding of the concept of health and of the implementation of health care systems. There are several different culture change models

that support PCC and have been found to be successful—for example, the Regenerative Community, the Eden Alternative, the Wellspring Model, the Neighborhood Model, Green House/Small House, the Pioneer Network model, and the HATCh model (Jones, 2013). These models include various elements of what is now called PCC and are transforming facility practices to better address the needs of the whole person as well as enrich work environments for direct care staff (Jones, 2013).

Education and training are key to successfully implementing a PCC model. Menne (2008) conducted a survey which suggested that initial training and the continuing education of direct-care workers were subpar based on workers' requests for further training, especially in their current field setting. Direct care staff who are expected to implement PCC practices should receive adequate training and education (Laci J. Cornelison, et al., 2019). Long-term studies suggest that the knowledge acquired in a training situation does not always lead to the correct implementation of the acquired skills to the work situation (Viau-Guay et al., 2013). For example, a certified nursing assistant (CNA) may have been trained in person-centered bathing practices from watching one video on the different approaches to bathing. However, when CNAs attempt those steps on their own, they may incorrectly implement the steps that were provided in the video; more importantly, they may continue to engage in these incorrect practices. To effectively change care practices in LTC facilities, it is necessary to ensure that the training is integrated into practice; this may mean conducting repetitive return demonstrations to reinforce and maintain these skills over time, similar to annual skills competencies, like cardio-pulmonary resuscitation (Marcus, 2014).

Background

The focus of this research was on exploring direct care staffs' perceptions of training and education when a PCC model was introduced in their LTC facility, specifically whether staff perceived the training and education to be effective. PCC practice is the culture change that is impacting the provision of aged-services around the world (Santana, 2018). Developing PCC is not a one-time event; rather it requires a sustained commitment from organizations to the ongoing facilitation of education and training. An Institute of Medicine (2008) report suggests that strategies for improving the training of direct caregivers are critical.

There has been a proliferation of training programs for direct care staff related to PCC, yet little is known about the effectiveness of the training. Although researchers continue to produce evidence showing that PCC models facilitate PCC (Bockhour, 2018; Moore, 2017; Santana, 2018; White-Chu, 2009), the problem is that barriers such as lack of education and training prevent facilities from achieving this goal. Moore et al. (2016) identified PCC training and education as a commonly cited facilitator to the implementation of PCC. Moore et al. noted that the strategies used in training direct care staff are important to communicate any type of PCC practice. In an Australian study conducted by Stein-Parbury et al. (2012), the authors initiated a two-day PCC training course for direct care staff and then followed up at two- to four-week intervals. The researchers identified that theoretical understanding, education, and training alone were insufficient to bring about the PCC practice change and that the importance of on-site follow up and continuing education in the participants' care setting was vital to the

success of the PCC interventions (Stein-Parbury et al., 2012). Straker, Boehle, Nelson, and Fox (2013) noted that staff education and training are important in the implementation of PCC and that continuing education is vital. Other studies have shown that the successful implementation of culture change models requires consistent leadership and management, efficient communication systems, and an investment in staff training and education about culture change (Barba, Tesh, & Courts, 2002; Keane, 2004). The American Geriatrics Society Expert Panel (2014) concurred that including the principles of PCC in the education and training of all healthcare providers contributes to direct care staff's understanding of and commitment to providing PCC, including consistent recognition and maintenance of the person's autonomy. Thus, the variable of education is vital to a facility's successful implementation of PCC practices and is ultimately a main component in contributing to direct care staff's complete understanding of these practices. In other words, the tenets of PCC should also be integrated and reviewed in every training and education program in order for staff to be reminded that PCC forms the basis of everything they do in providing care of their resident.

Problem Statement

Many LTC facilities have replaced the institutional model of care with one that accepts PCC as the guiding standard of practice (Andrew & Ritchie, 2017; Flagg, 2015; Nancarrow & Brownie, 2013, Van Haitsma et al., 2014). This culture change is impacting the provision of aged-care services around the world (Brownie & Nancarrow, 2013). Quality training ensures that direct care workers have the skills and knowledge in the deliverance of quality PCC, according to researchers (Moore et al., 2016)).

There has been a proliferation of training programs for direct care staff related to PCC, yet little is known about the effectiveness of the training (Kusmaul & Waldrop, 2015; Wilberforce et al., 2016). The Institute of Medicine's (2008) report suggests that strategies for improving the effective training of direct caregivers are critical. Developing PCC is not a one-time event; rather, it requires a sustained commitment from organizations to the ongoing facilitation of education and training. However, while researchers continue to produce evidence that PCC models facilitate PCC (Kim & Park, 2017, Li & Porock, 2014), barriers such as lack of education and training prevent facilities from achieving the goal of implementing PCC (Rodríguez-Martín et al., 2015; Tappen et al., 2017).

Limited research has been conducted on direct care staff's initial training in a model of change (Tappen et al. 2017). Coleman, Carissa, Fanning, Williams, and Kristine (2015) suggested that LTC staff development coordinators and providers should be charged with providing pertinent information to keep staff up-to-date on current PCC practice, including skills for culture change. West, Barron, and Reeves (2005) reported that many U.K. nurses expressed a desire for further training in PCC practices in an attempt to deliver quality PCC. Maslow, Fazio, Ortigara, Kuhn, and Zeisel (2013) affirmed that the training of staff members is an important component of healthcare staff development and their readiness to provide PCC.

Purpose of the Study

The purpose of this study was to examine the perceptions of training and education of direct care staff when a PCC model was introduced in their LTC facility,

specifically whether staff perceived the training and education sufficient to prepare them to implement these practices. To explore the study phenomenon, I used a qualitative interpretative phenomenological research design. There is a lack of literature on CNA educational experiences in PCC. I sought to fill this gap by exploring common themes related to direct care staff's experiences of PCC training and education and exploring any commonalities or differences of these perceptions based on the type and length of the trainings. I conducted interviews with CNAs to understand their perceptions of their PCC training and education with specific emphasis on the length of time in the training and education was provided. Hence, I identified training modalities as part of my research.

Research Questions

I sought to answer the following two research questions (RQs):

RQ1. What are the perceptions of direct care staff in relation to the training and education that was provided when a PCC approach was implemented in their setting or when they came work in the setting?

RQ2. Does the length or type of training and education practices affect the ability for CNAs to implement PCC practices effectively?

Theoretical Framework

For the framework for this study, I used Carl Rogers' person-centered approach theory and philosophy. This theory is based upon the belief that to actualize human growth in late life, individuals should be able to access and experience opportunities for ongoing learning, personal challenges, and close and intimate relationships (Violet, 2006). Rogers was committed to the belief that human capacity for growth does not

diminish with age, nor does the need for growth become less important as individuals age. The emphasis of PCC is on the well-being and quality of life as defined by the person (Santana, 2018). PCC is based on acceptance, empathy, caring, sensitivity, as well as active listening, which ultimately promotes optimal human growth (Brownie & Nancarrow, 2013).

Carl Rogers' conceptual framework suggests that, for effective teaching and learning to transpire, members who are instructing others must acquire suggested attributes that will cultivate positive interpersonal relationships, hence facilitating a growth promoting atmosphere. The suggested attributes are "realness (authenticity, congruence, or compassion), prizing (trust or acceptance), and empathetic understanding" (Bryan, Lindo, Anderson-Johnson, & Weaver, 2015, p. 142).

The quality of interpersonal relationships that one shares with a student is the most significant element in determining the effectiveness of their learning experience (Bryan et al., 2015). The PCC conceptual model allows for a therapeutic approach to educating the whole person as compared to teaching direct care staff members a singular concept. Use of the theory allows for implementation of the concepts of PCC to residents in not only a direct hands-on way, but in a psychological, emotional, and spiritual way. This aspect not only applies to the learner but to the educator, as congruence, unconditional positive regard, and empathy are conveyed by the educator, so learners can feel as if they can express themselves without being judged. According to Constand, MacDermid, Dal Bello-Haas, and Law (2014), this will also allow for person-centered communication aimed specifically at ensuring that the direct care staff attend to the

whole resident while sharing information and decisions and being sensitive to resident needs.

Nature of the Study

I used the qualitative interpretive phenomenology approach (IPA) to examine the lived experiences of direct care staff related to PCC in their work setting. A quantitative research approach would not have provided a complete analysis of the participants' individual descriptions of their lived experiences. A phenomenological approach is best for the collection and extraction of data from participants to capture their thoughts and feelings, producing credible data (Van Manen, 2014). I conducted semistructured interviews to gain in-depth information about the participants' lived experiences. LTC administration and leaders may be able to use study findings to efficaciously transition to and implement PCC educational reform in their facilities.

The collected data pertained to the perceptions of direct care staff in relation to the person-centered training and education that was provided to them within their LTC facility. The participants consisted of direct care staff, specifically CNAs I collected data through semistructured interviews with the participants in which I obtained descriptions of their educational experiences. All interviews were digitally recorded with the permission of each participant.

Coding data in qualitative research enables the researcher to establish the meaning of the data (Ravitch & Carl, 2016). By coding data, I was able to search for common themes related to the perceptions that the direct care staff had in relation to their provided PCC training, identify length or type of training and education practices that were

provided, and assess how training and education affected the ability of the direct care staff to implement PCC practices effectively. To organize written text as well as audio and visual data, I used a computer program.

Definitions

The following terms are associated with direct care staff and PCC. The terms have been identified in numerous studies concerning direct care staff and PCC practice. I provide definitions related to the terms' usage in this study.

Direct care staff: In this study, direct care staff are certified nursing assistants (CNAs).

Medical model: A model of "hierarchical" care in which "care is dictated to patient. Patient has little to no choice in treatment or care. Patient's expertise in own health is seldom or not taken into consideration" (Sillars, 2015, p.6).

Perceptions: A term that describes a person's subjective thought of an experience (Wilberforce et al., 2016)

Person-centered care: "Care that is co-developed with residents and their families, in which the person is treated holistically" (Health Innovation Network South London, 2013, p. 4; see also United States Department of Health and Human Services, 2017).

Person-centered care model: A model of care in which "participant and staff are equal, and care is collaboratively agreed upon. Participant knowledge of self and choice is integral to improving health. Participant expertise in own life is paramount to determining course of care" (Sillars, 2015, p. 6).

Transformational change: A culture shift within a facility that will result in strategy and processes (Wheeler, Tofani, & Morris, 2016).

Assumptions

The assumptions of this study include that direct care staff require ongoing education to efficiently implement PCC practices. It is also an assumption that the length of training, type of training, and the CNA's type of learning style are major factors to facilitate the staff's ability to reach PCC outcomes. Limited training and education are a concern when seeking quality care within the LTC setting (Dobbs et al., n.d.). Direct care staff's training, within care settings, is potentially valuable in improving resident well-being and staff delivery of quality care (Spector, Revolta & Orrell, 2016).

Scope and Delimitations

The scope of this study will include direct care staff who are CNAs. Personal care attendants (PCAs) and patient care technicians (PCTs) will not be included in the participant pool. The participants will have been employed in a LTC setting that has implemented a PCC model. Home health, assisted living, acute, or sub-acute settings will not be considered. At least 15 to 20 participants will be utilized or until data saturation has occurred. Delimitations may also consist of the participant's geographical area, as the state of Rhode Island will only be considered.

Limitations

A possible limitation of this study may include the large pool of direct care staff. The interview will consist of the category of CNA staff members, as this narrows down

to the resident's direct care staff. There may be bias amongst these categories with their leadership or managers, therefore, results may be skewed.

Significance

The aim of this study is to explore LTC direct care staff perceptions of the PCC training that was provided when a PCC model was implemented in the LTC facility. By providing evidence-based research on this topic, it will ultimately provide, at a national level, the refocus of (LTC) organizations in their core beliefs, values, and culture towards a culture that considers the whole person. Thus, positive social change could be realized because of the change to PCC. Enhancing the life of long-term care residents provides each community with a rich resource of the past that can be used to improve community life. Additionally, positive social change could be realized for families of the residents because the stress they can experience in transitioning their loved one to long-term care would be lessened. The decrease in this type of stress for families would enhance family life and productivity in the work they perform. Finally, by improving and enhancing the experience of (LTC) residents, the knowledge that is gained from the interventions that are used could be used by others to develop innovations that facilitate geriatric growth and development and organizational evidence-based practices.

Chapter 2: Literature Review

Introduction

PCC in the LTC environment is defined by CMS as "focus[ing] on the resident as the locus of control and support the resident in making their own choices and having control over their daily lives" (Evans, 2017, p. 6). Direct care staff are on the frontlines of implementing this practice model. The literature identifies the magnitude of adequate training and education within this arena. With lack of training and education that meets the general guidelines of the specific model, direct care staff are unable to provide quality care to their residents (Fazio et al., 2018, Kim & Park, 2017). Houghton, Murphy, Brooker, and Casey (2016) and Kolanowski et al (2015) discuss the gap in the literature regarding the perceptions of education and training related to PCC of direct care staff. The concern is that researchers do not fully know CNAs' thoughts of PCC (Kusmaul & Waldrop, 2015). The education provided to direct care staff is associated with the amount of person-centeredness that is implemented. Furthermore, direct care staff have expressed the need for training and education to implement quality resident care, according to researchers (Fazio, Pace, Flinner, Kallmyer, & Pace, 2018). The purpose of this study was to examine if there is a difference in the way PCC education is provided to direct care staff. This chapter includes an overview of the literature search strategy and theoretical framework for the study, followed by a review of the literature relevant to PCC education and training.

Literature Search Strategy

I conducted a literature review on current research related to PCC training and education for direct care staff. Prevalent research on person-centered care extends back to the 1980s. I chose articles with a publication date between 2014 to 2018; however, I also included older articles due to the gap in literature on the study topic. In addition, I included literature on the concept of PCC as well as the challenges in the delivery of PCC. Databases included CINAHL Plus with Full Text, PubMed, Medline, and Education Source. The following key words were used to search databases: person-centered care, individualized care, patient-centered care, education, training, direct care staff, and CNAs. I noted the following themes in the literature that I reviewed: education, definitions of person-centered care, person-centered care in nursing homes, dementia care, direct care staff perceptions of person-centered education.

Theoretical Framework

The concept of PCC has existed since the 1980s (Flagg, 2015; Holder, 1983; Holder, 1985). PCC has been widely used in the literature; however, there is no consensus about its meaning. As researchers have noted, there is no one definition of PCC (Kitson, Marshall, Bassett, & Zeitz, 2013; McCance, McCormack, & Dewing, 2011). The concept of PCC places residents at the heart of direct care staffs' care. Other related terms are as follows: *patient-centered*, *family-centered*, *user-centered*, and *individualized* or *personalized*. Regardless of the terms used, the core principles are essentially the same. The concept of PCC concerns encompasses an interdisciplinary approach to planning, developing, and monitoring individuals' care to make sure their

needs are met, thus putting people and their families at the center of decisions, seeing them as experts of their care, and working alongside interdisciplinary professionals to experience quality outcomes (Health Innovation Network, 2013). The Institute of Medicine (2001) defined patient-centered care as "providing care that is respectful of, and responsive to, individual patient preferences, needs and values, and ensuring that patient values guide all clinical decisions" (p. 3). The philosophy of PCC challenges the traditional medical model of care that leans towards processes, schedules, and organizational needs of staff. The philosophy of PCC depends upon commitment from everyone within an organization.

The origins of PCC are in humanistic psychotherapy. Carl Rogers (1951) believed we need to "learn throughout our lives and we are capable of achieving personal growth through unconditional positive regard within trusting, genuine and open relationships, whatever our age" (as cited in Hazel, 2017, p. 12). If there is no growth due to feelings of insecurity, one becomes unhappy. In Rogers' person-centered model, a trusting relationship requires the therapist to be truthful with clients and to understand and share feelings of another (understand the service user's world from the user's own perspective; (McLeod, 2014)). It is also important to value clients without judging them. Caring is the key to the practice of PCC in nursing. The resident (service user role) is one component of a partnership and not a passive receiver of care. A person-centered relationship encourages positive self-regard and a feeling of being able to achieve one's goals.

This concept of PCC as defined by Rogers (1951) was the catalyst to this study. The model provides a therapeutic approach to educate the whole person without simply

teaching direct care staff members a concept. Use of this theory further allows for implementation of the concepts of PCC to residents in not only a direct hands-on way, but in a psychological, emotional, and spiritual way. This theory not only applies to the learner but also the educator, as congruence, unconditional positive regard, and empathy are conveyed by the educator so that learners can feel they can express themselves without being judged. Therefore, the quality of interpersonal relationships that one shares with a student is the most significant element in determining the effectiveness of the learning experience (Bryan et al., 2015).

Literature Review Related to Key Variables and/or Concepts

Perceptions of Person-Centered Care

There has been a plethora of literature regarding the perception of PCC by nursing staff. The following review of the literature provides the evidence required to support the necessity of this study. Carl Rogers has been recognized as the father of person-centered approaches to care (Ward, 2014)). Although his 1950's work concentrated on the counseling of clients, his principles of PCC have been developed and applied across health disciplines and beyond (Wilson, 2018). Since its formulation in the 1950s, PCC has blossomed into a phenomenon that has been recognized by health regulatory agencies (e.g., the U.S. Department of Health and Human Services and CMS) as an essential feature in the deliverance of care (Kim and Park, 2017).

Edvardsson et al. (2011) conducted a study to explore job satisfaction amongst staff. The results showed that PCC positively correlated with staff job satisfaction in that supporting staff in providing PCC can enhance job satisfaction and may facilitate in

attracting and retaining staff in residential aged care (Edvardsson et al., 2011). The findings of this study justify the need to shift the focus from merely being task-oriented and following facility routines to providing high quality PCC that ultimately promotes quality of life in residents in LTC.

Potential for Social Change

The results from this qualitative research study will assist in promoting positive social change. The results will ultimately provide, at a national level, the refocus of long-term care organizations in their core beliefs, values, and culture towards a culture that considers the whole person. Thus, positive social change could be realized because of the change to PCC. Enhancing the life of long-term care residents provides each community with a rich resource of the past that can be used to improve community life. Additionally, positive social change could be realized for families of the residents because the stress they can experience in transitioning their loved one to long-term care would be lessened. The decrease in this type of stress for families would enhance family life and productivity in the work they perform. Finally, by improving and enhancing the experience of long-term care (LTC) residents, the knowledge that is gained from the interventions that are used could be used by others to develop innovations that facilitate geriatric growth and development and organizational evidence-based practices. It is important for LTC facilities to be aware of the how they are providing PCC education and training to their staff, in order to provide their residents with quality individualized care.

Summary and Conclusions

The literature review in Chapter 2 provided evidence to suggest that PCC is the path in which health care providers should take to provide the highest quality of care possible. The literature also assists in confirming the requirement of this study. However, the literature does not provide evidence on how direct care staff perceive the education or training that has been provided to them.

Chapter 3: Research Method

Introduction

As stated in Chapter 1, the purpose of this qualitative interpretative phenomenological research study was to examine the perceptions of direct care staff toward the training and education they received when a PCC model was introduced in their LTC facility, specifically whether they perceived the training and education adequate in preparing them to implement these practices. This chapter contains an explanation of and rationale for the research design; a discussion of my role in the research process; an overview of the study's methodology including the population, sampling procedure, and procedures for recruitment, participation, and data collection and analysis; and a discussion of issues of trustworthiness. The method for this dissertation was qualitative with a phenomenological approach. An interpretative approach was necessary to gain the described experiences of the participants (see Dusi, Girelli, Tacconi, & Sità, 2011). Using an interpretive approach, I was better able to probe participants' experiences and perceptions related to their exposure to a PCC culture change model while also investigating the training and education that was provided to prepare the staff to implement these practices.

Research Design and Rationale

I sought to answer two RQs:

RQ1. What are the perceptions of direct care staff in relation to the training and education that was provided when a PCC approach was implemented in their setting or when they came to work in the setting?

RQ2. Does the length or type of training and education practices affect the ability for CNAs to implement PCC practices effectively?

An IPA is a type of qualitative research approach in which interviews are used to gather verbatim data as part of an open-ended inquiry. IPA offers a versatile and flexible approach to understanding participant experiences (Tuffour, 2017). IPA is a phenomenological approach that can be used as a tool to better understand individuals' shared experiences of a phenomenon (Van Manen, 2014). This goal of using this design was to provide rich and distinctive insight into the experiences of participants to pinpoint areas for enhancement. The purpose of this qualitative study was to give voice to the unique experiences that direct care staff had based on the PCC education and training that was provided to them. I determined that a qualitative approach was most appropriate for probing participants' experiences and exploring the study phenomenon in-depth.

I gathered data of individual lived experiences through semi-structured interviews with a small purposive sample. The goal for conducting these interviews was to understand the participants' experiences and explore the type of education and training provided to them. By using the semistructured interview format, I was able to reveal participants' explanations and encourage participants to describe their personal experiences (see Creswell & Creswell, 2017; Maher, 2017).

Role of the Researcher

I prepared semi-structured questions for the participants. I had no personal or professional relationships with any of the participants prior to the interview. Each interview began with a broad question of daily job duties to start the conversation. After

setting the tone of the interview, questions were introduced to have participants define PCC practices. Sharing my own direct care experiences assisted in gaining the participants' trust (see Rubin & Rubin, 2005). The goal was to remain open-minded throughout the course of the research study and refrain from sharing opinions to avoid any biases and ethical concerns.

Methodology

Participants

It was essential to select participants who have experienced the phenomena; therefore, I selected participants purposely. I selected 20 direct care staff from LTC facilities that have implemented a PCC approach and that are currently providing PCC practices. Several directors of nursing and nurse educators within the State of Rhode Island were contacted to assist with participant recruitment. A letter of invitation was generated to provide the details of the study. To gain access to participants, I asked the contact person from each LTC facility to assist in the distribution of the research invitations to the possible participants. All willing participants were notified via the invitation on how to contact me. Snowball recruitment was used after I made contact with the first participant from each facility. This type of recruitment procedure allowed for participants to refer me to other potential participants, a process which enriched the sampling cluster and provided access to new participants (see Lavrakas, 2008). A prescreening was also performed on all participants to determine if they met the criteria for the study. The prescreening questions for participation in the study included having participants agree that they (a) are a certified direct care provider (nursing assistant), (b)

currently working in the LTC field with at least two years of experience, and (c) employed in a facility where a PCC model or approach has been implemented. When participants made contact, the screening questions (see Appendix A) were used to identify participants who did not meet the criteria. In the event they did meet the criteria, an interview date was scheduled at the participants' place of employment.

I chose a sample size of 18 participants based on the recommended amount for saturation in a phenomenological study (Guest, Bunce, & Johnson, 2006). All the participants were informed of the nature of the study and were requested to provide informed consent, thus making a commitment to the interview. After receiving consent, I performed one-to-one semistructured interviews to gain insight into participants' thoughts and feelings about the implementation of PCC practices in their facilities.

Instrumentation

I posed open-ended interview questions (see Appendix B) based on PCC educational practices to participants. These questions were presented to the participants during the face-to-face, semi-structured interviews. Using a semi-structured interview format, I encouraged participants to discuss at great length and in detail their PCC educational experiences.

I examined direct care staff's experiences as they pertained to their everyday implementation of resident care. The type and length of both education and training were also examined. All interviews were audio taped for accuracy and later transcribed. Participants were notified in advance that the conversations will be kept confidential and will be recorded. Participants were also be notified that note taking would also occur

throughout the interview.

Procedures for Recruitment, Participation, and Data Collection

The purpose of this phenomenological study is to investigate educational practices and examine the in-depth experience amongst direct care staff working in a PCC environment. Data was collected using self-developed, open-ended questions based on the current training and educational practices surrounding transformational change in the LTC environment. These questions were presented to the participants during face-to-face, semistructured interviews. The interviews took between 30 – 60 minutes and were audio recorded, after gaining permission from each of the participants.

Each participant was assigned a code for confidentiality and identification prior to the interviews. After each participant was determined eligible to participate in the study using the participant pre-screener questions, the face to face interviews were held at a location chosen by the participant. Once all questions were addressed on the interview protocol, all participants were asked if there are any other information they would like to share about their experiences. Once the data analysis process was completed, the participants were invited to member check to review their interview transcripts and the interpretations of the data. Feedback from the participants was requested via email or phone. Member checking is a research process that will allow participants to provide additional information (Creswell, 2013).

Data Analysis Plan

The interview questions were created to collect data for the study based on the theoretical framework and recent research outlined in Chapter 2. Transcription of the

interviews required careful identification as to what each participant discussed, and to develop an understanding of the crucial themes and concepts (Rubin & Rubin, 2005). The IPA structure was a guide to maintain a hermeneutic circle to operate at various levels in order to understand the whole.

To identify the unique lived experiences of the direct care staff, the six-step data analysis process for IPA was followed (Smith et al., 2009). These steps included note taking, reading and reviewing, developing emergent themes, searching for connections across these themes, and looking for patterns across transcripts.

Issues of Trustworthiness

Creswell (2013) designed eight standard procedures for verification: prolonged engagement, triangulation, negative case analysis, member checks, peer checks, thick rich descriptions, clarifying researcher bias, and external audits. Reflexivity was also added to the list of strategies by Barusch et al. (2011). Researchers are advised to use at least two verification procedures (Barusch et al., 2011; Creswell, 2013). Therefore, trustworthiness can be verified in qualitative research.

The first procedure to be utilized for trustworthiness was member checks with each participant. During the interviews, follow-up questions and probes for clarification and clear representations of the participants' experiences were utilized, to allow participants to correct any misinterpretations. These member checks also allowed the participants to provide any additional information in order to gain concise and clear data of the experiences. During the face-to-face interviews, participants were also allowed to verify information. An e-mailed copy of their interview transcript was sent to the

participants to review for any potential errors and allow for clarification of data.

The second procedure used were was peer checks, through peer checks this brought forth awareness of posture toward the data, and in the process, uncovered any biases. Measures to foster reflexivity and avoid researcher bias was completed by a journal. Reflexivity can be defined as clear self-exploration and presentation of the researcher's underlying assumptions attributed to various aspects of the research (Barusch et al., 2011). Making regular entries into the journal during the research process, assisted in preserving reflections in their true state.

Ethical Procedures

Following IRB approval, each participant was provided information on informed consent, and each participant signed a consent form prior to their interview, to indicate their acknowledgement and acceptance. Privacy was crucial for participants; therefore, a number was assigned for each participant throughout phases of the study. Every participant's confidentiality and privacy were maintained throughout collecting the participant's personal experiences. Each of the participants in the study were also informed of the study's purpose, what to expect during the interviews, and how the data will be used. Lastly, all transcripts and audiotapes are currently kept in a locked safe for seven years, and then will be destroyed. This researcher and her committee are the sole viewers of this material.

Summary

In this chapter, I discussed IPA as the phenomenological approach I used to better understand the participants' lived experiences. I also discussed the semistructured, audio-

taped, and one-to-one interviews I used as the means for collecting participant data. To interpret the data, the six-step data analysis process for IPA was utilized. I also provided information on how I ensured confidentiality and privacy throughout the study. As I discuss, trustworthiness was achieved using member checks and peer checks. In Chapter 4, I will discuss the participant demographics, data collection, data analysis, evidence of trustworthiness, and results of the study.

Chapter 4: Results

Introduction

Understanding direct care staff's perceptions of their PCC training is crucial in filling the gap in literature pertaining to the education and training practices that are currently being provided in facilities, especially those that seek to meet current CMS regulations (CMS, 2018). In conducting this study, I also sought to identify areas for improvement in the educational practices currently being used by LTC facilities. I especially wanted to identify what strategies should be encouraged to effectively implement PCC practices to reach positive resident outcomes.

In Chapter 4, I will present my analyses of the data collected from the 18 CNA participants, all of whom were employed in first-shift position at the time of the study. An overview of the data collection and analysis procedures is also provided. The results are conveyed and include participant excerpts.

Setting

I conducted the face-to-face interviews in the conference room of each of the three LTC facilities included in the study. All participants possessed LTC experience as they were working in a nursing home that had applied either the Household, Green House, or HATCh model of care. All three facilities offered an intimate living environment that included 24-hour care/7 days per week and featured private bedrooms, spacious living rooms, private dining, and areas for both residents and families. Facility 1 encompassed Participants 1-6 and applied the Household model of care, Facility 2 encompassed Participants 7-12 and applied the HATCh model of care, and Facility 3

encompassed Participants 13-18 and applied the Green House model of care. Use of the PCC design promotes resident independence as well as family-like relationships (Cohen, 2016).

Facility 1's point of contact noted that all staff are "oriented" to the Household model of care training during their "first weeks on the job." Facility 2's point of contact noted that the HATCh model of care training presented to staff in the "old building" and the "team" is amid creating a new orientation plan that coincides with the training that was previously offered to employees "2.5 years ago." Facility 3's point of contact stated that the Green House model was infused into their new employee training "the first week of orientation." There were no personal or organizational conditions that influenced participants, their experience, or interpretation of the study results

Demographics

Demographic information is presented both in tabular and narrative format. Table 1 displays the demographic information for each of 18 participants in the study.

Table 1

Demographic Data

Facility	Gender	Age	Years of experience	PCC model
Facility 1				
Participant 1	Female	26	3	Household
Participant 2	Female	32	2.5	Household
Participant 3	Female	23	8	Household
Participant 4	Female	34	13	Household
Participant 5	Female	31	6	Household
Participant 6	Female	40	18	Household
Facility 2				
Participant 7	Female	20	3.5	HATCh
Participant 8	Female	33	11	HATCh
Participant 9	Male	20	2	HATCh
Participant 10	Female	22	2	HATCh
Participant 11	Female	44	16	HATCh
Participant 12	Female	62	21	HATCh

(*table continues*)

Facility	Gender	Age	Years of experience	PCC model
Facility 3				
Participant 13	Female	58	6	Green House
Participant 14	Female	33	2	Green House
Participant 15	Female	26	7	Green House
Participant 16	Female	24	13	Green House
Participant 17	Female	40	3	Green House
Participant 18	Female	24	10	Green House

The ages of the participants ranged from 20 to 62. Their length of experience as a CNA ranged from 2 to 21 years. Of the 18 participants, 17 were women and one was a male.

Data Collection

The data collection began in January 2019 after Walden's Institutional Research Board (IRB) granted approval (# 12-24-18-0142815). Recruitment lasted for approximately three months. After the first month, I sent follow-up e-mails to facilities to redistribute recruitment flyers to complete the recruitment process. The data collection was closed at the end of March 2019. The response rate was initially slow due to requests of the study's abstract and interview questions by facility leaders. There were no variations in the data collection process or any unusual circumstances.

I recruited participants using purposive sampling. Six to 12 participants were proposed, and 18 were utilized in order to meet data saturation. Having a sample size of fewer than 20 participants in a qualitative study assists the researcher to build and

maintain a relationship that improves the open exchange of information (Crouch & McKenzie, 2006). The three LTC facilities displayed recruitment flyers within their facilities, and the participants contacted me directly via phone. After making contacting with participants via phone, I used the prescreening questions to uphold the recruitment goals for this study. Length of time in the CNA role, number of years worked in LTC, and if their LTC facility implemented a PCC model or training program were some of the screening questions (see Appendix A) asked. Each participant screened met the inclusion criteria and was individually scheduled for interviews. All participants were scheduled for interviews that took place in a quiet conference room, within the facility in which they were employed.

At the start of each interview, I reviewed the consent form and the overall interview process with each participant. After permissions and signatures were attained, the interview began and was audio recorded. Participants were notified that they could stop or exit the interview at any time.

I asked nine semi-structured questions (see Appendix B) followed by verbal and nonverbal prompting. Prompting was utilized to draw further information from the participants (Heath, Williamson, Williams, & Harcourt, n.d.). Upon completion of each interview, the participants were provided with a gift card as stated on the initial recruitment flyer to thank them for their participation.

After the 16th interview, there were no new themes generated from the interviews. Therefore, it was deemed that the data collection had reached a saturation point. Data collection continued for two more interviews to ensure and confirm that there

were no new themes emerging (Jassim & Whitford, 2014, pp. 190–191).

Data Analysis

In this section, I describe the IPA process I used to explore the perceptions of the CNAs in the study. This approach allowed for reading, reflecting, and taking notes to fully understand the data generated by the interviews. Through the hermeneutic circle of this process, the data collected from the participants involved a movement between the smaller units of meaning and the larger units of meaning, or between the parts and the whole of the investigated lived experience (Peat, Rodriguez, & Smith, 2019). To explore the unique experiences and perceptions of direct care staff on PCC training, I used the following six-step data analysis process:

Step 1. Read and reread: The first step in conducting IPA research is to engage in reading and rereading interview transcripts (Smith et al., 2009). Meanings were identified in the data and helped in interpreting the data as a whole.

Step 2. Note taking: This step allowed for the documentation of ideas and observations that arose from the repetitive reading of the transcripts. This detailed step of the process took place from January to March 2019.Note taking consisted of 3 categories: Linguistic, descriptive, and conceptual noted for exploratory note taking. Linguistic comments were noted such as tone, pauses and repetitions. Descriptive comments which were rephrasing of the participant's data, were also noted in the margins. Conceptual comments that involved my knowledge from relevant literature and life experiences were noted.

Step 3. Emergent themes. This step allowed for identifying emerging themes. Looking at the linguistic and descriptive comments and the original source, themes centrally from conceptual comments, mostly in the form of a phrase and sometimes in a sentence. The hermeneutic circle was identified in this step. The focus was on the parts and not the whole for contextual analysis. Phrases taken from notations were noted to have connections within interviews.

Step 4. Locating connections across emergent themes. Emergent themes from Step 3 were charted in order of events and listed accordingly. All themes that had a connection were grouped and others were removed. All grouped themes that identified similarities were given a title. Also, other notations and comments continued to be identified during this step.

Step 5. Moving to the next transcript. Steps 1 through 4 were implemented systematically while each transcript was analyzed for emergent themes. Ways were recognized in which accounts from participants were similar but also different.

Step 6. Looking for patterns across transcripts. In this step, superordinate themes were mapped by searching for patterns amongst all interviews. These themes identified concepts that were shared by most of the participants. Similar meanings were identified across data and highlighted making note of any idiosyncratic differences.

After completing the six-step process, I contacted participants and offered them the opportunity to review their transcripts as part of the member checking process as recommended by Creswell (2013). Out of the 18 participants, 10 replied with no request for change in the data. Therefore, no adjustments were made to the transcripts.

Chapter 3 indicated that NVIVO software would be used to assist with the data analysis stage of the study. However, upon reviewing the NVIVO software, it was realized that the software was complex, and was noted to be used for much larger data sets. For this reason, I chose to use Temi a web-based site that uses automated speech-to-text algorithms to convert audio and video files into text, which converted the audio recorded interviews into transcripts. For the coding of the data, I chose to utilize Microsoft Office Suite. With respect to this research study, a combination of the software programs Microsoft Word and Microsoft Excel were used to organize, analyze, and synthesize the data collected.

Therefore, color coding for the superordinate themes was implemented immediately after the development of each theme in Microsoft Office. In the results section of this chapter, transcript passages that contributed to the development of themes are illustrated. According to Smith et al. (2009), this assists in the comprehension of interpretations from the participants' perceptions.

Once the interviews were transcribed, the data was coded into superordinate themes that stemmed from participant responses. There were five themes created, identification of Person-Centered Care (PCC) practices, identification of the Types of Training Modalities, the Initial Introduction to PCC, Length of Initial Training, and types of Learning Styles. The Superordinate themes were then thematically coded by using Subordinate themes which represent the individual perceptions of each CNA participant in exploring their PCC training experience.

Evidence of Trustworthiness

In order to establish the study's findings to be credible, transferable, confirmable and dependable, trustworthiness was verified using member checks and peer checks. Credibility rests on the qualitative interpretive phenomenological approach to discover how CNAs' implement PCC based on their lived experiences as discovered from the identified themes. Credibility was established through diversity of participants, immersion in the data, and the time spent in the field. I included participants from three long-term care facilities and conducted all interviews within these facilities in order to engage myself in the CNAs' working environment. Also, I became intimate with the verbal words of the participants while reviewing the narratives after transcription and reflected on their rich stories of resident engagement multiple times through the process of coding and theme identification.

In this study, transferability was established through the inclusion of participants from three LTC facilities and through the use of thick description that enables someone to reach a conclusion about whether transfer can be contemplated. Dependability was established through a review of the study by my dissertation committee chair, and another faculty committee member from Walden University, who is well versed in interpretive phenomenological research.

During the interviews, follow-up questions and probes for clarification and clear representations of the participants' experiences were done to allow participants to correct any misinterpretations. These member checks allowed the participants to provide any additional information in order to gain the concise and clear data of their experiences.

During the face-to-face interviews, participants allowed to verify information. An e-mailed copy of their interview transcript was sent to the participants to review for any potential errors and allow for clarification of data. Through the process of peer checks, this brought forth awareness of my posture toward the data, and in the process, uncover any biases.

To establish confirmability of the research findings, reflexivity was fostered through the use of the journal. Reflexivity can be defined as clear self-exploration and presentation of the researcher's underlying assumptions attributed to various aspects of the research (Barusch et al., 2011, Hoover & Morrow, 2015). I maintained thorough documentation throughout the research process to also ensure confirmability and provided regular journal entries, as to assist in preserving reflections in their true state.

Results

The purpose of this qualitative phenomenological study was to examine the perceptions of direct care staff in relation to the training and education that was provided when a PCC approach was implemented in their long-term care (LTC) setting or when they came work in the setting. I also looked at the length, type of training and education practices that affected the ability for CNAs to implement PCC practices effectively and what type of learner they were.

Table 2 shows how superordinate themes were generated based on the participant's similar words or phrases that grouped into subordinate themes in Table 3. I reviewed the transcripts and searched for patterns. Superordinate themes included

concepts that were shared by the majority of participants. These themes were cultivated based on the richness of the data and not the frequency in which they were arising.

Table 2: *List of Superordinate and Subordinate themes*

Superordinate themes	**Subordinate themes**
Ability to identify person-centered practices	Types of personal choice Hairstyle Clothing Food Personal hygiene practices Sleep/wake cycle
Ability to identify training modalities	Types of modalities PowerPoint Handouts Role play Videos
When the PCC education was introduced	Time of introduction Prior to newly built facility Orientation upon hire
Length of the initial PCC training	When training occurs 7-hour training one day Weeks of training over several months Monthly in-services Daily 10-15 minute stand up meetings
Learning style of the CNA	Type of learner Met Learning Needs Auditory Y=Yes Visual N=No Kinesthetic Combination

Research Question 1

RQ 1 was, What are the perceptions of direct care staff in relation to the training and education that was provided when a PCC approach was implemented in their setting or when they came to work in the setting? Three themes emerged during the data analysis to answer this RQ, including (a) Ability to Identify PCC Practices, (b) Ability to Identify the Training Modalities Used in Their Education, and (c) Learning Style of the CNA

Table 3 through 7 represent the frequency in which a subordinate theme was supported by each participant. To develop my emerging themes into subordinate themes I focused on capturing essential pieces from the participant's narrative, paying more attention to the parts rather than the whole.

Ability to Identify PCC practices. In Table 3, 18 of the participants identified a PCC practice by providing an example. Participants 8, 9, 10, and 13 stated one practice in which they provided PCC. However, 13 were able to state more than one PCC practice that they had implemented with a resident. Participant 1 stated "I give my resident the option everyday of what they want to wear and how they want their hair done." Participant 3 stated "I ask them what do they want for breakfast and what time they want to take a shower, this gives them choices in their care". Participant 11 stated "Our kitchen will make anything my resident wants to eat, like a grilled cheese sandwich or something like that." Participants 2 and 7 added that getting to know your resident is important for what "choices they want to make". Participant 13 described PCC as "The resident can make their food choices, if they want eggs, or if they want to eat oatmeal". Participant 2 also added:

> I have to focus on the person, it's like giving that person that priority of care and that they are giving you permission to care for them. So, you try to make them feel like they have a voice and ask them, what do you want to wear today, do you want a shower or a bath, what would you like for lunch today, would you like to take your nap today at 1 o'clock?

It is important to note that Facility #1's point of contact stated that all staff were "oriented" to the Household model of care training during their "first weeks on the job". Facility #2's point of contact noted that the HATCh model of care training presented to staff in the "old building" and the "team" is in the midst of creating a new orientation plan that co-insides with the training that was previously offered to employees "2.5 years ago". Facility #3's point of contacted stated that the Green House model was infused into their new employee training "the first week of orientation".

Table 3: *Person-Centered Practices*

Ability to identify PCC practices (Resident choices)	P 1	P 2	P 3	P 4	P 5	P 6	P 7	P 8	P 9	P 10	P 11	P 12	P 13	P 14	P 15	P 16	P 17	P 18
• Hairstyle	X																	
• Clothing	X	X				X	X				X							
• Food	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
• Personal hygiene practices	X	X	X	X	X	X											X	X
• Sleep wake cycle	X	X	X	X										X	X			

Ability to identify training modalities in PCC. In Table 4, all 18 participants identified a training modality that they were exposed to for PCC training. However, seventeen of the participants were provided handouts, whereas 12 participants were

exposed to more than 1 training modality. Facility 1 exposed more than half of their CNAs to four modalities.

Participant 1 stated:

> I remember my orientation time in this and "Joe" showed a video and gave us a handout and test on this care. I also had to act in a thing where me and another new CNA had to act on what we do if I was the resident and she was the CNA. She asked me what I wanted to wear and what I wanted to eat and things like that.

Participant 8 added:

> I remember before moving here to the new building, they taught us all about the HATCh model I think it was called and they showed us a bunch of PowerPoints over the course of the culture change training. We had to watch a video about the model and they said how the resident would have their own rooms and a kitchen in the neighborhood and have no more trays coming from the kitchen and it would be like their home. We were also told that we needed to start giving our resident choices in their care now (at old building) and ask them things like "what do *you* want to eat for breakfast, and things like that".

Participant 9 also recalled:

> I had my training in the old building for a while on person-centered care and how we need to ask residents what they want and when they want it. We had to do certain exercises and act out like a play or something like that which is good because I learned better by acting it all out. So, we read too about it (PCC) and things like that". Participant 14 did not recall a teaching modality that was used in

> their PCC training and stated "I'm not sure what that is was never trained in person-centered care here, I just had a regular orientation to the floor.

Participant 13 explained:

> When I was trained I was given a handout and I don't think that was good enough to learn about it (PCC) and to do it every day. I feel better about learning a new thing if I can do it and someone watched the way I do it.

Participant 15 added:

> When someone tries to teach me something, I like doing it first with them then I feel comfortable knowing what to do. For example, if in the training session the nurse asked me a question on how I would ask a resident if they wanted a shower or when to wake up, then I would've been given a scenario, I would learn it better.

By providing a variety of teaching modalities, educators engage students in an active learning process and the students are more likely to memorize the information associated with the topic (Xu, 2016). Participants 1 through 6 were provided all 4 training modalities for their training.

Table 4: *Teaching Modalities*

Ability to identify teaching modalities in PCC	P 1	P 2	P 3	P 4	P 5	P 6	P 7	P 8	P 9	P 10	P 11	P 12	P 13	P 14	P 15	P 16	P 17	P 18
• PowerPoint	X	X	X	X	X	X	X	X	X	X	X	X						
• Handouts	X	X	X	X	X	X	X	X	X	X	X	X	X		X	X	X	X
• Role Play	X	X		X		X												
• Videos	X	X	X	X	X	X	X	X	X	X	X	X						

Learning style of the CNA. In Table 5, all participants identified what type of learner they were (auditory, visual, kinesthetic, or combination) and voiced if their learning style was met or not met, when the PCC training was introduced to them. Three participants stated that they were auditory learners.

For example, participant 5 stated:

> When I hear something like studying in a group or listening during a presentation, I learn the information better." "When I learned about PCC here, I had papers, a presentation and watched an Alzheimer's video about it. This participant stated that their learning style was met, due to the modalities utilized.

Five participants stated that they were visual learners and that their learning style was also met during their training. Eight participants stated that they were kinesthetic learners, although their learning style was not met with the modalities offered. Lastly, 2 participants stated they learned in a combination of ways and their learning style was met during their training session.

Participant 6 described her learning experience as:

> I like to learn by doing something and showing that I can do it, but I also learn by listening to people speak." "So, I can learn both ways by someone telling me step by step how to do something like emptying a Foley catheter, then I like to actually do it though, to learn better.

In short, this data suggests that the majority of the CNAs are kinesthetic learners and from the 18 participants, 10 stated that their training did not meet their learning style.

Table 5: *Learning Styles*

Learning Style of CNA	P 1	P 2	P 3	P 4	P 5	P 6	P 7	P 8	P 9	P 10	P 11	P 12	P 13	P 14	P 15	P 16	P 17	P 18
• Auditory					X								X	X				
• Visual	X	X						X			X						X	
• Kinesthetic			X	X			X		X	X		X			X			X
• Combination						X										X		
Training Met CNA Learning Style • Y=Yes • N=No	Y	Y	N	N	Y	Y	N	Y	N	N	Y	N	N	N	N	Y	Y	N

Research Question 2

Research Question 2 was, Does the length or type of training and education practices affect the ability for CNAs to implement PCC practices effectively? Two major themes emerged during the data analysis to answer the research question, including: (a) When the PCC education was introduced and (b) The length of the PCC training.

When the PCC education was introduced. Table 6 identifies when the PCC training was introduced. Participants 1 through 6 and Participants 7 through 12 were two separate groups of participants that were working in a newly built facility. Therefore, Participants 1 through 12 stated their training took place prior to working within the newly built facility. Participant 1 stated they "first
learned about person-centered care before in my old job then when I came here to the new building I learned it at my orientation". Participants 2 through 5 &14 stated they learned about PCC at orientation upon hire in their current job. Participants 13, 15, 16 &

18 stated they received their PCC education from another LTC facility prior to their current job.

Table 6: *Introduction to Person-Centered Care*

When the PCC education was introduced	P 1	P 2	P 3	P 4	P 5	P 6	P 7	P 8	P 9	P 10	P 11	P 12	P 13	P 14	P 15	P 16	P 17	P 18
• Prior to new facility built (In "old" facility)						X	X	X	X	X	X	X						
• Orientation upon hire (In current LTC facility)	X	X	X	X	X									X				
• Prior to current job (In another LTC facility)	X												X		X	X		X

Length of the PCC training. The length in which the PCC education and training took place is identified in Table 7. Again, Participants 1 through 6 and Participants 7 through 12 were two separate groups of participants, that were working in a newly built facility. Participants 1 through 4 and Participant 6, stated the length of their training was received in a 7-hour orientation day upon hire. Participant 5, 7, 8, 12, 15, 16 &18 stated they received an unspecified amount of training that recalled to weeks of training over several months. Participants 9-11, 13, 14 & 17, stated that they did not recall the length of training received.

Table 7: *Length of Initial Person-Centered Training*

Length of the initial PCC training	P 1	P 2	P 3	P 4	P 5	P 6	P 7	P 8	P 9	P 10	P 11	P 12	P 13	P 14	P 15	P 16	P 17	P 18
• A 7- hour training (one orientation day)	X	X	X	X		X												
• Weeks of training over several months					X		X	X				X			X	X		X
• No recall of length of training									X	X	X		X	X			X	

Summary

In this chapter I discussed the use of interpretive phenomenological analysis (IPA) and presented the results of two research questions: RQ1 What are the perceptions of direct care staff in relation to the training and education that was provided when a PCC approach was implemented in their setting or when they came to work in the setting? Three superordinate themes emerged during the data analysis to answer this research question, including: (a) ability to identify PCC practices (b) ability to identify the training modalities used in their education and, (c) learning style of the CNA. RQ2 Does the length or type of training and education practices affect the ability for CNAs to implement PCC practices effectively? There were two major themes that emerged during the data analysis to answer this research question, including: (a) when the PCC education was introduced and (b) the length of the PCC training. These five superordinate themes

represent the individual perceptions of each CNA participant in exploring their PCC training experience.

In addition, the findings of the study were unveiled, identifying the frequency with which a superordinate theme was supported. Participant direct statements strengthened their perceptions, bringing about their uniqueness. In the following chapter, I will identify and interpret themes and discuss limitations of the study. Lastly, future study recommendations as well as its significance will be discussed.

Chapter 5: Discussion, Conclusions, and Recommendations

Introduction

The purpose of this qualitative, phenomenological study was to examine the perceptions of direct care staff toward the training and education they received when a PCC model was introduced in their LTC facility, specifically if the training and education that was provided prepared the staff to implement these practices. I explored how CNAs received their training and education, what training modalities were used, if they felt prepared to deliver PCC practices with the length of the training they were provided, and if their learning style was accommodated. Minimal research has been conducted on actual perceptions of CNAs and their satisfaction with PCC trainings (Kusmaul & Waldrop, 2015; Moore et al., 2016; Wilberforce et al., 2016,). There is a myriad of literature regarding PCC, culture change, and barriers to implementing PCC; however, there is minimal research regarding perceptions of CNAs and the training that they are provided in order to implement PCC practice. Without appropriate training, new person-centered practices such as instinctual wake-up/sleep times, and personal choices around dining; as they may be considered by CNAs as a brand-new way to complete a care task, rather than an important shift of resident power and influence (Chenoweth et al., 2015; Roen et al., 2017). The findings of this study revealed that the CNA's perception of person-centered care education and training was viewed as a necessary component in a direct-health care worker's job orientation in order to implement their PCC practices. The subordinate and superordinate themes stemmed from the CNA participants' perceptions of PCC education and training.

Interpretation of the Findings

The purpose of this qualitative phenomenological study was to examine the perceptions of direct care staff in relation to the training and education that was provided when a PCC approach was implemented in their LTC facility. The following are the RQs that were addressed:

RQ1. What are the perceptions of direct care staff in relation to the training and education that was provided when a PCC approach was implemented in their setting or when they came work in the setting?

RQ2. Does the length or type of training and education practices affect the ability for CNAs to implement PCC practices effectively?

I identified the following themes as a result of data analysis: PCC practices, teaching modalities, learner type, length and introduction of training.

Person-Centered Care Practices

As stated in Chapter 2, Houghton et al. (2016) and Kolanowski et al (2015) discuss the gap in the literature regarding the perceptions of education and training related to PCC by direct care staff. The education provided to direct care staff is associated with the amount of person-centeredness that is implemented. Direct care staff have expressed the need for training and education to implement quality resident care (Fazio, Pace, Pike, & Kallmyer, 2018). The data in this study revealed that all the CNA participants were able to provide a verbal example of a PCC practice. They explained how residents were offered choices to adhere to the model of PCC. By including residents in their care, it includes understanding in their beliefs and lifestyles (Tayab &

Narushima, 2014). However, only a small sample of CNAs verbalized the actual implementation of those practices such as offering choices in their resident's daily routines, the choice of what time they would like to get out of bed, or asking how the resident would like their hair styled. The majority of the CNAs in this study explained their hourly working shift duties when asked how they implement PCC practices; they described the tasks being performed and did not include the resident preferences in those duties to be performed. For example, bathing/dressing a resident, cleaning medical equipment, assisting with "feeders," and documentation of tasks were described.

Ultimately, PCC is more than offering a resident a food choice. The philosophy of PCC is about doing things with people, rather than to them, and it is crucial for direct healthcare staff to know what is most important to the individuals for whom they care. According to Moyle et al. (2014), quality of life can decline when the focus is exclusively task-oriented. To fully realize PCC and the practices that stem from the concept, a significant change in the way healthcare facilities consider LTC is vital, as it is a profound change in both consumer and direct health care staffs' mindset and in their delivery of care (Alzheimer's Association, 2017).

Teaching Modalities

The majority of CNAs in this study identified a teaching modality that was utilized during their initial PCC training. However, 12 CNAs noted that they had been exposed to more than one teaching modality for their training. Facility 1 provided four training modalities that were recalled by four of their CNAs. These CNAs verbalized that they felt prepared to carry out person-centered practices because of the variety of

modalities provided. In contrast, other CNAs in the study described role-play or scenario typed modalities to facilitate their learning of PCC practices. Findings suggest that offering a variety of modalities influences the learning of students and makes it easier for CNAs to learn.

In a literature review conducted by Peters and Ten Cate (2014), researchers noted that bedside teaching is seen as an important teaching modality and is declining as a way of educating many skills in the medical profession. The modality of role-play is also a strategy for teaching a concept or skill to students. It also encourages self-reflection about the skill as well as the ability that is required for the act of caring for an individual (Sebold, 2018).

Learning Styles

According to Vizeshfar and Torabizadeh (n.d.), students have a broad range of individual differences in learning methods. Many research studies have been conducted to examine the variation of teaching methods with styles of learning (Ranadev et al., 2018). It is crucial for educators to know the learning styles of their audience, which will in turn assist in positive learning outcomes. In this study, the majority of CNA participants were kinesthetic learners. Therefore, when PCC training was initiated with these CNAs, it would have been beneficial to the CNAs for the educator to engage them in kinesthetic activities that require movement, because they learn by doing (Ranadev et al., 2018). Activities could have included role-play and return-demonstration to promote their learning. It is important to note in this study that 10 participants stated that their training did not meet their learning style. Therefore, when introducing PCC trainings to

direct healthcare staff, it is imperative for LTC facilities to assess and provide training that meets staff learning styles.

Introduction of PCC Training and Length of Training

Participants also noted that the initial PCC training they received was provided at varied times. The first and third facility provided their training when the CNA began the orientation to the position. The second facility introduced PCC to all their current staff members prior to moving into their new building; facility leaders stated that they had not yet trained their newly hired CNAs in PCC but were creating a new orientation plan to included previously used training information regarding the HATCh model and PCC practices.

The length of training also varied within the three facilities. Participants stated that either a one day 7-hour training was implemented in their facility or weeks of training occurred over several months. Other participants stated that they did not recall how long their training was in PCC.

Findings in Relation to the Theoretical Framework

The framework for this study was based on Carl Rogers' person-centered approach theory and philosophy. This theory is based upon the belief that to actualize human growth later in life, people should be able to access and experience opportunities for ongoing learning, personal challenges, and close and intimate relationships (Wilson, 2018). In PCC, the caring is central to nursing practice, and direct care staff relationships with the residents are fundamental to that individual's experiences of care. The resident's role is one of a partnership, rather than a receiver of care. A person-centered relationship

promotes self-esteem and self-efficacy. A few participants of this study were able to verbalize that PCC is the "focus on the person that they were caring for and making them feel that they have a voice". However, many participants were focused on task completion when questioned about PCC practices, which is deterrent in the implementation of PCC. Unfortunately, it is too often recognized that direct-care staff are task-oriented and fail to include residents in their plan of care. Researchers have identified direct-care staff to more often organized their duties and routines according to the urgency of the task at hand, combining tasks with a compassionate care approach is key when implementing PCC practices (Kristensen et al., n.d).

The data gathered from this study align with the Carl Rogers' person-centered approach, which is based on acceptance, empathy, caring, sensitivity, and active listening and which promotes optimal human growth. The data from this study suggest that in order for CNAs to implement PCC practices, the training curriculum and modalities must be individualized to the learner population. Person-centered approaches to long-term care (LTC) promote conditions for LTC residents to participate in meaningful lives, and enhance their well-being. Therefore, when the theory's concepts are threaded throughout the training curriculum this can be achieved.

Choice and education are paramount to PCC, which is also related to increased resident satisfaction. However, this move from a dependent resident or receiver of care to an empowered partner in care depends on a trusting relationship in which direct care staff do not react negatively to perceived non-compliance of the resident. Rather, direct care staff support the resident to express their fears and concerns, and to develop a trusting

relationship that will ultimately promote self-caring behavior (McCormack, Dewing, & McCance, 2011). The under-pinning of CNAs implementing PCC, is of use of these concepts such as mutual respect, resident's right to self-determination.

Limitations of the Study

This study had several limitations in exploring direct care staff's experiences and perceptions of PCC training. This study was limited to the perception of a small group in a localized area. Only eighteen CNAs of three long-term care facilities, from Southern New England were engaged in the study; therefore, limiting the diversity of responses and shared experiences of all CNAs. Also, three models of PCC were explored, the HATCh model, Green House model, and Household model; therefore, reducing the information in operations in facilities as it pertains to the implementation of PCC training. This study identified the implementation of three models, however, there are a multitude of PCC models to be evaluated in a number of long-term care facilities. Therefore, future research is required to evaluate how other LTC facilities implement their required training curricula.

Recommendations

Most previous research has focused on the concept of person-centered care rather than identifying direct care staff's experiences and perceptions of PCC training. The concept of person-centered care (PCC) has existed since the 1980s (Flagg, 2015; Holder, 1983; Holder, 1985). This study made a meaningful contribution to the literature gap of CNA perceptions of their training. Houghton et al. (2016) and Kolanowski et al. (2015) discuss gap in the literature regarding the perceptions of education and training related to

PCC by direct care staff. The education provided to direct care staff is associated with the amount of person-centered components that is infused in their training.

This study contributed to filling the gap by examining the unique, experiences of eighteen CNAs and what they found to enhance PCC practices. Recommendations for future research include:

1). Analyzing the perceptions and experiences of direct care staff in other demographic areas of Southern New England and other areas of the United States.

2.) Analyzing other PCC models experienced by direct care staff, due to the variety of models associated with PCC.

3.) Further research should be conducted on the perceptions of PCC training of other direct care staff such as RNs, LPNs and Physicians; as this may be beneficial to explore their implementation of PCC practices with their specific training.

Implications

With this study, CNAs are now heard in conveying crucial insights into their perceptions of training. PCC is essential in providing exceptional care to residents and to the underlying philosophy of the Alzheimer's Association (Fazio, Pace, Finner, & Kallmyer, 2018). Many long-term care (LTC) facilities have now replaced the institutional model of care to one that accepts person-centered care (PCC) as the guiding standard of practice. Therefore, quality training that is ongoing ensures that CNAs have the skills and knowledge in the delivery of quality PCC.

Implications for Individuals and Facilities

CNAs are well trained during their certification classes; however, the minimum academic requirements in order to attain certification, can only explain so much and the minimal clinical experiences focuses on preparing them for the completion of tasks. Nursing assistant programs could add person-centered components to their current curricula, to instill a basic PCC foundation, that is needed prior to the novice CNA entering their first job.

According to participants in this study, the assessment of CNA learning styles is essential upon initiating a PCC training program within a LTC facility, as well as an educator's utilization of different teaching modalities. By providing a variety of teaching modalities, educators engage students in an active learning process and the students are more likely to learn the information associated with the topic (Xu, 2016). As stated by participant fifteen "When someone tries to teach me something, I like doing it first with them then I feel comfortable knowing what to do. For example, if in the training session, the nurse asked me a question on how I would ask a resident if they wanted a shower or when to wake up, then I would've been given a scenario, I would learn it better".

LTC facilities should include the delivery of PCC both as a major component of new employee orientation and in their yearly education program for direct care staff. This study highlights the importance of providing LTC residents with services that are nurturing and compassionate. When direct care staff are attentive and collaborative, the residents are happier, and more satisfied (Keeley et al., 2015). This study also provided

an understanding that CNAs perceived that including the resident in decision making was a primary component in providing PCC.

The results will ultimately provide, at a national level, the refocus of long-term care organizations in their core beliefs, values, and culture towards a culture that considers the whole person. Thus, positive social change could be realized because of the change to PCC. Enhancing the life of LTC residents provides each community with a rich resource of the past that can be used to improve community life. Ongoing research to justify the effectiveness of the CNAs perception of PCC in LTC would be beneficial.

Conclusion

In Southern New England and across the United States there is a need to implement PCC to its fullest capacity. Minimal research has been completed in looking at direct care staffs' perceptions of PCC training (Kusmaul & Waldrop, 2015). The purpose of this study was to examine the perceptions of training that direct care staff experienced when a PCC model was introduced in their LTC facility, and, specifically, if the training and education that was provided prepared the staff to implement these practices. Education and training are key to successfully implementing a PCC model (Menne, 2008). The results from this study enhances the overall concept of PCC and that it involves a good working knowledge of a resident as whole person. It is also important that direct staff involve them in their own care assist them in assessing their own needs and plan their own care. The theory is to be free of the task-focused approach when implementing PCC practices, and encompass an individualistic approach. Ultimately, it is important for LTC facilities to be aware of the how they are providing PCC education

and training to their staff, to provide their residents with quality *individualized care* that emphasizes the whole person.

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Appendix A: Screening Questions

1. How long have you been a certified nursing assistant?
2. How many years have you worked in long-term care?
3. Currently, what population do you care for?
4. Do you know what Person-Centered Care pertains to?
5. Has your facility implemented a Person-Centered Care Model or approach in PCC?

Appendix B: Interview Questions

1. Tell me about yourself.
2. Describe a typical day as a nursing assistant?
    a. What time do you start and end work?
    b. What do you do during your shift?
3. What is your perception of Person-Centered Care (PCC)?
    a. When was the first time you heard about PCC?
4. What PCC practices do you perform, on a daily basis for your residents?
    a. When, where examples?
5. How do you describe the type of learner you are? How do you learn best? For example, visual, tactile, or auditory/kinesthetic.
6. Was PCC training introduced before or after you were hired? How does your facility train staff on PCC practices? Specifically, nursing assistants.
    a. How long is/was the training? How many hours?
    b. Do you feel the training that was provided to you was sufficient? Please explain.
    c. How were you evaluated?
    d. What type of teaching methods were used during the educational sessions? For example, PowerPoints, videos, or handouts.
    e. Were they classroom sessions or in-services that you attended? If so, how many?

   f. Were you provided reading material such as handouts or guides?
   g. Do you feel these trainings met your learning style?
7. Do you feel the training you received, prepared you to be effective in providing PCC?
   a. What topics do you wish were included in the PCC training to better prepare you in implementing PCC?
   b. If any, what type of follow up training was provided after the initial PCC training?
   c. Do you continue to have in-services or follow up training sessions to follow up on your training?
8. Do you feel that the leadership/management team supports the follow through of PCC practices?
9. What have we not discussed that you feel is important for others to know?