EDUCATING NURSES FOR PERSON-CENTERED CARE

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Abstract

Background and Objectives: A person-centered model for long-term institutional care of elder persons is supportive of Arab societal values and Islamic beliefs. Four workshops were conducted for nurse leaders from long term care facilities in Qatar with the overall objective of initiating a practice culture change which would result in evidence of more person-centered care practices.

Methods: Workshops were held weekly for 4 weeks. Participants were 23 nurse managers and supervisors from 3 long term residential facilities in Doha, Qatar. Evaluation forms were completed by participants after each workshop and a focus group was conducted with the participants from one facility 12 weeks after the workshops.

Results: Participants reported increased person-centered care practices on their units. These practices began with staff coming together around shared values and philosophy and included: more attention to residents' personal preferences; inclusion of residents and family in decision-making and social activities; individualized care plans; therapeutic relationships.

Discussion: More research into the implementation of care models that support Arab religious and family values is essential to meet the growing need for high quality long term residential care in the Arab Gulf region.

Key Words: Person-centered care, education, elders, Arab society

Introduction

Long term institutionalized care for elderly persons is a relatively new phenomenon in the Arab Gulf countries. However, the Arab population, like the rest of the world, is aging and the need for residential long term care for older people is likely to increase. This need will be exacerbated by societal and family changes related to modernization that will challenge traditional expectations of the family to provide all care for its aging members (1,2). At present, residential long term care in the region tends to be clinically and task oriented (3, 4). In most instances, care is provided by expatriate nurses of diverse backgrounds and various levels of knowledge of Arab culture and society. Models of care that support Arab religious and family values are required for high quality long term care alternatives for Arab families.

A person-centered model of care ensures the dignity of the individual and encourages involvement of the family unit in care, in keeping with Arab societal values and Islamic belief. As well, a person-centered care framework could bring a diverse nursing workforce together around a common philosophy and consistent approach, leading to improved health outcomes and satisfaction of residents and their families (5). Person-centeredness is grounded in shared values and expressed through the workplace culture of care.

This paper describes an educational program provided to nurse leaders of long term care facilities in Qatar. Utilizing the person-centered care framework developed by McCormack & McCance (5), the intent of the program was to introduce nursing leaders to the concepts of person-centered care, investigate shared values that facilitate the development of a person-centered workplace culture,

and analyze how the shared values are operationalized in practice. By directing the education to nursing leaders, it was hoped that they would transfer their knowledge to front-line staff, encourage action learning by staff and begin a culture shift on their units.

Literature Review

Nursing has long identified person-centeredness, holism and individualized care as being integral to quality patient care. However, within the past decade the international focus on humanizing health and social services has precipitated extensive research and literature on the meaning of the term "person-centered" and its implications for nursing and other healthcare practice (5). Person centered care has been defined as "an approach to practice that is established through the formation and fostering of therapeutic relationships between all care providers, patients, and others significant to them" (6, p. 3) and is based on the values of respect for persons, self determination, mutual respect and understanding.

McCormack & McCance (5) purport that nurses often experience person-centered "moments" in their practice, but that sustained cultures of care where person-centeredness is commonly recognized as the "way of doing business" are infrequently encountered. Person-centered cultures of practice are cultivated through a commitment to change and careful attention to the care environment and care processes as well as the attributes and skills of the nurses providing care (5).

The framework developed by McCormack & McCance (5) places person-centered outcomes at the center of a care environment that is supportive of person-centered care processes and dependent on the person-centered skills and attributes of the care givers. The outcomes-satisfaction with care, involvement in care, feeling of well-being, creation of a therapeutic culture-are achieved only when there is synergy between the care processes, the care environment and the attributes of the carers. Person-centered processes describe the approaches taken in completing the tasks of care: working with patients' beliefs and values; shared decision making; engagement of nurse and client; having sympathetic presence, and providing holistic care (5). The processes can happen only in an environment that supports shared decision-making, power sharing, and effective staff relationships, that attends to appropriate skill mix and that facilitates innovation and risk-taking. Both the care processes and the care environment are made possible by the pre-requisite attributes of the nurses: professional competence, developed interpersonal skills, commitment to the job, clarity of beliefs and values, and a good knowledge of self (5).

Procedure

The overall goal of the workshops was to begin a practice culture change which would result in evidence of more person-centered care practices. The objectives were (5):

- To promote an awareness and understanding of person-centered nursing
- To articulate explicit values and beliefs that inform the provision of nursing care
- To develop a shared vision that promotes person-centered nursing practice
- To collect information on the quality of resident and staff nurse experience in order to benchmark practice change
- To identify areas for practice change

The workshops were facilitated once a week over four consecutive weeks. Participants included head nurses and nursing supervisors of two long term care facilities and a newly opened community care facility for assisted living. There were 23 participants in all. Attendance at each workshop varied from 23 to 16. A focus group was conducted with participants from one of the long term care facilities 12 weeks later to evaluate the outcomes in practice. Written consent was received from all participants in the focus group.

Nurse leaders were targeted as participants with the expectation that they would become facilitators of practice change on their units. The workshops utilized creative ways of unleashing the nurses' leadership potential. By co-creating a shared vision for care, and critically reflecting on care practices, they moved a step toward developing a culture of person-centered care. During the final workshop, they agreed on one priority area for change. They clearly identified the problem, and brainstormed on an action plan for change. The nurses were enabled to use the action learning cycle, to critically reflect on their work and work environment and to develop alternative ways of thinking and doing that would enhance quality of life and satisfaction for residents and families.

The first workshop introduced the participants to the concept of person-centeredness and the person-centered care framework. An activity called "Victorian Parlour Game" (7) was used to help participants recognize empathy for the residents under their care. In this activity, participants were asked to think about the question: "if I were one of my residents, how would I feel right now?" The answers of all the participants were then organized into an insightful poem that indicated that each participant was aware of the feelings of isolation, loneliness and hopelessness often felt by residents of elder long term care. (See "In Long Term Care")

In small groups, participants mapped aspects of a case study against the person-centered framework. After plenary discussion of this activity, participants discussed in pairs how these concepts could be used to change some practices on their units, and decided on three ways that they could use these ideas in their practice in the coming week.

Component	Description
Person-centered Outcomes	• Satisfaction with care • Feeling involved in care • Having a feeling of well-being • Creating a therapeutic culture
Care Processes	• Working with patients' values and beliefs • Engagement of nurses and clients • Shared decision-making • Having sympathetic presence • Providing holistic care
The Care Environment	• Appropriate skill mix • Shared decision-making systems • Effective staff relationships • Power sharing • Potential for innovation and risk taking • Homelike, welcoming physical environment
The Prerequisites	• Professional competence • Developed interpersonal skills • Commitment to the job • Clarity of beliefs and values • Knowing self

Components of the Person-Centered Nursing Framework (5)

In the second workshop, participants reflected on their individual values and shared these with one other person in the group. Then they worked with others from the same nursing unit to agree on a common set of values and write a shared vision of nursing care in their unit using the following headings:

- We believe the purpose of our nursing care is...
- We believe this purpose can be achieved by...
- The factors that will help us achieve this purpose are...
- Other values and beliefs about nursing in our unit are...

The groups then created a poster depicting their vision and developed a plan for sharing this with their staff in the coming week. As preparation for the next workshop, they were asked to observe care on their unit in the coming week and note one instance of care that was in keeping with the vision, and one that did not fit with the vision.

During the third workshop participants evaluated the quality of the patient-centered processes on their units by comparing their observations of care with the vision that they had developed and identifying sources of data for evaluating practice. Using a provided set of questions to guide their

reflection on each of the person-centered processes, unit groups were asked to evaluate the quality of care on their units. They then brainstormed how they could validate these evaluations by using sources of data available to them. Each group developed a plan for evaluating the use of person-centered processes on their unit and for identifying areas of practice that needed to change.

The final workshop examined the attributes of the nurse and the care environment that are essential for a person-centered culture of care. It also aimed to assist participants to plan for a continuous trend toward a person-centered culture of care. In their unit groups, participants evaluated the context of care in their facility and discussed how the care environment contributes to the areas of care that they had identified for change. Plenary discussion identified and prioritized common themes related to change to the care context.

The top priority theme was then analyzed by the group to clarify the problem, identify the evidence of the problem, suggest desired outcomes, develop possible solutions, and decide on how outcomes could be evaluated. The action learning cycle (plan, act, observe, reflect) was presented as a process for ensuring continuous change in the care culture.

By engaging nursing leaders in reflecting on their practice settings and comparing what they see with the visions that they have developed, these workshops initiated a process of change toward more person-centered care. Identification of one priority area of change, and employment of the action learning cycle created the opportunity for the change process to be sustained.

Evaluation

An evaluation form was completed by participants at the end of each workshop. Participants commented: "have started (a change process) and will continue"; "very, very much excited (to initiate a change in care practices)". Responses to the evaluation questions indicated that participants understood the concepts from the workshop, and were able to identify significant sources of data for evaluating care practices on their units. Many participants identified incongruence between care being provided on the units and their shared vision: "care is task centered" and "nurses do not spend time talking with residents". They recognized methods for gathering data on the care processes on their units including: talk with the residents and let them tell their stories; patient satisfaction survey; observation; asking questions; random visits; interviews with the residents and families; getting feedback from staff. The participants' high level of engagement in the unit group work as well as the plenary discussion indicated that the workshops were relevant to them. They commented after each workshop that they had enjoyed and learned from each session.

In order to evaluate the usefulness of the workshops in starting a process of change, a focus group was conducted at one of the participating long term care facilities 12 weeks after the workshops were completed. The purpose was to ascertain if indeed practice change had occurred that would provide greater quality of life and satisfaction for residents and families.

Focus group comments indicated that practice change related to individualized care, inclusion of residents and families in care decisions, and improved services to residents and families had indeed occurred. Admission assessment forms had been modified to include more information about residents' likes and dislikes, preferred activities, hobbies, etc. and individualized care plans were developed based on these preferences. Copies of the care plans were shared with families as well as the interdisciplinary team. Interests of family members were being noted and families were included in activities on the units. Recognizing the desire of one resident to be involved in meal preparation, opportunities to help prepare meals for her family were provided, and a weekly cooking activity was made available to all residents.

A committee had been established to plan activities for residents and more activities were offered in the afternoon and evening to accommodate family participation. A volunteer visitor program provided residents with greater variety in interaction as well as companionship.

Nurses noted that residents were "more cheerful" and more active participants in their care. One nurse commented that resident/staff relationships were stronger. Nurses said that family members, too, indicated that they appreciated the extra attention.

Change did not come without some challenges. Nurses noted that it had been difficult to readjust care routines to accommodate resident preferences. There were on-going efforts to educate all staff about the unit vision through making it visible on posters throughout the facility and communicating it consistently at monthly unit meetings. The vision had also been published in both Arabic and English in the form of a handbook, an information booklet and a poster at the bedside along with the resident bill of rights.

Nurses also commented that the atmosphere at work had become more positive and that staff felt informed and involved in the changes being instituted. They felt that the challenge now was to increase the momentum of the change and to gain a reputation as a superior place to work.

Conclusion

Focus group comments indicated that a culture change was happening in this long-term care facility and that resident care was becoming more person-centered as outcomes of

of the workshops. In this case, a work environment that allowed nurses the freedom to create a unified vision for care and to recognize and change practices that did not conform to the vision resulted in greater satisfaction and quality of life for both nurses and residents.

This paper has described an educational program for nurse leaders in long term care intended to generate a work culture change to support the practice of person centered care. More research into the implementation of care models that support Arab religious and family values is essential to meet the growing need for high quality long term residential care in the Arab Gulf region.

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In Long Term Care

Longing for compassion and loving care
For feelings of belonging
And the hugs and kisses that is sweet
Lonely and useless
Frustrated and sometimes afraid
They pity me
Such boredom, sadness and loneliness
But even though I am sick I am in safe hands
Anxious but
If my parents are around, beautiful the life is
Need for much attention and love
The time is too long: nothing to do
Bored and depressed
Rejected, alone, pitiful, powerless, depressed
I want to be with my family right now
The touch of their caress, the smile on their faces
Their voice saying how much they love me
Repulsed by wound exudates and smell
Pain but
Life here is better than at my house
Cannot express my feelings
Useless, wasted, a burden to society
They deal with me as an object not
A human being
Machine centered care
Upset and irritable
Lonely and irritable
Thank God for what and who I am
I will overcome and use the best of my abilities
To survive.