MOVING PERSON-CENTRED PHILOSOPHY INTO PRACTICE WITH OLDER PEOPLE IN RESIDENTIAL CARE: A QUALITATIVE DESCRIPTIVE STUDY

BY

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ABSTRACT

The overall aim of this study was to describe how enrolled nurses and personal care assistants (care providers) operationalised person-centred care (PCC) with older people in a residential care setting. While there is growing theoretical and research literature about PCC, there is a paucity of knowledge in understanding what care providers do to operationalise PCC with older people. The researcher conducting this study explored the perspectives, beliefs and practices of these care providers in operationalising PCC. The VIPS framework for PCC, which consists of four constructs 'valuing the person', 'individualised care', 'understanding the person's perspective', and 'positive social psychology', was used to theoretically frame this study.

A qualitative descriptive study using focus groups and individual interviews, with nine participants, drawn from one residential care setting, was adopted as a methodology and method. The data collection provided a snapshot of what was happening in practice according to the perspectives, insights or experiences of the care providers in this residential care setting.

The findings of this research has generated important new knowledge about PCC in this residential care setting and new insights into what care providers do in operationalising PCC with older people in a residential care setting. This field study also resulted in findings that confirmed and are consistent with the literature relating to the operationalisation of the philosophy of PCC by care providers with older people in a residential care setting. These findings have implications for practice, given the limited studies available, for theory, education and policy, and raise questions for further research.

Keywords: Nursing, Person-centred Care, Patient-centred Care, The VIPS Framework, Qualitative Description, Older People, Residential Care, Aged Care, Nursing Home, Long Term Care

TABLE OF CONTENTS

DECLARATION

This research project does not contain any material which has been accepted for award of any other degree or diploma in any university and that, to the best of the candidate's knowledge and belief, the research project contains no material previously published or written by another person except when due reference is made in the text of the research project.

Catherine Ann Wilson

Signed: 

Date: ___8___/____11____/____2015_____

Ethical approval for this research was granted by the Standing Committee on Ethics in research Involving Humans from Monash University on 22nd December 2014, Project CF14/3869 – 201 4002016.

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LIST OF TABLES

LIST OF FIGURES

LIST OF TERMS

Term	Definition
Dementia Care Mapping (DCM)	DCM is a model where the expert in PCC, an external facilitator, observes the care providers caring for people with dementia, for an extensive period of time and on a number of occasions, provides feedback to support their development of PCC (Rokstad et al., 2013).
Eden Alternative	Culture change model where the individual comes first and promote Individualised care and seeks to eliminate loneliness, helplessness and boredom to improve quality of life (Brownie & Nancarrow, 2013; Junxin & Davina, 2014).
Emotion – Orientated Care	Experience of the person in terms of quality, togetherness, appropriateness and autonomy (van den Pol-Grevelink, Jukema, & Smits, 2012).
EN	Enrolled Nurse
Green House	Culture change model where the person comes first to promote Individualised care and seek to improve quality of life by transforming the physical environments, radically revising staff configurations and emphasizing companionship under normal rather than therapeutic circumstances (Brownie & Nancarrow, 2013; Junxin & Davina, 2014).
PCA	Personal Care Assistant
PCC	Person-centred Care
PCNF	Person-centred Nursing Framework (McCormack & McCance, 2010)
PCC Environment	"Is where the care environment is designed to reduce confusion, agitation and depression whilst improving social interaction and engagement with other and the environment" (Chenoweth et al., 2014, p. 1148)
Personhood	The meaning of personhood is complex and is underpinned by relationships and how life is shaped, the values and perspectives that are developed and how others see the person as a unique human being (Kitwood, 1997; McCormack, Karlsson, Dewing, & Lerdal, 2010)
RN	Registered Nurse
Relationship base care	Six evidence based senses framework for relationships based on security, belonging, continuity, purpose, achievement and significance (McCormack, Roberts, Meyer, Morgan, & Boscart, 2012)
Snoozelen	Establishing positive relationships between people with dementia and care providers. A component of emotion-orientated care (van den Pol-Grevelink et al., 2012).
VIPS	This is a theoretical framework that has four constructs (Brooker, 2003): 1. 'Valuing the person' 2. 'Individualised care' 3. 'Perspective of the person' 4. 'Positive social psychology'

CHAPTER ONE: INTRODUCTION

The focus of this research is the operationalisation of Person Centred Care (PCC) with older people in residential care by care providers. In this chapter an overview of this research is provided, this includes the justification, research questions, my interest in this research and the key concepts that define this research. An explanation of how this research fits with the current literature, the research design, anticipated outcomes and limitations of this research is also provided. This chapter is concluded with the thesis outline.

Justification of Research

Internationally person-centred care (PCC) is seen as a central aspect of providing the best quality of care for older people in residential care (Brooker, 2003; Brownie & Nancarrow, 2013; Junxin & Davina, 2014; McCormack, Karlsson, Dewing, & Lerdal, 2010; Rosvik, Kirkevold, Engedal, Brooker, & Kirkevold, 2011). There is a growing trend to ensure that residential care uses a PCC framework.

Research Questions

The aim of this study is to describe the experiences of nurses and personal care assistants in relation to operationalising the philosophy of PCC with older people in a residential care setting.

The aim is expressed as a single overarching question, that is: 'What are the experiences of nurses and personal care assistants (PCAs) in operationalising the philosophy of PCC with older people in a residential care setting?' The theoretical framework for this research is the VIPS framework; and the methodological approach is qualitative descriptive.

My Interests in the Research

I have been interested in the philosophy of PCC for many years. Much of my nursing experience has been involved in supporting people in aged care, with kidney disease and in rehabilitation. The pursuit to provide quality care and a humanistic approach has been at the centre of my work ethic. This challenge requires a collaborative and evidence based approach.

Residential aged care has been at the forefront of adopting the philosophy of PCC, nationally and internationally, and building the body of knowledge through research. Locally, the creative strategies that I have seen care providers use in PCC are inspiring. These developments in care perspective for older people in residential care, that is, treating people as unique human beings, valuing them and connecting with their previous life, so that their life continues in this new residence, is why I have embarked on this research. I am interested in how health professionals in residential care move PCC into practice. This became the topic for my research project. Therefore I refer to the research team specifically that is myself and my supervisors, Associate Professor Cheryle Moss and Dr Georgina Willetts (Appendix 1).

Background

In this background key features of ageing in Australia, residential aged care and workforce needs, are identified.

Ageing in Australia

The number of Australians aged over sixty five years has grown significantly over the past forty years and is predicted to grow at an even greater rate over the next forty years (Australian Government, 2015). This prediction also suggests there will be an increase in the number of people aged over 85 years from 0.5 to 2 million and there will be nine times more people aged 100 years. This change in ageing demographics is due to Australians living longer. The significance of this is that the demands for aged care services in Australia will more than double over the next forty years.

Residential Aged Care

According to the Australian Institute of Health and Welfare (2015) there were 189,283 people living in residential care at 30th June 2014. About 77% of these residents were over eighty years old, and of these 57% were over eighty five years. Residential care facilities within Australia are managed by not-for-profit, government (local and state) or private service providers. The length of stay in residential care is increasing as people are living longer. There has also been an increase in the number of residential places in response to increasing demand and ageing population. Residential aged care services are classified as either 'ageing in place' (level of care depends on the needs of the person), high level care, low level care or

supported accommodation. The level of care required will determine the staffing skill mix to ensure quality of care is provided.

Workforce

The residential care workforce comprises registered nurses (RNs), enrolled nurses (ENs) and personal care assistants (PCAs) and these collectively are described as care providers. Small numbers of allied health are also care providers however were not represented in this research. The Australian Department of Health and Ageing commissioned research about the aged care workforce (care providers) in 2003, 2007 and 2012 with the aim of understanding what pressures occur within this sector (King et al., 2013). The priority was to address issues concerning recruitment and retention of aged care staff given the projected increase in demand for these services. King et al. (2013) acknowledge reform for this workforce is required so that better working conditions, educational and career development opportunities and improved remuneration in accord with the increased acuity, thus complex needs of people living in aged care residential services. King et al. (2013) described a good care provider as not only having knowledge and experience in aged care but also identified the importance of possessing attributes to care for older people effectively. These are empathy, compassion, good interpersonal skills, respectful, patience, caring and ability to interact well with older people. These attributes are closely aligned with the philosophy of PCC (McCormack, Karlsson, et al., 2010; Rosvik et al., 2011).

The increase in the ageing population and subsequent demand for residential aged care services will lead to an increase in the recruitment of aged care staff. In Australia, aged care staff have described the workforce as having attributes (King et al., 2013) that align with the PCC philosophy. Therefore adopting the philosophy of PCC could enable care providers in aged care to achieve this and thus provide quality care for older people in residential care.

PCC and the VIPS Framework

A preliminary literature review identified the paucity of research regarding the operationalisation of PCC. However, there are several PCC theoretical frameworks. This is a small scale study, therefore it is the view of the research team that the VIPS model (Rosvik et al., 2011) of PCC is appropriate to employ as the conceptual framework.

PCC is a philosophy that has personhood as the fundamental principle (Brooker, 2003; Buckley, McCormack, & Ryan, 2014; Edvardsson, Varrailhon, & Edvardsson, 2014; McCormack & McCance, 2010; McCormack et al., 2012; McKeown, Clarke, Ingleton, Ryan, & Repper, 2010) The meaning of personhood is complex and is underpinned by relationships and how life is shaped, the values and perspectives that are developed and how others see the person as a unique human being (Kitwood, 1997; McCormack & McCance, 2010).

The VIPS framework was adopted for this study. Original work by Brooker (2003) saw the need to define PCC clearly to enhance understanding of this complex philosophy. More recently, the use of the VIPS theoretical framework was seen as an evidence based way for care providers to facilitate PCC in residential care (Rosvik, Brooker, Mjorud, & Kirkevold, 2013). Further to this, the VIPS framework has provided guidance for care providers on how to interact and communicate with older people living in a residential care home in a person-centred way. PCC in the form of the VIPS framework, as described by Brooker, encompasses the sum of four constructs, 'Valuing the person', 'Individualised care', 'Perspective of the person' and 'Positive social psychology' known as VIPS. These four constructs are defined in Table 1.1.

Table 1.1 Definition of the Concepts in VIPS (Brooker, 2003)

Value	**Individualised Care**	**Perspective of the Person**	**Positive Social Psychology**
See all persons as a unique human being. Aim to treat all people as they want to be treated. Seeing all people to be worthy of respect and being valued.	See all persons as having individual strengths and vulnerabilities. Each person is unique with life experiences, coping mechanisms and having friends. Each person will experience a unique illness trajectory.	Understanding the world from the other person's perspective. Having empathy, which is not an easy process. There is a need to be imaginative and creative	Promoting relationships so that people can maintain or develop new friendships and maintain connection/ inclusion with the environment so that personhood is maintained.

The VIPS framework has been used to frame the research sub-questions, literature review, data collection, data analysis and the findings. The application of the VIPS framework in this way has not been reported before so the findings may be useful for further studies.

Overview of Research Design and Methods

The methodology chosen for this research project was qualitative descriptive research informed by Sandelowski (2000, 2010), which is a naturalistic form of inquiry that seeks to give insight into the context of the phenomena being studied by gaining accurate accounts about situations in context from the participants (Neergaard, Olesen, Andersen, & Sondergaard, 2009; Sandelowski, 2000, 2010). Data was obtained from conducting focus group and individual interviews using open ended questions providing a snapshot of people's perspectives, insights or experiences in operationalising PCC. This data was coalesced as a description and analysed. The method of description ensures that analysis stays true to the participants' meanings, therefore it results in a low inference description. There was no manipulation of the data. The qualitative content and thematic data analysis render transparency of the PCC practice context at that point in time (Sandelowski, 2000, 2010).

Anticipated Outcomes and Significance

This research is important as little is known about how care providers operationalise PCC (Edvardsson et al., 2014). Although this was a small research project it will provide some insight and contribute to the body of knowledge about the operationalisation of PCC with older people in residential care.

The purpose of this research was to describe and to understand what was happening in practice (in a particular context) to operationalise PCC. I was not seeking to develop new theories but rather to understand how PCC was facilitated in practice. The chosen methodology resulted in an account of what care providers were doing to operationalise PCC in a context, and more broadly add to the sparse body of knowledge regarding the operationalisation of PCC. The research was limited by scale, the qualitative nature, and the sample size and temporality of data collection.

Thesis Outline

This thesis has six chapters that are set up in a logical sequence. The VIPS framework for PCC has provided structure for the following chapters. Chapter two details the literature search

and the literature review. The research design, including the methodology and methods, and ethical considerations are outlined in chapter three. The findings from the data collection are revealed in chapter four. Chapter five provides a discussion outlining the findings and how they contribute to the body of PCC knowledge. The final chapter completes the research project with the limitations, implications, recommendations and conclusion.

CHAPTER TWO: LITERATURE REVIEW

In this chapter the literature is reviewed and the research evidence about PCC with older people in residential care in relation to the practice of care providers is discussed. The details of the search strategy inclusive of the PICo, search terms, selection criteria, appraisal and classification of the selected research papers follow. The papers were analysed and these are discussed in relation to the research aim.

Search Strategy

The following PICo was used to establish the basis of the search strategy (Stern, Jordan, & McArthur, 2014).

Table 2.1: The PICo Used to Operationalise the Search

PICo	Criteria
Population	Care providers, inclusive of RNs, ENs and PCAs
Phenomena of Interest	Person-Centred Care (VIPS) in residential care
Context	PCC with Older People (≥ 65)

The databases searched for this literature review were CINAHL Plus, Ovid MEDLINE, Cochrane library and the Joanna Briggs Institute of EBP. The reason for choosing these databases is that CINAHL Plus has over 4,000 nursing and allied health journals and Ovid MEDLINE, the US library of medicine, includes medicine, nursing and allied health plus other unrelated fields.

The Cochrane library and the Joanna Briggs Institute of EBP were also included to identify any related systematic reviews (SR). The University of Ulster Centre for Person-Centred Care website, and reference lists from retrieved articles were hand searched for further sources. The following table outlines the search terms used with each database.

Table 2.2: Database Searches

Database	Search Terms	Articles
CINAHL Plus	"Aged Care" OR "residential care" OR "nursing home" OR "long term care" OR Subject terms (MM "Gerontologic Care") OR (MH "Gerontologic Nursing") OR (MM "Long Term Care") OR (MM "Nursing Home Patients") AND "person cent*" OR "patient cent*"	247
Ovid MEDLINE	Nursing Home [MeSH] OR Aged Care [MeSH] OR Residential Care [MeSH] "Aged Care" OR "residential care" OR "nursing home" OR "long term care" AND Patient-centred care [MeSH] OR "patient cent*" OR "person	243
Cochrane library	"Aged Care" OR "residential care" OR "nursing home" OR "long term care" AND Patient-centred care [MeSH] OR "person cent*"	2
the Joanna Briggs Institute of EBP	"Aged Care" OR "residential care" OR "nursing home" OR "long term care" AND Patient-centred care [MeSH] OR "person cent*"	1

Overall Results and Critiquing Procedures

The procedures for selecting papers for inclusion and exclusion, appraising the quality of the relevant papers, and for extracting the data and grouping the results are described below. The section is commenced with an account of the search outcomes and depicted in a PRISMA style flow chart (Moher, Liberati, Tetzlaff, & Altman, 2009)

PRISMA Style Flow Chart

The overall stages and outcomes of the literature search are depicted in Figure 2.1. A PRISMA style format has been adopted. Numbers within the PRISMA flow chart relate to listing of citations in Appendix 2.

The database search resulted in the retrieval of 590 papers. The duplicates (n=242) were removed. The remaining papers were screened by reviewing the title and abstract and papers were excluded (n=302) according to the selection criteria. The remaining papers (n=46) were read fully and screened for eligibility (n=25). The quality assessment of these papers resulted in 24 papers being selected for this literature review.

Papers were retrieved from the databases and the duplicates were extracted resulting in 387 papers being screened by title and abstract. Papers were excluded if the research focus was on specific aspects of care such as palliative care (end of life), transitional care, therapies, meal times, or bathing.

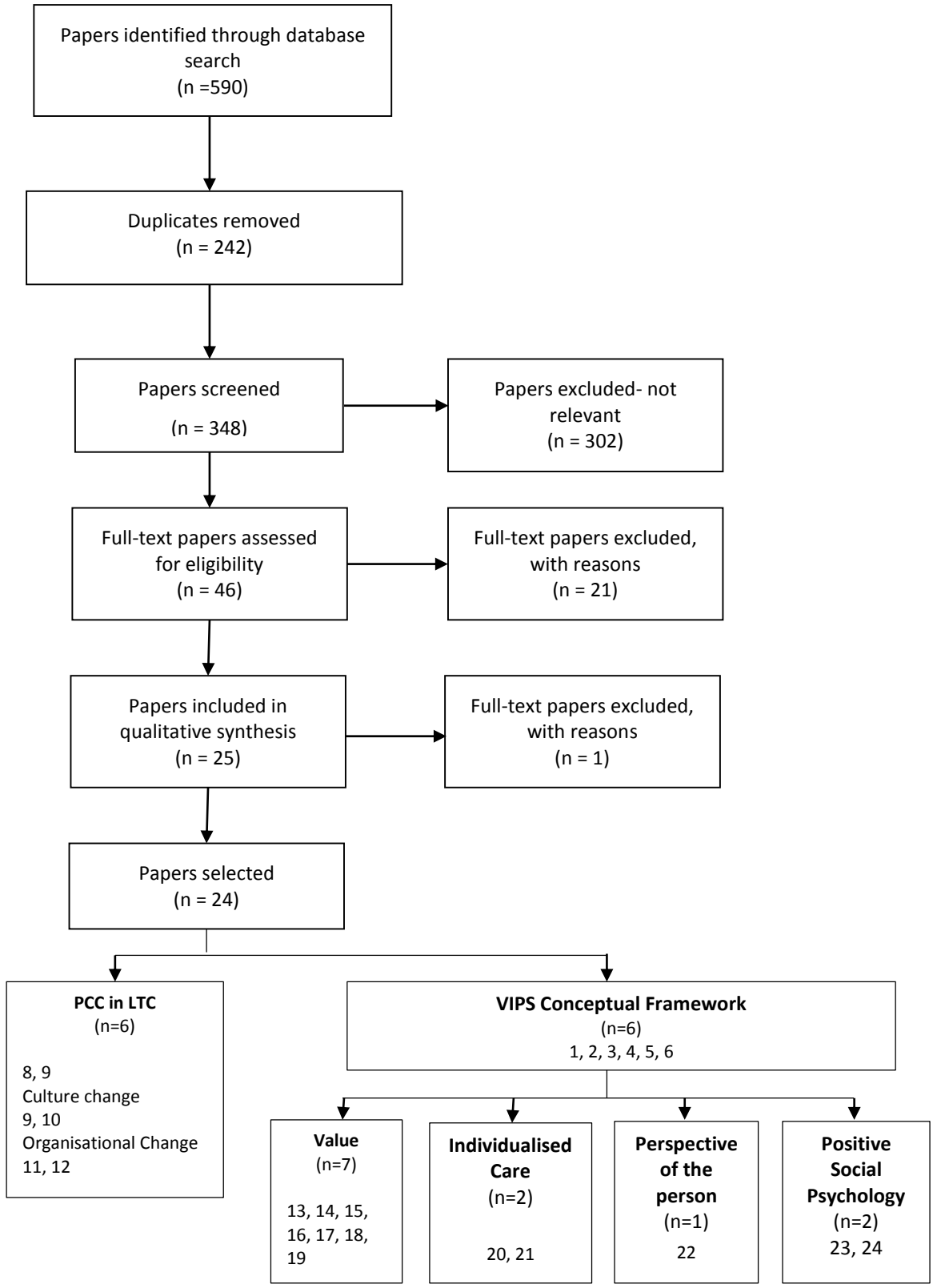

Figure 2.1: PRISMA Style Flow Chart for Retrieved, Excluded, and Included Papers (http://www.prisma-statement.org/statement.htm)

Methods: Selecting Papers for Exclusion and Inclusion

Other exclusions were those that were specific to allied health, medical practitioners, budget outcomes and learning disabilities. Papers were selected according to the following criteria. The papers were required to meet criteria numbers 1, 2, 6, 7, 8 and at least one criteria related to 3, 4 or 5.

Table 2.3: Criteria for Selection of Papers

	Criteria for Assessing Eligibility of Papers for Inclusion in the Review
1	Papers discussing, researching, identifying the use, or reporting outcomes in relation to the philosophy of PCC in residential care settings.
2	The papers will be related to care provider perspective (Registered and Enrolled Nurses and Personal Care Assistants) of PCC in residential care settings.
3	The researchers will have used VIPS as a framework to facilitate PCC.
4	The researchers will have recorded, commented or used categories relating PCC in residential care settings which includes Valuing the person Individualised care Perspective of the person Positive social psychology.
5	The facilitators, challenges or barriers to implement PCC in residential care settings will be defined by the researchers.
6	The papers will be systematic reviews, original research papers, literature reviews or opinion papers.
7	The papers will be published in academic journals.
8	The papers will be full text and published in the English language.

Methods: Appraising the Quality of Papers

The 24 papers were screened for quality. The full text articles were read and assessed according to the relevant Critical Appraisal Skills Programme (CASP) checklists. Author credibility was assessed according to their H index and citation rates. The ranking of each journal and relevant impact factors were recorded. These assessments were combined to assess the quality of the paper, thus the researcher's experience, the type of publication and the rigour/trustworthiness of the research itself. A report of the critique and quality assessment of each paper can be found in Appendix 2. The type of papers selected are detailed in the following table.

Table 2.4: Type of Papers Selected for the Literature Review

Type of Paper	Number of Papers
Systematic Review	3
Metasynthesis	1
Primary Research	16
Expert Opinion	4

Methods: Grouping Results and Extracting Data

The papers were selected according to the selection criteria and appraisal of quality. For the purposes of data extraction, each paper was reread and categorised according to the selection criteria. The papers were then grouped into two groups. The overarching two groups were PCC in residential care with older people and the VIPS conceptual framework for PCC. The VIPS group was then divided into subgroups (for each construct). Themes emerged within each subgroup. As each of the VIPS constructs are interconnected, some papers were relevant to more than one of the constructs.

The first group, PCC in residential care with older people was further categorised into culture change and organisational support. The second group, the VIPS conceptual framework for PCC comprised of papers dedicated to VIPS. The remaining papers were then categorised into each of the four constructs of VIPS. Papers for 'Valuing the person' were then categorised into shared vision, leadership and job satisfaction. Papers for 'Individualised care' was categorised into knowing the person. Papers for 'Perspective of the person', 'Positive social psychology' and discussion followed. This classification forms the outline of this literature review.

PCC with Older People in Residential Care

The literature has indicated that PCC is seen as the providing the best quality of care for older people living in residential care. This discussion will focus on reviewing the literature to describe PCC with older people in residential care in relation to care providers.

Brownie and Nancarrow (2013) undertook a literature review, because there was a scarcity of research on the impact of PCC approaches with residents and staff in aged care facilities. Their literature search detailed the search strategy, inclusion criteria and assessed the quality

of research studies. This resulted in seven studies being selected, six were quasi-experimental and one cluster randomised control trial (RCT). Due to the heterogeneity of the study designs, the results could not be pooled therefore were presented as a narrative review. Three studies used the Eden Alternative, one study used the Green House model and the remaining three used facility specific PCC. The six quasi-experimental studies had weak study designs resulting in limitations and ability to generalise results. However, there were some positive outcomes for residents and staff. One Eden Alternative study, using the Geriatric Depression Scale (GDS) demonstrated significant changes in reduced levels of residents' boredom and helplessness whereas a similar study showed a significant reduction in depression. The cluster RCT findings were significant for reduced agitation. The results of the facility specific PCC models demonstrated links with job satisfaction, confidence by staff in providing PCC and increased communication between residents and staff, and with residents themselves. However, the cluster RCT and one of the Eden Alternative studies found that falls had increased. Brownie and Nancarrow (2013), indicated that due to the lack of information about the implementation process it was difficult to determine why this occurred. PCC is multifactorial and as such can present difficulties for researchers to apply rigour. Further research is required which includes uniform language and detailed information about the intervention specific to the PCC model or approach (Brownie & Nancarrow, 2013).

Junxin and Davina (2014) conducted a systematic review on the resident outcomes of PCC in long term care. Their comprehensive literature search resulted in the selection of 24 articles based on the quality assessment and fit with inclusion criteria for this review. The studies were then sorted into two groups, culture change (n=15), conducted in the US and person-centred dementia care (n=9), conducted in the US, UK and Australia. The culture change studies were assessed as weak in the design resulting in limitations, in particular generalisation of the outcomes. There was also a lack of understanding about the PCC education programs and the organisational support, which may have affected the researchers understanding of the full impact of these changes. Nevertheless, Junxin and Davina (2014) found that some culture change models had some positive effects on residents well-being. The person-centred dementia care (PCDC) studies were more rigorous, thus better quality demonstrating significant findings for decreased behavioural symptoms such as agitation, therefore reducing the requirements for psychotropic medications. What is missing from

these studies is a mutual agreement of the definition of PCC for researchers and the organisations. Further high quality research is required to replicate these findings and to further understand the impact of culture change to achieve and sustain PCC.

Culture Change to Achieve PCC

The literature informs that nurses often struggle to achieve PCC with older people in residential care, given the nature of their work, embedded routines with the emphasis on getting the work completed on time. Implementation is also affected by the lack of a unified meaning or approach to achieve PCC. McCormack, Karlsson, et al. (2010), undertook a qualitative metasynthesis by analysing four different and unrelated primary studies (by each of these authors) with different groups of people with chronic conditions. The purpose was to increase understanding of PCC and prevent dilution of its meaning through a silo approach to implementation of PCC by various organisations. The authors used hermeneutics to analyse the data (descriptions of lived experiences). The findings were coalesced with the Person-Centred Nursing Framework (PCNF) consisting of three concepts, 'prerequisites' (dedication to work, knowing ones values and beliefs), 'the care environment' and 'care processes'. The fourth concept 'person-centred nursing' was not used as none of the studies incorporated this into their outcomes. The findings from this study indicate the need for nurses to be competent in interpersonal skills so that the people they care for can have 'meaningful engaged relationships' with the people in their lives. There is also a need to know how skill mix, autonomy and risk impacts PCC practice. As a result of this study, McCormack, Karlsson, et al. (2010), indicated that the meaning of PCC had been too narrow, therefore it needs to broaden incorporating the attributes of the practice setting. Hence the application of PCC needs to include an organisation wide approach to understand how to sustain the continuation of a person's life so that they are engaged, particularly with their physical and natural environment.

McCormack, Dewing, et al. (2010) conducted a multi-method study to report on nursing outcomes when developing a PCC environment with older people in residential care. The Person Centred Nursing Index (PCNI) incorporating the Nursing Context Index (NCI) and the Caring Dimensions Inventory (CDI), focusing on the characteristics of the care environment of PCNF, was used to analyse the development of PCC practice across three points in time and

across 19 residential care settings. This study also used 'emancipatory practice development' where facilitators support staff to change cultures and the care environment to achieve PCC. Each site was allocated a trained facilitator to work in a collaborative and systematic way to assist in the change to PCC practice. Following each survey the facilitators reported back to each site their results, which informed their action plan for implementing PCC. The response rate reduced over this time period, which could have been attributed to opposing views and support from management. However, there were significant findings from the NCI that related to job satisfaction, decreasing in stress levels and a more satisfying work environment. The results of the CDI demonstrated a change in priorities from a technical perspective to one that values relationships with the people they work with and their families, thus portraying a more PCC culture. The findings also indicated that effective teamwork, empowerment and organisation and staff commitment were important to enable this change. This study (McCormack, Dewing, et al., 2010) demonstrated that PCC is multifactorial and it takes time to transform cultures to achieve and sustain PCC in practice.

Organisational Support

A cluster randomised control trial (RCT) by Chenoweth et al. (2014) hypothesised that the impact of combining PCC and a PCC environment (PCE) would result in decreased agitation for people with dementia in residential care. Thirty-eight residential care homes (attempted to recruit 15 residents per home) were randomly assigned to either an intervention (PCC, PCE or PCE + PCC) or control group. Data was gathered prior to the start of the study, on completion of the implementation program and eight months follow-up. The results were significant albeit small for the PCC and PCE but not for PCE + PCC in decreasing agitation. Quality of life improved for all three intervention groups. The PCE + PCC had significant results for emotional responses and quality of care interactions. This study faced issues with disguising the intervention group staff from each other and some managers not complying with the study requirements. There were also site initiated activities that could have affected the results. Nevertheless, this study presented positive outcomes for people with dementia in residential care (Chenoweth et al., 2014).

Jeon et al. (2012) conducted a cluster RCT to determine the outcomes for staff when implementing PCC or dementia care mapping (DCM). Jeon et al. (2012) hypothesised that PCC

model or DCM would decrease staff burnout and ameliorate their well-being, perspective and response to behavioural disturbances. Fifteen residential care sites were randomised into PCC intervention (n=5), DCM (n=5) and usual dementia care (n=5). The collection of data (questionnaires n=194) occurred pre intervention, post intervention then at a four month follow up with 64% completion at all three times. The results were for some characteristics positive. Jeon et al. (2012) identified the requirement for more PCC instruments that measure staff perception about the need to provide PCC. Staff involved in the DCM intervention reported a decrease in emotional exhaustion. However, as DCM sites have a facilitator to drive and support the changes, this could be the reason why the DCM intervention resulted in more positive changes whereas in PCC the staff had to drive the change. Depersonalisation with residents reduced with both intervention groups throughout the study period. There was also a relationship between 'being listened to by managers' and 'emotional exhaustion and personal development' (Jeon et al., 2012, p. 516). This is central to Kitwood's (1993, as cited in Jeon et al., 2012) philosophy of PCC, as it is not only important to have interactions with residents but also staff need value their interactions amongst themselves. Managers, in particular, must be role models for PCC to enable care providers to embrace and continue to provide PCC.

VIPS Conceptual Framework for PCC

As reported previously, Brooker (2003) also saw the need to define PCC more clearly to enhance understanding of this complex philosophy. Underpinning the meaning of PCC is Kitwood's concept of personhood. While Brooker (2003) focuses on people with dementia, she also acknowledges that PCC is used more broadly across different settings with different people. Rosvik et al. (2011) developed and evaluated the VIPS practice model to support the implementation of PCC.

VIPS Practice Model (VPM)

Rokstad et al. (2013) conducted a cluster RCT to assess whether the implementation of two models of PCC reduces agitation for people with dementia in long term care. The researchers compared DCM, VIPS model for practice (VPM) with a control group across 14 residential care settings. Training for both groups was provided and all three groups were provided with five

DVDs about dementia. This study involved the data collection at baseline, and at one month, then 10 months later. The primary outcome was not proven however, resident neuropsychiatric symptoms decreased. Both models disclosed statistically significant results, DCM for PCC improved residents' quality of life whereas the VPM showed a reduction in depressive symptoms. The VPM result could be attributed to the care provider's pursuit to understand the perspective of the resident, their life story, assess the challenging situations thus have a heightened awareness of the resident's mood and changes in mood (Rokstad et al., 2013).

Rosvik, Engedal, and Kirkevold (2014) identified that the cluster RCT by Rokstad et al. (2013) had different results for various units that were involved in the study. This resulted in a secondary study to determine what factors influenced the successful application of VPM. They found that leaders need to be available to provide support while empowering staff to make decisions, which was more apparent in smaller units. They also found that the individual unit culture was more important than that of the whole organisation.

The VIPS conceptual framework for PCC was first tested by Rosvik et al. (2011). They developed the VPM to support its application. Rosvik et al. (2011) designed the model based on recurring, structured, problem-solving meetings, effective teamwork and supportive management. This qualitative evaluative study focused on the application of the model rather than assessing the effectiveness of VIPS for PCC. Two focus groups interviews (one for RNs and the other for Auxiliary Nurses - ANs) were conducted following a nine week pilot VPM program. This program included an education program, role clarification for staff and development of structured meetings. The roles were in line with change management principles and the VIPS framework. The role of the leader was assigned to ANs and they led the meetings where the primary nurse would be the spokesperson for the person in their care, to enable presentation of the person's perspective. The RN's role was to provide professional support for decision making and evaluations of change in practice.

The analysis by Rosvik et al. (2011) revealed that effective teamwork, respecting everyone, and having dedicated leaders from within the ward to facilitate change were significant factors for implementing VPM. Knowledge of PCC, together with an understanding of the milieu and how it effects the people within it, is a critical aspect of implementing PCC. The

structured meeting was a time to reflect on the challenging situations that presented, and provided a means to develop PCC strategies and authority for change. The role of the leader was crucial for facilitating this change therefore needed to be accepted by all. When the leader was not accepted the changes were difficult to implement, as there was no authorisation or consensus for the change. Rosvik et al. (2011) have recommended that the leaders required more training and supervision for the initial phase of implementation.

Rosvik et al. (2013) identified that following the development and qualitative descriptive evaluation of the application of the VPM to facilitate PCC and the cluster RCT on the impact of VPM for people with dementia in residential care, there is still a gap in the literature about the delivery of VIPS framework for PCC. The VPM was developed to provide a structure for implementing VIPS. Rokstad et al. (2013) argue that to implement PCC the VPM should be applied from the perspective of culture change. This means that the care providers need a means to transfer the knowledge of PCC into everyday practice. VPM provides structures to facilitate this change, particularly with the focus on reflective practice meetings that promote shared values and teamwork. Achievement is also dependent on leaders having the ability to overcome the barriers thus have the legitimacy of the role function to change and embed PCC into the organisations culture (Rosvik et al., 2013; Rosvik et al., 2011).

Passalacqua and Harwood (2012) conducted a quasi-experimental study (One group pre-test post-test design) to find out if a VIPS communications skills training program will enhance PCC for people with dementia in residential care. The training program presented each of the VIPS constructs in four one hour workshops. The analysis revealed significant changes, increased hope and decreased depersonalisation use in communication. There was also a positive change for empathy. Passalacqua and Harwood (2012) reported that the care providers were discovering new skills to communicate in a person-centred way to connect with the person with dementia. A diverse range of interpersonal skills is essential for achieving PCC, because people in residential care will have different styles, abilities and cultural preferences.

‘Valuing People’

Three key findings in relation to valuing people were identified these were the importance of shared vision, leadership and job satisfaction. The findings are reported below.

Shared Vision

McCormack et al. (2012) reviewed three models of care that were based on person-centredness. These were PCNF, relationship-centred care (RCC) and culture change. They identified that the models were defined as being different to each other yet had some similarities and if combined could further strengthen the meaning of PCC. The meaning of the 'person' was also defined differently. McCormack et al. (2012) acknowledged the need to value all persons (residents, staff and families) and how personhood is understood by the organisation to ensure PCC meaning is not diluted. PCC models for residential care need to have a shared meaning so that the original humanistic values underpin their philosophy. RN's have a key role in fostering PCC cultures and shared vision with older people in residential care.

Lynch, McCormack, and McCance (2011) indicate that residential care organisations need to have a shared vision to drive a focused change to achieve PCC with older people. Supporting this was the study by Rokstad, Vatne, Engedal, and Selbæk (2015), who found that having a shared vision was important so that leaders were able to empower staff to implement PCC.

Leadership

There is often the expectation by the organisation that nurse leaders will facilitate culture change at the unit level in terms of supporting and managing staff through the change process (Lynch et al., 2011). To do this the nurse leaders need to understand how a care provider moves through the continuum of change to eventually become competent in PCC. Lynch et al. (2011), as part of a larger action research study, analysed two empirical studies to determine the skill set required by nurse leaders to support the care provider through this transition. A model was constructed by integrating concepts of PCNF and a 'situational leadership' model developed by Hersey and Blanchard (1982, cited in Lynch et al., 2011). The model identifies the stage of development of the learner according to motivation to learn and their skill level, and matches the supportive characteristic of the nurse leader, such as 'directing', 'coaching', 'supporting' and 'delegating' to empower the learner to provide PCC (Lynch et al., 2011). This conceptual model has the potential to enhance the effectiveness of PCC however, requires testing to confirm its applicability.

Rokstad et al. (2015) conducted a qualitative descriptive study to examine the role of leaders in residential care when implementing PCC. Two focus group interviews (leaders and the other group care staff) were performed at six months and at the end of implementation. This study included the previous work of Lynch et al. (2011), situational leadership for PCC model defining these type of leaders as 'highly professional', providing support and engagement with care staff. They found that care staff had the confidence, thus they felt supported and empowered to make decisions about care for older people. They also worked as a team, having shared responsibility for achieving PCC. Staff were seen as being valuable for implementing PCC. The residential care settings that lacked leadership struggled to implement PCC. The combination of having a shared vision and supportive, active leaders resulted in care staff's ability to adopt and practice PCC (Rokstad et al., 2015).

A qualitative descriptive study, by Ericson-Lidman, Larsson, and Norberg (2014), was undertaken to ascertain the experiences of care providers caring for people with dementia in a residential care home. Focus group interviews were completed with nine participants (7 ENs and 2 NAs). The findings indicate that the care providers found it challenging to achieve PCC due to the lack of, leadership, support and a unified meaning of how to implement PCC. This meant that care providers struggled in their everyday practice trying to justify that they were 'doing a good job'. Ericson-Lidman et al. (2014) indicate that the care providers could use this to problem solve with co-workers and as an impetus for change. Functional leaders having shared values would further support and empower care providers to provide PCC.

Job Satisfaction

A systematic review by van den Pol-Grevelink et al. (2012) was conducted to uncover any evidence about various models of PCC and their effects on care providers in relation to job satisfaction. The findings were presented in a narrative form due to the heterogeneity of the seven selected Dutch studies. All of the studies demonstrated positive effects for at least one job satisfaction characteristic. Emotion-orientated care, snoezelen and small scale care had a positive influence on job satisfaction such as decreased demand, personal accomplishment and opportunities for development. Emotional exhaustion was reduced by snoezelen and small scale care. Less unplanned leave occurred with resident-orientated care and also had a positive effect for contextual autonomy. Overall this review has provided some insight into

PCC providing job satisfaction for care providers. Further research that is of high quality is required. Qualitative research could provide more insight into the adaptation and implementation of PCC (van den Pol-Grevelink et al., 2012).

Two cross-sectional studies by Edvardsson, Fetherstonhaugh, McAuliffe, Nay, and Chenco (2011) and Willemse et al. (2015) explored associations of person-centredness and job satisfaction for care providers. Edvardsson et al. (2011) found that the associations were significant. The staff that perceived themselves as providing PCC were associated with an even workload, harmonious team and 'feelings of worthwhile accomplishment'. The care providers valued the importance of providing care for residents according to their preference and their colleagues respect for their care practice (Edvardsson et al., 2011). Willemse et al. (2015) following the analysis of 1093 self-report surveys, also found relationship between person-centredness and job satisfaction. They established that care providers whose 'person-centred attitude' was high had an increase in personal accomplishment, which was attributed to being empowered to do their job, with supervisor support and understanding the resident from the resident's perspective. Willemse et al. (2015) identified that there was a negative effect associated with PCC, 'emotional exhaustion', therefore support to balance the PCC environment needs to be considered.

'Individualised Care'

A qualitative hermeneutic study by Buckley et al. (2014) was undertaken to construct a person-centred narrative (life story and experiences) approach framework to be used with older people in residential care. Residents were interviewed to find out what was important for staff to know when planning care. Nurse managers (focus group interviews), experts and the researchers analysed 46 transcripts from a previous study. Themes evolved using the PCNF. The framework resulted in identification of three constructs. 'Narrative being' is related to knowing what is happening now and what has happened in the person's past and understanding what may happen in the future. 'Narrative knowing' is acknowledging and valuing the individual person as a human being, one that has a past lived experience and can continue with a new experience in a new environment. 'Narrative doing' is about ensuring all activities are meaningful for the person. The authors argue that this person-centred narrative

framework can assist care providers to adopt PCC that is specific to the person, thus in an individualised way (Buckley et al., 2014).

Hunter and Levett-Jones (2010) explored the role of the RN working with older people in residential care in Australia. This was a mixed methods study, comprising of surveys (48 RNs and 16 nurse managers) and focus group interviews. This study revealed that the RN role was becoming more complex and it involved some elements of PCC. The RNs reported that they provided individualised care plans that incorporated social activities from the perspective of the person and family. Hunter and Levett-Jones (2010) concluded that RNs need to endeavour to continuously expand their practice to incorporate all the dimensions of PCC.

'Perspective of the Person'

Bedin, Droz-Mendelzweig, and Chappuis (2013) also explored the role of the RN (Gerontological) working in residential care. They conducted a qualitative descriptive study recruiting 16 RNs to participate in focus group interviews. This study revealed that RNs by knowing the life story of the person were able to understand the person's beliefs and values and adapt their responses accordingly. Preserving self-worth of the person by proving personalised approaches was seen as an important function for RNs, thus supporting the continuation of the persons' life when living in residential care (Bedin et al., 2013).

'Positive Social Psychology'

Edvardsson et al. (2014) conducted a qualitative study to explore how nurses advance PCC in residential care. Written self-reports (n=436) were completed by care providers, managers and other staff from twenty six residential care facilities. The analysis revealed four themes that focused on promoting person-centred activities: 'promoting decision making', 'promoting meaningful living', 'promoting pleasurable living' and 'promoting personhood' (Edvardsson et al., 2014). These results were consistent with the VIPS conceptual framework and further support the importance of older people in residential care having meaningful experiences in their everyday life. Staff wrote about how important is was that the residents have choice, and that their choices are respected and not judged. This also included involving residents in domestic activities, playing games, physical exercise and festivities, not only for enjoyment but to maintain their functional capacity. Edvardsson et al. (2014) suggest that

'small talk' is noteworthy in enhancing pleasurable and meaningful lived experience and that reflective practice driven by leaders will facilitate this.

Edvardsson, Fetherstonhaugh, and Nay (2010) also conducted a qualitative study to explore the meaning of PCC from the perspectives of people with dementia, their families and staff who work in residential care. Individual, group and telephone interviews were completed with participants from rural and metropolitan settings. This study uncovered an overarching theme 'promoting a continuation of self and normality' with subthemes 'knowing the person', 'welcoming the family', 'providing meaningful activities', 'being in a personalised environment' and 'flexibility and continuity of care and activities'. These themes are also consistent with the VIPS framework and encompass all four constructs. In particular the family is treated with respect and involved in the care, thus valued. Knowing the life history of the person and personalising the environment enables seeing the person's uniqueness and creates opportunities for meaningful communication, addressing care needs and understanding their preferences. Meaningful activities enabled the person to contribute and continue with their own life, and interact and contribute to other lives (Edvardsson et al., 2010).

Discussion and Conclusion

In this chapter the literature in the use of PCC with older people in residential care has been reviewed. This review has demonstrated that PCC is complex and multi-faceted. The meaning of PCC can sometimes become diluted and unclear, and there is a need for shared vision at an organisational level to achieve PCC (McCormack, Karlsson, et al., 2010). Many studies have discussed the culture change approach to facilitate PCC. These studies discuss how the leader requires a number of skills including: being flexible, a role model, available, listening to and, being able to trust and empower the learners when ensuring the transition to PCC. Whereas the care providers require competency in interpersonal skills to understand the perspective and develop good relationships with the people they care for and their colleagues, thus value these people (McCormack, Karlsson, et al., 2010; Passalacqua & Harwood, 2012).

Job satisfaction rated by care providers was evaluated and discussed in a number of studies. The practice of PCC showed some positive benefits in regards to personal fulfilment, a more

satisfying work environment, decreased stress and commitment to work. The systematic review by (van den Pol-Grevelink et al., 2012) suggests that a qualitative study may provide more insight of the care providers' perspective about their work.

The research on PCC has focused on developing conceptual frameworks and evidence to establish whether the different models of PCC provide high quality care. These models have been evaluated in a number of ways using either quantitative or qualitative methods, resulting in positive outcomes for both older people in residential care and care providers. The VIPS conceptual framework, in the form of VPM is revealing positive outcomes. However, the transition of the philosophy of PCC into practice is still unclear. There is a paucity of literature regarding the operationalisation of PCC from the perspective of care providers (Edvardsson et al., 2014; Jeon et al., 2012; McCormack, Karlsson, et al., 2010; Rosvik et al., 2013). There is a need to understand what it is that care providers do in everyday practice to achieve PCC with older people in residential care.

CHAPTER THREE: METHODOLOGY AND RESEARCH DESIGN

In this chapter I will discuss the chosen methodology for this study, qualitative description informed by Sandelowski (2000, 2010) and its relevancy for this study. I will justify the use of this methodology thus determining its appropriateness to answer the research question. Moreover, this part of the discussion will focus on qualitative description informed by Sandelowski (2000, 2010), followed by the procedures for sampling, recruitment, data collection, data analysis and trustworthiness and how these elements are all connected. This chapter will be concluded with an account of the ethical considerations for this study.

Reason for Research

As demonstrated in the previous chapter, the gap in the published literature was identified as a need to comprehend the operationalisation of PCC from the perspective of care providers (Edvardsson et al., 2014; McCormack, Karlsson, et al., 2010). I intend to research the perspectives and actions of the health care team (nurses and personal care assistants) as they seek to provide PCC in a residential care setting. Theoretically I regard this as an exploration of the operationalisation of the philosophy of PCC in a clinical context. This research will make an important contribution to PCC theory and practice, and will assist other residential care facilities as they seek to adopt and apply PCC in practice.

For this study, the research team agreed that the VIPS framework (Rosvik et al., 2011) was appropriate to employ as the conceptual framework because of its centrality to PCC despite the fact that it had only been used in dementia settings. As described in the previous chapter the VIPS framework has four constructs, comprising of: 'Valuing the person', 'Individualised care', 'understanding the person's Perspective', and 'positive Social psychology'. This framework is less complex with fewer elements than other PCC models, it fits with the scale of this research, and there are some national and international benefits to researching this aspect of PCC. Therefore this research will also contribute to PCC policy development and education.

Research Aim and Research Question

The aim of this study is to describe the experiences of nurses and personal care assistants in relation to operationalising the philosophy of PCC with older people in a residential care setting.

The aim is expressed as a single overarching question, that is: 'What are the experiences of nurses and personal care assistants (PCAs) in operationalising the philosophy of PCC with older people in a residential care setting?'

When considering this question in respect of the VIPS conceptual framework, four sub-questions were formed:

1. What are the experiences of nurses and PCAs in operationalising 'valuing the person' while working with older people and the care team in a residential care setting?
2. What are the experiences of nurses and PCAs in operationalising 'individualised care' while working with older people and the care team in a residential care setting?
3. What are the experiences of nurses and PCAs in operationalising 'understanding the person's perspective' while working with older people and the care team in a residential care setting?
4. What are the experiences of nurses and PCAs in operationalising 'positive social psychology' or related processes while working with older people and the care team in a residential care setting?

Conceptual Framework

The constructs of the VIPS framework are included in many PCC models, therefore can also be applied across the residential care setting in terms of including residents with or without dementia. The VIPS framework (Rosvik et al., 2011) will be used to guide the interviews and to provide a framework for the open ended questions. Care providers will be asked about what they believe and practice in relation to each construct. By exploring these constructs with the care providers, through qualitative descriptive methodology informed by Sandelowski (2000, 2010) the research will attain a practical understanding of the philosophy of PCC as it is operationalised by the clinical teams.

The figure below depicts this conceptual framework for the research; the 'blue' coloured circles represent the interests of the research conceptually and in practice and the 'mauve' coloured circle in the background reflects conceptually the context and the practices of the care providers in the residential care setting in which the research will be conducted.

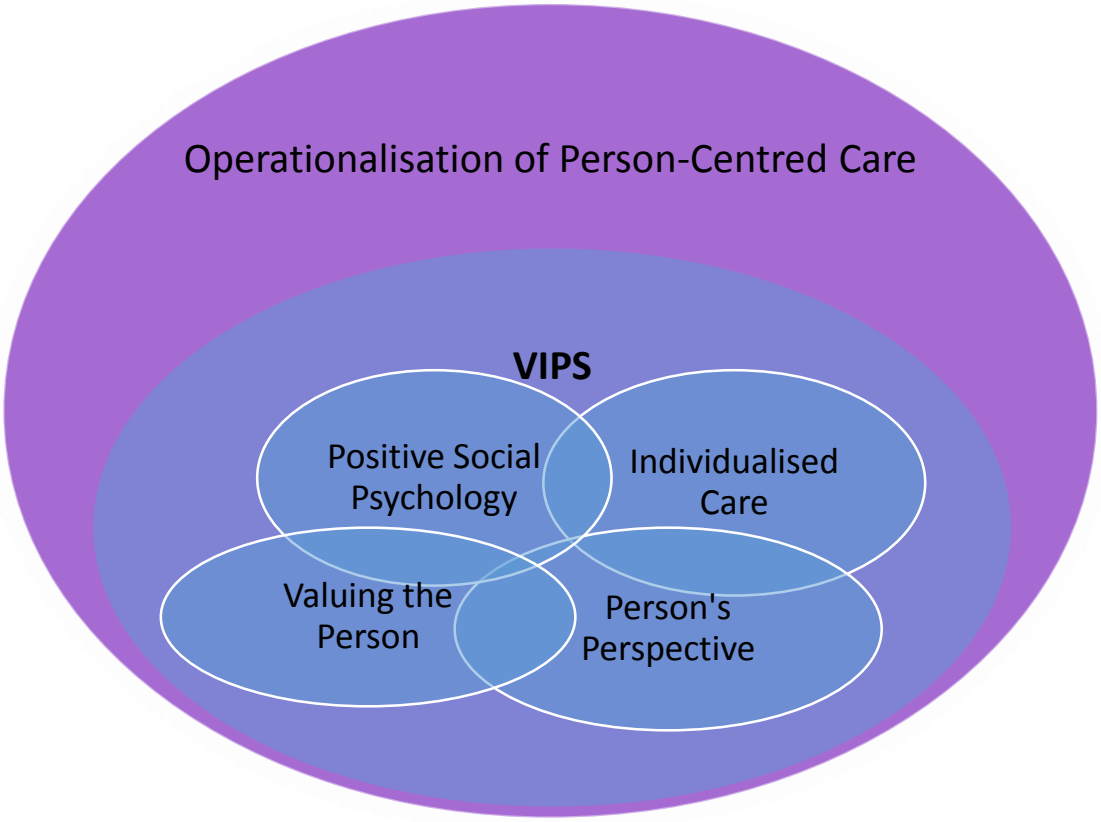

Figure 3.1: The VIPS Framework as a Conceptual Framework for this Study

Research Design

In the following sections the research methodology, research methods and overall design of the study are identified.

Research Methodology

The methodology chosen for this research project is qualitative descriptive research informed by Sandelowski (2000, 2010). Sandelowski is well-respected and an expert in the field of qualitative descriptive research which is validated by the number of citations (>1300) of her

work (2000). This methodology is used to answer specific questions that are important to clinicians and health care strategists (Sandelowski, 2000).

Qualitative descriptive methodology is a naturalistic inquiry that seeks to give insight into the context of the phenomena being studied by gaining accurate accounts about situations in context from the participants (Neergaard et al., 2009; Sandelowski, 2000, 2010). The purpose is to provide a snapshot of what is happening in practice according to the perspectives, insights or experiences of the care providers. It is not intended to discover new phenomena like other qualitative methodologies. Therefore qualitative descriptive methodology is appropriate for this research because the intention is to obtain a description of operationalising the philosophy of PCC with older people in a residential care setting.

Unlike quantitative research, the researcher does not investigate the situation from predetermined variables (Sandelowski, 2000). Instead the VIPS (Rosvik et al., 2011) conceptual framework has been used to frame the inquiry, but only in ways that support the phenomenon in its context, to be explored naturalistically and openly.

When using qualitative description, Sandelowski (2000) recommends that purposive sampling is used to gain participants, who have particular experience, for the research. Moreover, the participants possess the knowledge that is information rich required for the research (Coyne, 1997). The sampling technique is not as concerned so much with the sample size, rather it is concerned with having an adequate sample size or cases resulting in the collection of rich information. This is determined by the number and duration of the focus group interviews. Consequently interviewing participants followed by listening to the interview assists the research team to determine the number of interviews required to provide a summary of what is happening with regard to the phenomenon being studied (Chang, Voils, Sandelowski, Hasselblad, & Crandell, 2009; Sandelowski, 1995). Focus group numbers should be aligned with the intention of the data collection, and the interview strategy (Lopez & Whitehead, 2013).

The aim of the data collection was to take a snapshot of what is happening at that point in time (Sandelowski, 2000, 2010). Focus groups were conducted using open-ended questions to obtain a snapshot of people's perspectives, insights or experiences in operationalising PCC. Language was the means for collecting the data hence retrieval of the facts that give rise to

the descriptions provided by the care providers. Moreover, this data that has been gathered by traditional qualitative research methods is eventually coalesced as a description and analysed. The description stays true to the meaning therefore is minimally analysed resulting in a low inference description. There is no manipulation of the data. The data analysis will render transparency of the PCC practice context at that point in time (Sandelowski, 2000, 2010).

Table 3.1: Theoretical Description of Qualitative Content and Thematic Analysis (Vaismoradi, Turunen, & Bondas, 2013)

Data Analysis	Description of Processes
Content Analysis	Concerned with coding and categorising the text, staying true to the meaning and involves 3 stages; 'Preparation' is where the researcher reads the transcript numerous times to gain a sense of the whole and then determines the 'unit of analysis' that is categories or themes. The 'Organising' stage is when the codes are arranged into subthemes and or subcategories then these are compared with the all of the data, looking for patterns and trends in relation to the research question. This is the abstraction process. 'Reporting' of the entire data in the form of a conceptual map, process and an account of what is happening within the context of the research question.
Thematic Analysis	Concerned with identifying the patterns within the data and involves 6 phases; 'Familiarising with data' is where the researcher reads the transcripts numerous times identifying initial thoughts. 'Generating initial codes' is where the researcher applies codes to all of the data, systematically arranging into data sets. 'Searching for themes' is where the codes are grouped together to form themes. 'Reviewing themes' to assess they are relevant to the entire data through the development of a concept map. 'Defining and naming themes' thus ongoing analysis to determine relevant meaning of each theme. 'Producing the report' that is a comprehensive analysis related to the research question.

Qualitative content and thematic analysis is the appropriate method to analyse qualitative descriptive research informed by Sandelowski (2000, 2010). This involves a liberal approach that is not bound by strict rules, except that the text is described at the level at which they described their stories, but rather it considers the language as the data that will be organised into themes (Taylor & Francis, 2013; Vaismoradi et al., 2013). The themes stay true to the language, thus descriptions provided by the participants, resulting in a summary of their perceptions and experiences (Sandelowski, 2000, 2010). The analysis involves low inferential interpretation and has the potential to reveal hidden concepts. Moreover, the analysis

requires transcription of the digitally recorded interviews, active listening to the voice files and thematic analysis (Lopez & Whitehead, 2013). As Vaismoradi et al. (2013) indicates, the processes involved in both qualitative thematic and content analysis are very similar. These processes are outlined in Table 3.1.

Qualitative description results in a comprehensive summary that is organised and presented in relation to themes that are most relevant to the people being researched, thereby providing answers to questions of interest to the research. This result may also generate questions that lead to further research (Neergaard et al., 2009; Sandelowski, 2000, 2010). The application of these principles to the study is identified in Table 3.2.

Table 3.2: Application of the Principles of Qualitative Description to the Proposed Study

Principles of qualitative descriptive research informed by Sandelowski (2000, 2010)	**Application to my research**
Insight into the context of the phenomenon	Through focus group semi-structured interviews in the residential care setting with care providers.
Naturalistic inquiry	The focus group generated data will include descriptions from participants about the beliefs & experiences & actions in PCC.
Data collection (snapshot of what is happening at that point in time)	The primary open ended questions supported by prompts & probes, questions will be developed to elicit in depth discussion of the care providers' current experience of PCC. Data collected during a particular month.
Comprehensive summary	The data will be analysed & coded into themes or categories. The focus will be to provide an accurate account of what operationalising PCC means to the care providers. Member checking to confirm the accuracy of the account will be undertaken.
Questions for further research	There is one other previous international study regarding the facilitation of PCC, however, the data was derived from written descriptions. The data collection from this research is from group discussion & therefore has the potential to provide more in depth information. As the qualitative descriptive analysis will involve a low inference interpretation, there is the potential to generate further questions.

The purpose of this research is to describe and to understand what is happening in practice (in a particular context) to operationalise PCC. I am not seeking to develop new theories but rather to understand how PCC is facilitated in practice. The chosen methodology will result in an account of what care providers are doing to operationalise PCC in a context, and more broadly add to the sparse body of knowledge regarding the operationalisation of PCC.

Design of the Study

Setting

The residential care facility selected for this research opened in November 2013. This facility has a philosophy of PCC. The facility has 152 “Ageing in Place” rooms of which nineteen can accommodate two residents. There is also a palliative care suite and a day centre. Structurally this facility has four clinical units. Each unit has a RN manager, a team of workers comprising of ENs and PCAs. Shifts typically are composed of a team leader who is an EN and four PCAs; however, this is dependent on the number of rooms occupied and time of day. The Director of Nursing and Education Manager support the staff in operationalising the philosophy of PCC. The clinical site gave permission to be involved in this research.

Recruitment Procedure

Following approval (Appendix 3) from both Monash University Human Research Ethics Committee [MUHREC] (2013) and this residential care facility, I organised with the unit managers, a convenient time, to provide information sessions. Information sessions were advertised (Appendix 4). At these sessions I introduced myself, explained the purpose of the research project, what is involved in participating in the study and what happens with the research results as outlined in Appendix 5. Particular attention was given to explain the interview process, the need for confidentiality by all who participate and that data and individual contributions remain confidential (Taylor & Francis, 2013). I also explained that participants could withdraw from the project at any time. I allowed time to answer questions. I also made available my contact details for care providers to ask more questions and provide information to those who could not attend the session about the research.

Sampling for Qualitative Description

Purposive sampling resulted in nine care providers (who formed two focus groups) who had more than two months experience working in this residential care facility and working with the philosophy of PCC. Information packages were made available to each participant comprising of a plain language explanatory statement covering the details of the research, as explained at the information session (Appendix 6), the Consent Forms for the nurses and PCAs (Appendices 7 and 8) and the focus group schedule (Appendix 9).

To gain information rich data the researcher wrote field notes after each interview and later listened to each interview with the purpose of reviewing the discussion and to establish the questions required for the second interviews.

Data Collection – Focus Groups

Focus groups were set up by the researcher for participants who had experience and were interested in discussing the research topic (Jayasekara, 2012; Taylor & Francis, 2013). In this research the purpose was to extract descriptions of perceptions and experiences with the phenomenon (PCC) being studied through group discussions (with those that provide PCC in the research setting). Focus groups were a particularly useful technique when studying a complex phenomenon, such as PCC (Jayasekara, 2012).

The focus group discussions were moderated by the researcher where both the interaction between the group and their descriptions generated the data through focused conversation (Jayasekara, 2012). Focus group interviews generate more qualitative depth than questionnaires and they are believed to be less daunting than one-to-one interviews (Shaha, Wenzel, & Hill, 2011). Engaging and respectful group discussion can assist participants to speak up and clarify their views. The researcher was prepared and knew how to moderate, thereby ensuring the discussion was on topic and inclusive of all participants (Jayasekara, 2012).

It was the intention to divide the participants into two groups, PCAs in one group and ENs or RNs in the other. The separation of these care providers into different focus groups was because they have different roles and education backgrounds. However, due to working constraints and availability of staff there were 3 ENs and 1 PCA in the first group, 3 PCAs in the second group and 2 PCAs in the third group. The groups of participants changed for the second round of interviews. Again work constraints meant that a number of participants could not attend the interview on the designated day; consequently 3 ENs attended one interview and 1 PCA attended the other interview. The remaining second round of interviews were completed as individual (3 PCAs) interviews, to accommodate their work demands. These four participants agreed to proceed with individual interviews. Attrition of two participants occurred throughout the data collection (one had resigned from their position and the other

participant was on annual leave). Participants were interviewed twice to maximise the collection of information-rich data.

Table 3.3 Primary and Secondary Focus Group Questions

Question Context	Questions
1st Focus group	
Primary Questions	Introduction Following open ended primary questions provide structure for the focus group discussion. P1- What do you believe and practice in relation to valuing the person? P2- What do you believe and practice in relation to individualised care? P3- What do you believe and practice in relation to understanding the person's perspective? P4 - What do you believe and practice in relation to Positive Social psychology? Summary & closure
Secondary Questions	These primary questions will be supported by secondary probing and or prompting such as: S - Can you provide some examples of how you have operationalised this aspect of PCC? S - What motivates you to provide this aspect of PCC? S - Are there things you would like to introduce to promote this aspect of PCC?
2nd Focus group	
Primary Questions	Introduction/reminder of the previous session The following open-ended questions will support the original primary questions to promote further group discussion at the second meeting. P1- It has been several weeks since our last focus group, can you please share some stories from your practice that illustrate how you have used PCC in your practice during this time? P2- Can you describe any changes you have made to improve your practice in PCC? P3- What do you think you and the staff in this facility need to do in the future to continue to promote and advance practice in PCC in this residential care setting? P4- For the future in residential aged care generally (say in Australia), to achieve PCC, 'what would help?' and 'what do you think should be the vision'? Summary & closure & where to from here
Secondary Questions	Relevant probes and prompts

Focus Group Interview Structure and Questions

The first focus group interview aimed to elicit information about the care providers' current beliefs and practice in the philosophy of PCC. The interview questions, guided by the VIPS framework were explained to the participants. The second focus group interview built on the discussion from the first meeting and focused on eliciting their perspectives and practice

examples of PCC that had occurred since the first focus group. Examples of primary and secondary questions are provided in Table 3.3.

Interviews occurred several weeks apart at a mutually agreed time. They were held in a private room within the residential care facility to ensure confidentiality and convenience as it was in the participants' work time. Interviews were digitally recorded and voice files were stored on a password protected file on my computer in my office when not in use. Each focus group interview lasted between forty to sixty minutes. I welcomed and focused on building rapport with the participants so that they settled in together and gained confidence in the process.

I explained the purpose of the research and then asked if everyone was happy to commence. Once I asked the first question I concentrated on listening to the discussion, making sure all participants had the opportunity to speak, that no one dominated and used non-verbal gestures to encourage the discussion. I asked secondary questions through probes and prompts, when the discussion subsided but also asked if they have anything more to say and on agreement of the completion of that part of the discussion moved to the next primary question. On completion of the focus group I allowed time for questions and time for debriefing.

Data Analysis

The digitally recorded interviews were transcribed then analysed line by line to identify sequences such as similar words, phrases, sentences and sections in relation to the research question (Neergaard et al., 2009; Taylor & Francis, 2013; Vaismoradi et al., 2013). These sequences were studied holistically in relation to the overall research question and in relation to the four sub-questions generated by the VIPS conceptual framework of PCC. This resulted in the development of themes and subthemes (Sandelowski, 2000; Vaismoradi et al., 2013). These themes were summarised and represented in language that is close to the descriptions provided in the focus group meetings, that is they are true to the data collected and organised in relation to themes that are most relevant to the people being researched thereby providing answers to questions that are of particular interest to this research (Neergaard et al., 2009; Vaismoradi et al., 2013).

Trustworthiness

Trustworthiness, the term used to define the rigour of a qualitative study, refers to the auditability and appropriateness of qualitative research (Sandelowski, 1993). Quantitative research establishes rigour by evaluating the internal and external validity of a study. Sandelowski (1993) and Emden and Sandelowski (1998) indicate that the empirical method is not appropriate to critically appraise qualitative research as no two researchers will produce the same results. Trustworthiness in qualitative research is not defined by 'one set of criteria' but is more concerned with the quality, thus the artfulness, theoretical stance and morality of the research itself (Emden & Sandelowski, 1999, p. 6). To establish trustworthiness the researcher will provide a comprehensive audit trail and undergo checking by the research team and more broadly through peer reviewed publication (Neergaard et al., 2009; Sandelowski, 1993).

Member checking is the process whereby the participants review and comment on transcripts of the interviews they attended. Sandelowski (1993) indicates that this can be problematic as this will occur sometime following the interview. For this research, the research team decided to take a pragmatic approach given the organisational constraints (availability and accessibility of participants) in regards to member checking. However, throughout the focus group interviews the participants were asked if they agreed or disagreed with the comments being made, thus allowing time for review and further comment. The researcher will present the findings to the participants and explain how this was created so that it is realised that it is representing a group of participants.

The research team throughout the study was involved in the decision making process. This is particularly important so as to reduce bias, as the analysis is dependent on the researcher's low inference interpretation that can be subject to perceptions, ideas and preferences. This occurred simultaneously so that authenticity is maintained, in particular staying true to the descriptions provided by the participants (Neergaard et al., 2009; Sandelowski, 2000, 2010).

An audit trail began at the commencement of the project detailing decisions about the research plan and procedures undertaken (Neergaard et al., 2009; Sandelowski, 1993). Emden and Sandelowski (1999) argue that an audit trail that articulates thoughtful

consideration and transparency of all decisions and is accompanied by detailed and precise documentation, is applicable for judging goodness. Field notes are particularly beneficial in providing reflections on the progress and process and evolution of the decision making trail. Field notes have been written for all processes and encounters with participants and the research team. A comprehensive audit trail provides evidence, thus credibility about the research process thereby development of trustworthiness (Sandelowski, 1993).

Ethics

To conduct this research I have obtained permission from MUHREC (2013), as evidenced in Appendix 3 and then the residential care facility. MUHREC report to the National Health and Medical Research Council (NHMRC) and monitor research to ensure the principles of ethics are adhered to. The reason for this is that research has to be evaluated by professionals and members of the public to ensure the study will do good thus beneficial for the community at large (National Health and Medical Research Council, Australian Research Council, & Australian Vice-Chancellors' Committee, 2007). These ethical principles are research merit and integrity, beneficence, respect for human beings and justice and are discussed as they have been applied to this research.

Merit and integrity in conducting this research was substantiated by the approval process. This chapter has justified why this methodology and associated methods are appropriate to answer the research question. The trustworthiness, thus the checking of data and audit trail as previously described has demonstrated the fairness and transparency of this research. The findings will be presented to the residential care facility and disseminated more broadly to the Aged Care Sector and those with an interest in PCC. These findings will be subject to peer reviews thereby completing the evaluation in accordance with the merit and integrity of this research.

Prior to conducting this research, I spent time getting to know staff at this residential care facility, to build their trust in me as a research student and gain some understanding of their working environment. It was important that the organisation had confidence in my ability to conduct this research to ensure no harm comes to any of their staff (Maas, Kelley, Park, & Specht, 2002). Explanations were provided at management meetings to ensure transparency.

The approval and support by management was also important for the success of data collection thus the recruitment and participation of care providers. Maas et al. (2002) indicate that gaining the confidence of the staff is significant for the successful recruitment of participants.

Voluntary participation was sought from care providers therefore no one was coerced into participating in the research. Participants have been treated with respect and valued for their contribution to this study. Purposeful sampling for the recruitment of participants was undertaken to optimise rich descriptions (Sandelowski, 2000, 2010) of PCC. It was not intended as selection bias.

The consent process involved the distribution of participant information and consent forms as approved by the MUHREC (Appendix 3) prior to the interview so that the care providers were able to make an informed decision to consent to participate. As a part of this, the participants were informed that the interviews would be taped and transcribed therefore a pseudonym was allocated to ensure anonymity. They were informed that the recordings would be password protected. The contact details of the person who managed complaints was also provided to the participants.

Management permitted care providers to attend interviews within their paid work time. However, some participants were mindful of their colleagues work load while they attended the interview. The unit managers supported staff wanting to participate in this research, by organising a suitable time to attend the interviews. It is important that the feelings of all staff whether participating in the research or not were valued and not compromised as a result of this research (Maas et al., 2002).

This is considered low risk research (Monash University Human Research Ethics Committee, 2013). However, participants may find that the focus group discussions or reading of the comprehensive summary heightens their emotions. At the end of each focus group and individual interview time was made available to ask questions or discuss any issues. I have maintained contact with the participants throughout this study and also advised that counselling can be made available. Participants were also informed that they could withdraw at any time.

Ethical principles have been considered when conducting this research to prevent harm to any participants and to uphold the moral responsibilities of this research. The trustworthiness has been explored, identifying the criteria to protect the participants and enhance the quality of this research. The findings will be made accessible to the participants and to the wider community through presentations and publication in peer reviewed journal to ensure scrutiny of this research.

Conclusion

This chapter has focused on how the VIPS conceptual framework for PCC and the chosen methodology, qualitative description informed by Sandelowski (2000, 2010) is the most relevant for this study. This methodology and related methods have been described and their appropriateness to answer the research question has been justified. The purpose of this research is to describe and to understand what is happening in practice, in a particular context, to operationalise PCC, resulting in a comprehensive summary that is most relevant to the care providers. More broadly, this will add to the sparse body of knowledge regarding the operationalisation of PCC. Sandelowski's (1993) elements of trustworthiness have been established to ensure the progression of a quality research project. Also demonstrated, that the ethical principles have been acted on and guided the decision making process throughout the life of this project; that is data analysis, discussion and dissemination of the findings.

CHAPTER FOUR: THE RESULTS

As reported in the previous chapter the qualitative analysis revealed important themes. These themes were related to the overarching concepts of the VIPS framework. Therefore the results are reported and organised in relation to the VIPS concepts with relevant themes nested in each construct.

In this chapter the results of the research project are presented. In keeping with the conceptual framework of the research the VIPS framework is used to convey the themes that emerged from the interviews. The themes are supported by pertinent participant quotes. The format for reporting this data is the presentation of quotations in each section as follows:

- The abbreviation for focus group is FG
- The abbreviation for individual interview is II
- The relevant number for the focus group or interviews
- The participants are then recognised by a number code together with the relevant line numbers from the transcript

'Valuing the Person'

The first concept of the VIPS framework is valuing the person. The health care participants were clear that valuing the person was core to person-centred practice in the residential care setting. Thematic analysis revealed three key ways that the staff worked to achieve valuing the person. These are stated as 'residents get to know the care providers', 'care providers have respect for their role', and 'family involvement'.

Residents Get to Know the Care Providers

In all of the interviews the participants have discussed that it is important for the resident to get to know the care provider, thus to become familiar with those who are caring for them. Creating opportunities by which residents could come to know and understand the care givers, was seen by the participants as a highly important aspect of person-centred care.

Participants reported achieving this by various means. Some participants highlighted the importance of sharing themselves with residents, for instance it was stated that: "they need

to know a bit about our life as well… in order to communicate" (FG2, L65). Many of the participants shared techniques by which they aim to grow the residents trust in them as health care workers. For instance, they might aim to befriend the resident "you really have to befriend them and you know they really have to trust you [to] look after what their personal individual needs are" (II1, L251-3) or to create some other form of primary connection with them "trying to establish some sort of a connection with that person, whether they value you or not. I guess it's a trust thing really. With aged care it's definitely trust" (FG1, L46).

The caregivers also philosophically adopted the mantra of being here for the residents. For instance one of the focus groups stated that "we all... well most of us have the same values, and we're here for the residents" (FG2, L27). Further to this, groups identified that they have to have skills in showing that they are there for the residents regardless of personality or personal preference. As described by one participant:

> It doesn't matter if you get along with the person or not, you have to... you're not there for you, you're there for them, and you need to put it... what you have... the situation with the staff member or something, you just need to put it aside because you're there to look after them [residents], so you need to provide the right care for them, and not just hanging out with the person [care provider], you're there for a reason. (FG3, L82- 86)

Speaking truthfully to residents was another way of growing trust and helping the resident to come to know the care giver. An example of this was provided by a focus group, when it was stated that "Always be truthful with them [residents], and never tell them a lie. No No, never lie to them" (FG2, L 68). Another example was:

> You get to know them as a person. You get to know what their beliefs are, and you know they just love talking about their earlier life. And it helps you understand them because something... you know we've got some residents that you know don't like showers, and some other people come and say well they have to have a shower. Well no, because back in the Depression it never happened like that. It was weekly or something. And you need to respect them and do it the way that they want to do it. (FG2, L57-68)

Residents getting to know care providers was achieved by creating trust, by speaking truthfully and by being philosophically committed to being 'there' for the resident.

Care Providers have Respect for Their Role

Many participants believe that the care provider has to have respect for their role to achieve person-centredness. One participant recalled a discussion with a resident "he said you know some people are really dedicated to their jobs and love it, and others are just doing it because they have to and they've just got no love [for the role] and they're just task-oriented"-(FG4, L265-266). This opinion was raised in a number of interviews, where the participants believed that dedication to the job is important for achieving person-centredness. Their point was summed up that "you want people that value their job and know [that] I [care provider] am an important part of these people's [residents] lives"-(FG2, 280-281).

Many participants highlighted their commitment to their role by visiting residents outside their work hours. An example of this is that on Christmas day, care providers will visit the residents to make sure their day is special. As one participant explained:

> Coming into here, it's like you value what you have at home, but you value the relationships that you have in here, and you're getting to spend those special days with people [residents]. So this is our home away from home, and they're like our grandparents and people that we treasure and love you know. And you find the residents really appreciate it, and their face just lights up. And some of them don't have any family who see them, and we're basically their family. (FG2, L187 –91)

When reflecting on their role some participants agreed that "we're here because for most of us it's a passion... it's not a job, it's a passion what we do, and we love what we do"-(FG2, L32-33). Further to this "I think you have to be a special kind of person to work in aged care"-(FG2, L170). Care providers having respect for their role meant that they were dedicated and passionate about the work that they do and this was a prerequisite for achieving person-centredness.

Family Involvement

Family involvement is noted by participants to be very helpful, particularly when the resident with cognitive impairment is transitioning into their new home. The need to know the likes and dislikes of the new resident thus welcoming and involving family members is key to achieving person-centredness. As one participant explains: "talking to their family members that brought them in helps a lot because we might not have a lot of cognitively [intact] people

[residents] that come in, so we ask the families a lot as well" (II3, L174-176). Family involvement in daily life is also important for residents in that they maintain a connection with their family. "Family members help a lot, they do. Family members really help a lot in providing that individualised care, like information...Like certain residents in our wing will have the family come in every day" (FG1, L130 -131).

Tension can arise when the family, resident and care providers are at odds. For instance "[The daughter] keeps telling us [care providers] that her mother loves green tea, but every time we give [her] green tea, [her mother says] I don't like that, I don't want that" (FG 4, L31-32). This can present a challenge for care providers when there is a contradiction of opinions.

Family involvement is important for both the resident, in maintaining a connection with their family and for the care providers in providing information to provide individualised care. However, tensions can arise in the pursuit to achieve person-centredness.

To summarise, participants identified that, the residents get to know the care providers so that residents can trust and value the care providers. Whereas there is a need for the care providers to have respect thus value their role to support residents in this home. Family involvement is also valuable as they can provide personal information and maintain their connection with the resident. These are important aspects when 'valuing the person' to achieve person-centredness.

'Individualised Care'

The second concept of the VIPS framework is individualised care. The health care participants believed that providing 'individualised care' was essential for person-centred practice in the residential care setting. Thematic analysis revealed three key ways that the staff worked to achieve individualised care. These are stated as 'provide the right care', 'knowing the person', and 'knowing the differences'.

Provide the Right Care

Participants identified that providing the right care was related to knowing the resident. For example "it's just part of practice I guess – getting to know that person, providing that right care for that right person because they're all different" (II4, L189-191). In getting to know the

resident there was recognition of the differences in each person which, is important when providing individualised care.

Being aware of resident preferences was noted by participants, for instance:

> I guess it's more about what they want because it's meant to be a homely environment for them, rather than us coming in telling them what they have to do, so we try and make it their preference really of when they want to get up…. (II3, L86-87)

It was also perceived that care providers needed to be responsive to changes in the resident's preferences. Therefore knowing what the resident wants is established through meaningful communication.

One participant explains "instead of just walking in and doing it [task], and not bothering to ask your patient/resident/client how they are, and leaving, [instead] you can go in, do it, talk to them for a minute and a lot comes out of a little conversation" (II4, L354-355). Their workload limited the amount of time spent with residents however, the participants identified maximizing opportunities to communicate with residents was seen as significant in learning what they wanted.

Participants identified that it is important to provide the right care, thus individualised care. Knowing what the resident wants by seeking out opportunities to communicate with the residents in a meaningful way is a key aspect of an individualised approach to achieve person-centredness.

Knowing the Person

All participants identified that getting to know the resident was essential for providing 'individualised care'. One participant stated "I think it goes back to talking to them and getting to know them, what they like, is how you can provide the right care for them because everyone's different, they're all different" (FG4, L168-169). Getting to know the person can be enhanced by spending one-on-one time with the resident.

One participant stated "I like to spend one-on-one time with the resident, and knowing their personal interests, like their hobbies, their occupation, that's a big thing for them" (II3, L14-16). Another participant also highlighted that having a 'getting to know you folder' also

provides an avenue for getting to know the resident "it's interesting to read about their life, and they in turn interact with you better if you know a bit about them" (II2, L147). This also enhances a sense of familiarity thus understanding the life experiences of the resident.

Knowing the person is the core aspect of providing individualised care. Communication particularly one-to-one conversations and having reading materials about the resident's life are a means to acquire this knowledge about this individual person (resident).

Knowing the Differences

Again all participants recognised the significance of treating a resident as an individual person. In one focus group the discussion revealed "they all want to be treated differently… I think you like being treated as individuals rather than as a group" (FG3, L171). Recognising differences was important in understanding the resident's individuality. One participant described this as "they all have different beliefs, different care needs, different everything, so you can't just treat [them the same], not everyone's in the same boat" (FG2, L13-14). Additional to this is appreciating that every resident is unique. This can be summed up as "they're individuals so you have to have individual care for them, you have to provide different care for a different person because they are different people, and there's different challenges with a different person" (FG2, L210-212).

Providing 'individualised care' requires the participant to provide the right care according to the resident. The results reveal that this is achieved by getting to know the person (resident) and by identifying their preferences, differences and uniqueness as an individual person. Participants acknowledged that this was necessary to achieve person-centredness.

'Understanding the Person's Perspective'

The third concept of the VIPS framework is understanding the person's perspective. The health care participants sought to have an 'understanding of the person's perspective' to achieve person-centred practice in the residential care setting. Thematic analysis revealed three key ways that the staff worked to understand the perspective of the person (resident). These are stated as 'communicate with the resident', 'empathy', and 'continuation of life'.

Communicate with the Residents

To have an 'understanding of the person's perspective', the participants described using verbal and non-verbal forms of effective communication. One participant explained this as:

> Always look them in the eye, always speak to them clearly, listen to them [and] listen to what they feel or what their needs may be without interrupting them. Always let them speak. Never talk over the top of them. You just treat them as a person really. (FG2, L18-22)

Another participant also added "it's by listening to them, by asking the questions" (FG2, L227). Through effective communication "you just learn to get to know them, and then know what triggers them and know what they do like and don't like" (FG1, L50-51).

Empathy

Participants generally found it difficult to describe what they did with residents to understand their perspective. One participant explained this in terms of empathy:

> Actually having a conversation with them, and taking onboard their perception of things. So if they say I don't like that, I won't do that, [then] I'll say what will you do and how would you [like to] go about it, and let them talk about it themselves, to just get the general feel. (FG2, L164-167)

Another participant stated that "knowing that you're on the same page I guess is the one that sticks out for me and communicating with the patients" (FG1, L227). Here communication is also considered key to understanding the perspective of the resident.

Through having an understanding of the resident's perspective the care provider can provide support and comfort the resident. An example of this was described as "she was quite upset, and I just went in and sat with her for ten minutes and let her talk and she [became] good in the afternoon"-(II1, L9-10). For residents with dementia this was considered to be extremely beneficial because "you just learn to get to know them, and then know what triggers them off"-(FG1, L50). What most participants highlighted was "you have to understand them as a person before you can do the care" (FG2, L215).

Continuation of Life

Moving into residential care does not mean that the person (resident) is no longer able to contribute to life. Participants believed that it was important that the residents have continuation of life. This was evidenced by one participant's comment:

> Something that stuck out for us was that we were giving individual roles to our residents. So one gentleman washed the dishes, which he loves doing. There was [another] gentleman who would push all the chairs up and down the hallway, so in the end we got him a broom, so now he sweeps the floor. (FG1, L148-150)

The residents were able to contribute to their life as a result of the care provider seeking to understand what the residents wanted to do.

'Understanding the person's perspective' involves communicating with residents to realise their situation and what they want and need. Empathy can support the continuation of their (resident's) life, and provide the care provider with an understanding of the resident's perspective to achieve person-centred practice.

'Positive Social Psychology'

The final concept of the VIPs framework is positive social psychology. The health care participants believed that by providing 'positive social psychology' was at the heart of achieving person-centred practice in the residential care setting. Thematic analysis revealed three key ways that the staff worked to achieve 'positive social psychology'. These are stated as 'creating a homely environment', 'maintain a connection with their environment', and 'two-way relationship'.

Creating a Homely Environment

Many participants discussed the importance of providing a homely environment. One aspect of this was to have their own possessions in their room. For instance it was stated:

> The ones [residents] that can ambulate… [are] actually able to walk around in their own rooms, they've got their own settings in there to kick back if they don't want to go out… I think it's more like a homely environment. (FG3, L223-225)

Participants also highlighted the importance of having a warm and caring homely environment. One participant explained: "We have a great laugh you know… [one resident]

sits down with her head down, you say what are you doing? And she'll look [and say] oh dear it's you and she gets really excited" (FG2, L141-142). This warmth extends to the residents as they socialise amongst themselves. An example of this is provided below.

> All [of] the ladies joined in and told her [resident] how great she looked, and then one of the ladies said to her, oh we're going to have to come to your fiftieth birthday aren't we? And she… said, oh I just feel so good. (II1, L174-176)

The participants believed that by creating a homely atmosphere they assist the residents in connecting with the people who live within the residential care home.

Maintain a Connection with Their World

Participants believed that it was important for residents to maintain a connection with their world to create a 'positive social psychology'. Therefore enabling resident autonomy and choice over their usual daily activities is an important mechanism. This is described as:

> When they [residents] come into [this] facility we don't want to change their everyday living, we want to try and make it as homely as possible. So [the resident decides] what time they want to get up, what they want for breakfast and things like that. (FG1, L82-85)

Another description of this was "we've got a lady who likes to hang out the washing" (FG1, L152). However, another perspective provided by a participant was "[living in a residential care facility] doesn't mean that they aren't able to do anything. So if you give them the chance, you'll be actually quite surprised on what they can actually do" (FG1, L333-335). Connecting to their world means that the resident participated in the functional activities of everyday living, and care providers respected their decisions and provided opportunities to realise their potential.

Two Way Relationships

Having two-way relationships contributes to developing a positive social environment. Two way relationships can be between the resident and care providers. One participant explained:

> What's the harm in telling them a bit of your life? Is your life so secretive that you can't? And they love it too. They interact with you better, and you get this relationship with them, and like I said before you walk in the door and they smile that you've walked in because they know a bit about you too. (FG2, L73-76)

Participants recognise that the two way relationships were contributing to both resident and staff happiness. The next focus group also provided descriptions of similar interactions:

> One [resident] that I looked after this week she doesn't ever [leave] her room. She's had a stroke, [and] she's not that old but you know she actually gets excited when she sees me. You know she just has this little squeal and it's really good to know that someone's... really happy to see me. (FG3, L33-55)

Another participant added:

> I think it's more than just being their carer. You're being their friend, you're being there... you're who they see every day you know. You want a better relationship than just [a] carer. I want to make them happier and a difference for them, not just to feel that they're just being looked after you know. (FG3, L42-45)

Two way relationships enabled a connection between the residents and care providers. It provides a positive social and homely environment and can even promote the feeling of happiness for residents and with care providers, thus enhancing person-centred practice.

'Positive social psychology' was described by participants as the creation of a homely environment that embraced warmth, caring attitude and promoted happiness. This was enabled through developing two way relationships with residents, thus seeking opportunities to interact and socialise with the residents to maintain a connection with their home.

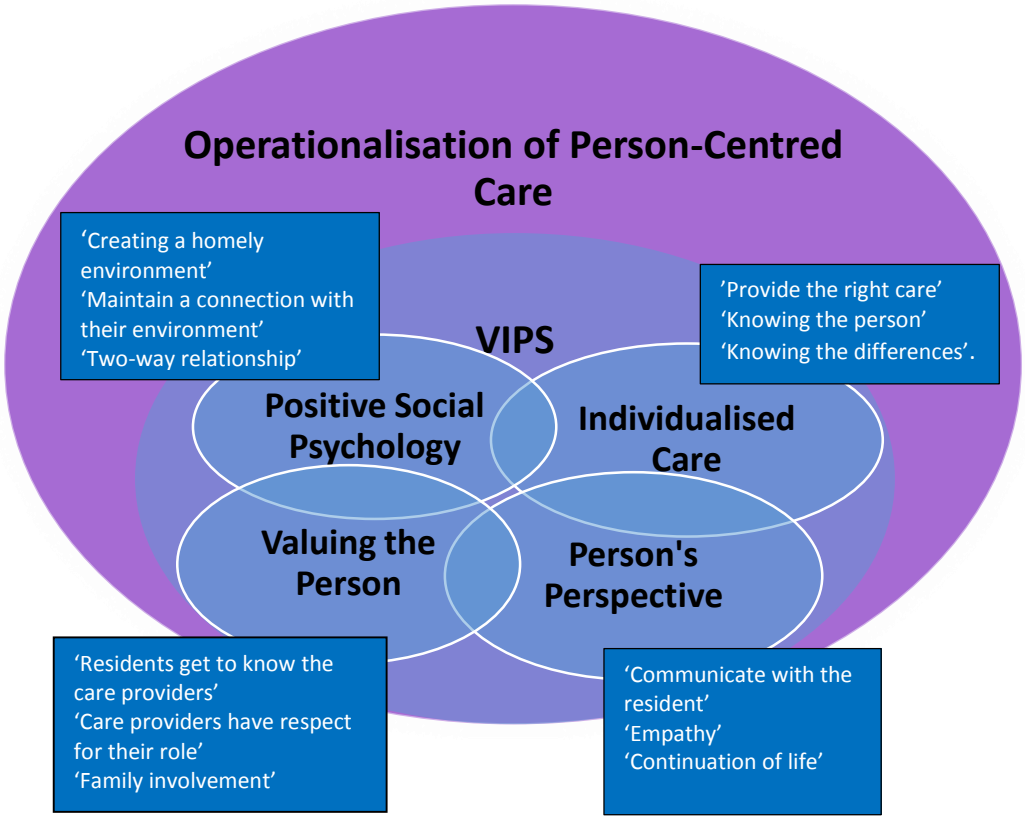

Figure 4.1 Qualitative Research Identified Themes Related To Each of the VIPS Constructs

Conclusion

The results of the research project have been presented and sequenced according to the VIPS conceptual framework. The themes that emerged from the interviews were supported by participant quotes. Participants identified that they require respect for their role, and that the residents get to know the care providers and involve the family were important aspects when 'valuing the person' to achieve person-centredness. Providing 'individualised care' requires the participant to provide the right care, facilitated by getting to know the person (resident) and identifying their preferences, differences and uniqueness as an individual person. 'Understanding the person's perspective' involves communicating with residents, to develop empathy, so that the care provider can support the continuation of their (resident's) life. 'Positive social psychology' was established by creating a homely environment where residents stay connected to their world through the development of two way relationships. These findings were what the participants reported and described as the ways in which they as care providers operationalise PCC.

CHAPTER FIVE: DISCUSSION

The overarching aim of this study was to describe and understand what care providers do in practice to operationalise the philosophy of PCC with older people in a residential care facility. Insights gained were based on the descriptions of these care providers. This chapter will discuss the overarching findings from VIPS, specific mechanisms for achieving PCC and the operationalisation of PCC in residential care. This chapter will argue the contribution that this research project makes to the body of knowledge about the philosophy of PCC practice by care providers with older people in a residential care setting.

Discussion

Overwhelmingly the participants in this study reported mechanisms and investments in being person-centred during the care that they provided and during engagement with residents. The overarching findings reveal that the nurses, the enrolled nurses and the personal care assistants were all similar in their strategies, there were no distinctive differences in the way in which they reported operationalising PCC. The results also show some coherence and homogeneity between the participants as they reported on the ways in which they work, what they believe and how they make it happen in this particular residential care setting. The use of VIPS framework operationally assisted the focus of the data reporting and the strategy for talking with the health professionals. VIPS, while previously having being used as a dementia only framework, proved a very useful framework, as all of the participants resonated with all of the four constructs of the VIPS framework and specifically had comments and information to give and share as they talked in the focus groups and individual interviews. For this reason VIPS was sustained in the reporting of the results as shown in the previous chapter, and is also used again in discussing the results.

Overarching Findings from VIPS

All of the participants had strategies for ‘valuing the person’, for ‘individualised care’, for understanding the ‘perspective of the person’ and for promoting a ‘positive social psychology’ and for working positively with people in residential care.

‘Valuing the Person’

This study has provided insights on how the care providers achieve ‘valuing people’ in a residential care setting. The themes revealed related to valuing the person were stated as ‘the residents gets to know the care provider’, ‘care provider has respect for their role’ and ‘family involvement’. Whereas the literature review about PCC for this study in relation to valuing people identified three key findings shared vision, leadership and job satisfaction. These concepts were not found in the data obtained in this study. What did transpired from the findings was the importance of the residents getting to know the care provider prior to them engaging in the care activities so that the resident feels valued as a person.

McCormack, Karlsson, et al. (2010) have identified that ‘meaningful engaged relationships’ are key to achieving PCC. However, in their work a description of what was required to do this was not revealed. The themes identified above add new insights into the ‘how’ of achieving valuing the person and the use of active resident engagement by the care providers. The results also identified that care providers valued family involvement because this assisted them with getting to know the resident and the residents remain connected to their families. Welcoming families of residents in residential care is central to the meaning of person-centred practice (Edvardsson et al., 2014; McCormack et al., 2012; Rosvik et al., 2011). The results also indicate that care providers may have to deal with the tensions that can arise when the families are not of the same opinion as the resident, and that this is a dichotomy often faced while striving to achieve PCC with the resident.

McCormack et al. (2012) acknowledged that all persons need to be valued as this underpins the philosophy of PCC. This was reinforced by the findings of the study. The results reveal that care providers needed to have respect for their role, as that this was a must for working in residential care to achieve PCC. It was described as a passion and dedication for what they do, therefore they as care providers must value their role to be able to operationalise PCC. This finding also has resonance with the PCNF in which it was also identified that care providers need to have a commitment to their work and that this is a prerequisite for their role to realise the philosophy of PCC (McCormack, Karlsson, et al. (2010).

‘Individualised Care’

This study revealed knowing the person, knowing their differences and providing the right care were key aspects of providing ‘individualised care’. However, what was different in this study were the participants’ descriptions of how to achieve this. Getting to know the resident in a person-centred way was achieved by optimising opportunities to communicate and engage with the resident. The findings support McCormack, Karlsson, et al. (2010) claim that employing competent interpersonal skills to engage meaningfully with the person (resident) while providing care is crucial for achieving PCC but they did not explain how to do this. Further they also support Buckley et al. (2014) recognition that for care providers in adopting an individualised approach need to know the resident’s past and present life experiences while valuing them as individuals.

The research revealed new insights in how care providers achieve ‘individualised care’ and how they recognise differences in and between the residents. This was a new perspective on how to see the person as an individual. The results reveal that the care providers believe they are empowered to provide the right care, to treat the residents as individuals, and to achieve PCC.

‘Perspective of the Person’

As reported in the previous chapter the participants mainly identified that communicating with residents, having empathy for residents and continuation of life were identified as important for understanding the ‘perspective of the person’. One participant stated that it was difficult to describe this aspect of care. This is consistent with Brooker (2003) work, where it is also acknowledged that having empathy is not an easy process.

A finding of this study was that care providers communicate with residents in a particular way to gain knowledge of their likes and dislikes and that this is key to gaining understanding the resident’s perspective. Understanding the person (resident) was also important prior to providng care. This approach by care providers also assisted in the development of empathy and the ability to provide comfort. This has resonance with Passalacqua and Harwood (2012) findings that as the care providers develop new communication skills to connect with the resident in a person-centred way their ability and capacity to develop empathy also grows. Therefore obtaining a range of interpersonal skills is essential for achieving PCC, because

people in residential care will have different likes and dislikes thus abilities and cultural preferences.

The results reveal that for care providers operationalising PCC also involves supporting the residents to choose to do what interested them and when to do their usual daily activities. This is a way of continuing with their life, and at the same time it achieves the gaining of further insight into the resident's perspective. Understanding the resident, from the perspective of their likes and dislikes, can assist in the continuation of the person's life and promote PCC (Bedin et al., 2013; Rosvik et al., 2013).

'Positive Social Psychology'

'Positive social psychology' was found to be operationalised by the care providers in three ways these are 'creating a homely environment', 'maintaining a connection with the environment' and supporting 'two way relationships'. This study found that that the care providers were invested in helping residents to maintain a connection with everyday living. This also involved creating a homely environment inclusive of their personal possessions, and supporting the moral stance of the resident maintaining a connection with the environment thus the residential care setting. The first three findings are well supported by other studies. Edvardsson et al. (2014) also found that meaningful and pleasurable living, thus having a homely and connection to the residential care setting by the resident were important in achieving PCC. Similarly previous research by Edvardsson et al. (2010), also found that 'Promoting a continuation of self and normality' was important in understanding how to facilitate the practice of PCC when caring for people with dementia. However, a new and different finding in this study was the ways in which care providers facilitated two way communication to achieve positive outcomes. For instance they believed that encouraging socialisation, whether with residents or between residents themselves, facilitated the creation of a home like and connection with the environment, consequently developing two way relationships promoted an atmosphere consistent with 'positive social psychology' and PCC.

A key finding from the study, was that the VIPS framework provided a practical means for care providers to describe what they do to operationalise the philosophy of PCC in a residential care setting. This research has provided new information about the

operationalisation of PCC in a residential care setting. Specifically these are the 'resident gets to know the care provider', the 'care provider has respect for their role', 'provide the right care', 'know the differences', 'connection to their world and 'two way relationships'. Descriptions of care providers intent and experience in enacting and operationalising these aspects of PCC were achieved through the focus group and individual interview medium.

Specific Mechanisms for Achieving PCC

A key finding was that the care providers used specific mechanisms for achieving and operationalising PCC in the residential setting. Specifically a finding that was extremely strong throughout the data sets was the ways in which the care providers worked to reveal themselves to the residents. They saw sharing who they were and having the residents get to know them was a part of the way of obtaining a two way exchange. A new finding was the importance that the care providers shared how it was important for them to speak truthfully to the residents, the ways they actually communicated with the residents, and how they spent one-on-one time with the residents. The results reveal that care providers in operationalising PCC use of verbal and non-verbal communication techniques such as: listening attentively, listening without interuption, not talking over the top of the residents, and asking questions. These were particulalrly important when spending one-on-one time with the residents, not only for them to get to know the residents but for the resident to get to know and trust them as their care providers. This was a surprise finding because the literature review did not reveal this as a key aspect of operationalising PCC. This was a new and important finding because it highlighted how care providers value the residents through the use of meaningful conversation to nurture two way relationships. The finding was very strong and actually seemed to be a cohesive way of operationalising PCC philosophically. Facilitating and achieving effective two way exchange seemed central to care providers achieving person-centredness with older people in the residential care setting.

The findings revealed that care providers believed that development of two way relationships was a key mechanism by which the residents would learn to trust in their care providers. Care providers shared that this two way relationship was particularly important for enabling the resident to open up and talk about their current and past lived experiences, and also to express their likes and dislikes. Thus revealing the resident's preferences, choices and

personal style differences. By consciously identifying these differences, the care providers believed that this enhanced their ability to provide individualised care, appropriate choices and value them as a unique, individual persons. This finding builds on previous knowledge, particularly in relation to personhood, in that they describe the way to intentionally care for the residents as individuals (Brooker, 2003; Buckley et al., 2014; Edvardsson et al., 2014; McCormack et al., 2012; McKeown et al., 2010). These were important findings as care providers believed that by consciously acknowledging the differences in residents and see them as individuals, contributed to PCC practice.

What was also strong in these findings was the how the care providers stimulated conversations with and between residents. Socialisation was embraced as a way of facilitating a connection to their home so that residents were part of the home that they lived in. Specifically the findings revealed how the care providers enabled this connection by spending more time with residents when confined to their room, laughing with residents, gently persuading those who are less confident to socialise and offering praise to raise the self-esteem of the resident. These findings have further strengthened understandings and insights into how the care providers interact with residents is central to operationalising PCC in a residential care setting.

Having respect for their role (care providers) was essential for adopting the philosophy of PCC in residential care. This was recognised as a prerequisite and caregivers thought that without this moral viewpoint there was an inability to operationalise PCC. This position is also a key concept of the PCNF (McCormack, Karlsson, et al., 2010).

The findings from this study have provided new information about the way care providers operationalise the philosophy of PCC in a residential care setting. These findings have demonstrated that these care providers (participants) adopt and operationalise PCC not as a one off approach or an intervention but rather as a way of doing, thinking and interacting to achieve PCC with older people in this particular residential care setting.

Operationalising PCC in Residential Care

As identified in the discussion in this chapter, this study's findings supported existing PCC literature in relation to the VIPS framework. What is different and transpired from the findings in this research was the insight of what care providers believe and do in the practice to operationalise PCC. Concrete examples were provided in relation to how care providers engage with residents and family members, hence were centred on developing and growing relationships between care providers and residents themselves. The findings revealed that the employment of sophisticated and conscious interpersonal skills by care providers to interact with residents was important for achieving PCC. Participants believed that to be able to practice in PCC they had to be passionate in what they do, thus have respect for their role.

The major findings regarding the operationalisation of PCC with older people in a residential care setting are described as:

- Recognising that it is just as important for the care provider to know the resident as it is for the resident to know the care provider
- Engaging in two way relationships, built on trust and honesty of the care providers
- Meaningful conversation when spending time with residents
- Consciously recognising the differences when seeking to understand the perspectives of each individual resident
- Creating opportunities for residents, particularly through socialisation, to be involved and connected to their environment

These findings have provided new and different insights on what they do in practice to operationalise PCC with older people in a residential care setting and are represented in the following diagram.

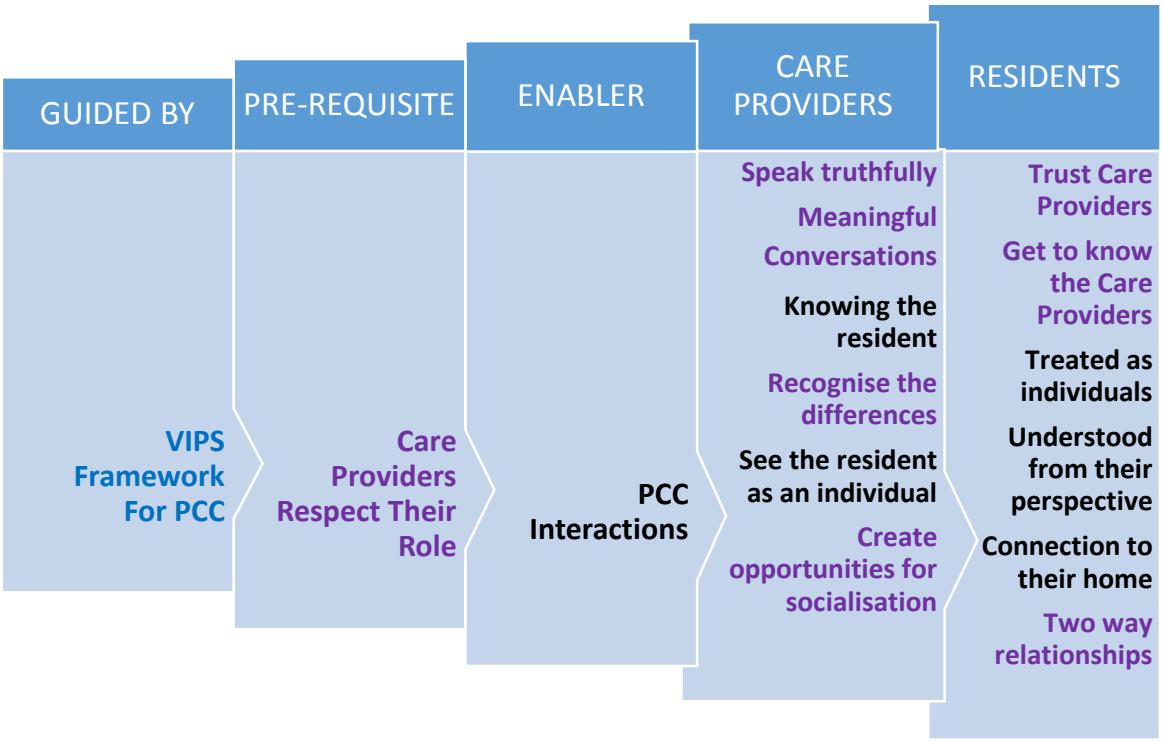

Figure 5.1 The Operationalisation of Person-Centred Care

This figure conceptualises the operationalisation of PCC in this residential care setting, thus the findings from this study. The colour in blue reflects the original use of the VIPS framework in a general residential setting rather than a dementia specific environment that is this is a new use that has not been previously reported in the literature. The colours in purple are the new findings from this study in relation to operationalising PCC in residential care. The findings in black reflect important findings that confirm and that are consistent with other literature.

This chapter has discussed the overarching findings from VIPS, specific mechanisms for achieving PCC and the operationalisation of PCC in residential care. This chapter has demonstrated that this research project contributes to the body of knowledge about the philosophy of PCC practice by care providers with older people in a residential care setting.

CHAPTER SIX: CONCLUSION

This research has investigated the operationalisation of the philosophy of PCC by care providers with older people in a residential care setting. In presenting the conclusion the limitations, implications and recommendations will also be discussed.

Limitations

This project has been contained to the scope of a 24 credit point thesis project. It could form the basis for further research in the residential care facility. The findings from this study were limited to one site, and one context in a residential aged care facility in the State of Victoria in Australia. The study was conducted with a small group of participants who were interviewed twice over a period of two months. Therefore the study was also limited in voice and temporality.

The level of data collection and analysis, is qualitative and descriptive, and it has low predictive and transferable power. Different methodologies may have different findings and will have different research power. The findings from this study could inform other studies designed with more powerful research outcomes.

Implications

This research has implications for practice, given the limited studies available, for operationalising the philosophy of PCC by care providers with older people in a residential care setting. The findings will contribute to the body of knowledge therefore will have implications for theory looking specifically at PCC through the VIPS framework in a particular context, and for education and policy emerging from the particular findings. As an aspect of qualitative research is the transferability related to the nuances of relevance and relatedness, then these findings could provide examples of how to practice in a person-centred way.

Further research is required as there is limited theoretical knowledge to assist in building the body of knowledge and to see if these findings are consistent in relation to practice patterns and strategies. The study needs to be repeated several times at the same facility with other care providers to further explore the findings for consistency and or differences. This study

also needs to be repeated nationally and internationally to see what keeps the findings the same and what is different and why this has occurred to give further understanding to this research question. The application of a different more powerful methodology and methods, using other theoretical frameworks while asking the same question would also contribute to the body of knowledge about PCC.

The VIPS framework resonated with the participants and provided a structure to report on what they did in practice to describe the operationalisation of PCC. The participants really enjoyed the discussions about operationalising PCC using the VIPS framework, in fact it promoted conversation about PCC in this clinical setting, therefore could be used by other care providers in other clinical settings. The VIPS framework could also be used as a vehicle for language and discussion for PCC education and policy. The application of the VIPS framework in this way has not been reported before so the findings suggest this may be useful for further studies.

These findings will be disseminated in a number of ways to ensure this information is communicated to interested parties locally, nationally and internationally. Research reports in plain language will distributed to the residential care setting where this study was conducted and MUHREC. Presentations will be delivered to the host organisation and abstracts will be submitted to conferences of interest in this study. Papers for publication will be sought with:

1. One paper with a low-level professional journal for local & wide dissemination. (Target 2015 for small paper - 500 words). For example with the 'Australian Nursing and Midwifery Journal' (ANMJ) (ISSN 2202-7114, no impact factor, readership 120,000) ANMJ, with the intention of targeting the 'Focus' section, which has research related to aged care.
2. At least 1 research paper with my supervisors in a relevant quality & professional journal (2016). Four journals that are likely choices: 'The International Journal of Older Person Nursing' (ISSN: 1748-3735; no impact factor as yet – emerging journal, features prominent articles on person centred care for older people), or 'Geriatric Nursing' (ISSN 0197-4572, Impact Factor 0.922) or 'The Journal of Clinical Nursing' (ISSN 1365-

2702, Impact Factor 1.233), or the 'Journal of Advanced Nursing' (ISSN 1365-2648, Impact Factor 1.685).

The findings from this study will contribute to the limited body of knowledge about the operationalisation of PCC with older people in a residential care setting. Further research is required. As reported in this study, the VIPS framework could be used to promote the uptake of PCC in residential care.

Recommendations

As previously discussed this research will provide additional information to the scarce body of knowledge relating to operationalising the philosophy of PCC with older people in a residential care setting. Therefore the following recommendations have been made to address the theory, education and practice contexts:

1. Further research is required to address the paucity of knowledge and progress the knowledge in relation to the operationalisation of PCC philosophy by care providers with older people in residential care.
2. Guided by judicious leaders and incorporating the VIPS framework, in the clinical setting to promote and assist in the discussion and operationalising PCC.
3. PCC education programs, such as short courses and workshops include the VIPS framework to provide structure and to promote conversation and uptake of PCC.

It is anticipated that these recommendations will also be disseminated as part of presentations and publications about this study and as described previously under implications.

Conclusion

The research interest that led to this study concerned the operationalisation of the philosophy of PCC in residential care settings. Specifically I had interests in understanding and describing the practicalities and the experiences of care providers as they worked with the philosophy of PCC as there was limited research regarding this. The overall aim was to describe the

experiences of nurses and personal care assistants (care providers) in relation to operationalising the philosophy of PCC with older people in a residential care setting.

Qualitative descriptive methodology informed by Sandelowski (2000, 2010) was chosen as it gives insight into the context at that point in time of the phenomena being studied. This research has provided important information that confirms and is consistent with other literature. This research has also provided new important findings, initially organised according to the VIPS framework and then coalesced to describe the specific mechanisms for achieving PCC. The major findings for operationalising the philosophy of PCC by care providers with older people in this residential care setting include:

- Recognising that it is just as important for the care provider to know the resident as it is for the resident to know the care provider
- Engaging in two way relationships, built on trust and honesty of the care providers
- Meaningful conversation when spending time with residents
- Consciously recognising the differences when seeking to understand the perspectives of each individual resident.
- Creating opportunities for residents, particularly through socialisation, to be involved and connected to their environment.

These findings have provided new and important information on what care providers do in practice to operationalise PCC with older people in this residential care setting.

A key finding from the study was that the VIPS framework provided a practical means for care providers to describe what they do to operationalise the philosophy of PCC in a residential care setting. As noted throughout this study the VIPS framework has been used effectively to frame the research sub-questions, literature review, data collection, data analysis and the findings. What was important was that the VIPS framework resonated and promoted discussion and descriptions by the care providers. It was recommended that the VIPS framework be used in education programs and in clinical settings by judicious leaders to promote conversations about PCC practice.

The findings have limitations as the data collection occurred at one point in time and at one site, therefore limited in voice and temporality. The research methodology provided a low

inference description yet they have provided important descriptions that have implications for further research, practice, policy and education. Further research is recommended, thus replication of this study, multiple times, locally, nationally and internationally to further develop the knowledge about operationalising the philosophy of PCC by care providers with older people in residential care settings.

This study will be disseminated to give voice to these findings. The intention is to present the findings to this residential care setting, at conferences and to other interested parties. Finally to ensure this study is disseminated broadly, abstracts will be submitted to peer reviewed, high quality, international journals to promote discussion about the operationalisation of the philosophy of PCC with older people in residential care.

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APPENDIX 1: RESEARCH TEAM EXPERIENCE

The Research Team Details Presented In the Ethics Application:

Chief Investigator: Associate Professor Cheryle Moss
Director Practice Development
Deputy Director JBI Centre for Chronic Disease Management (Monash University)
School of Nursing and Midwifery, Faculty of Medicine, Nursing and Health Sciences
Monash University, Clayton Campus
I am particularly interested in the philosophy and practice of person-centred care (PCC) with older people in nursing homes. I have been involved in practice development, where PCC is a key component, in residential care. In addition, I have expertise and track record in qualitative descriptive research which is the methodology being used in this research. My role in the study is as primary researcher and co-supervisor.

Co Supervisor: Dr Georgina Willetts
Senior Lecturer
Coordinator Bachelor Nursing
School of Nursing and Midwifery, Faculty of Medicine, Nursing and Health Sciences
I am interested in the philosophy and practice of person-centred care (PCC). I have been involved in practice development, where PCC is a key component. In addition, I have experience supervising students in Bachelor of Nursing Honours course and Master of Nursing students. I also have experience in ethnography and descriptive qualitative research which is the methodology being used in this research. My role in the study is as a co-supervisor.

Master of Nursing Student
Catherine Wilson
School of Nursing and Midwifery
Monash University
I am particularly interested in the philosophy and practice of person-centred care (PCC) with older people in nursing homes. I have been involved in deliberate improvement projects to promote PCC in subacute and residential care, presenting outcomes at a conference. I have also been involved in research projects, contributing to proposal submission, design of the intervention and collection of data. I have been successful in obtaining funding from DOH to implement Renal Nurse Practitioner role and Extended Scope of Practice for the Enrolled Nurse (Haemodialysis). I have completed GHS5841 – Research and Evidence for Practice unit and approved to progress to the Minor Thesis.

APPENDIX 2: INCLUDED PAPERS - QUALITY ASSESSMENT AND DATA EXTRACTION

1. Citation of paper: Brooker, D. (2004). What is person-centred care in dementia? Clinical Gerontology, 13(3), 215-222.

Author Credibility	Journal & Year Of Publication	Context	Population	Type Of Paper
Author 1 - Brooker, D., H index: 13 Key Affiliation: University of Bradford	Clinical Gerontology 2004 Impact factor:0.94 Rank: Q4, 43/50 (Geriatrics and Gerontology)	Country- UK Same healthcare context	People with dementia Setting: Care homes	Expert Opinion citations 138

Research Summary

Key Argument/Concern	Key Recommendations	Topic Relevance
Clarification of the meaning of PCC for people with dementia. It means different things to different people. It is multifactorial and not straightforward.	Proposes a meaning of PCC defined by 4 element 1. Valuing people 2. Treating people as individuals 3. Person's perspective 4. Positive social environment. All elements are interlinked and cannot be used independently to define PCC. PCC meaning needs to articulate clearly so that it influences public policy.	Very relevant as this paper articulated the origins of the VIPS framework which is being used to describe PCC in this study. Outcome: include

Data Extraction

PCC In Aged Care	Value	Individualised Care	Perspective Of The Person	Positive Social Psychology
Definition of PCC needs to be clearly defined. Influence public agenda. This should be part of value statements, training, recruitment, policies and national frameworks.	Aspire to treat all people as they would want to be treated. Seeing all people to be worthy of respect and being valued.	See all persons as having individual strengths and vulnerabilities. Each person is unique with life experiences, coping resources and social networks. Each person will experience a unique illness trajectory.	Understanding the world from the other person's perspective. Having empathy, which is not an easy process. There is a need to be imaginative and creative	Promoting relationships so that people can maintain or develop new friendships and maintain connection/ inclusion with the environment so that personhood is maintained.

2. Citation of paper: Rokstad, A. M., Rosvik, J., Kirkevold, O., Selbaek, G., Saltyte Benth, J., & Engedal, K. (2013). The effect of person-centred dementia care to prevent agitation and other neuropsychiatric symptoms and enhance quality of life in nursing home patients: a 10-month randomized controlled trial. Dementia & Geriatric Cognitive Disorders, 36(5/6), 340-353.

Author Credibility	Journal & Year Of Publication	Context	Population	Type Of Paper
Author 1 - Rokstad, A. M. H index: 1 Author 2 - Saltyte Benth, J. H index: 13 Last Author: Engedal, K. H index: 31 Key Affiliation: University of Oslo, Norway	Dementia & Geriatric Cognitive Disorders 2013 Impact factor: 3.547 Rank: Q1, 10/50 (Geriatrics and Gerontology)	Country- Norway Same healthcare context	People with dementia with a mean age > 75 years. Setting: Nursing homes	Cluster Randomised Control Trial

Research Summary

Research Summary	Data Collection & Analysis	Research Findings	Quality Research Assessment	Topic Relevance
Research design: Cluster Randomised Control Trial *Research question:* Will the implementation of PCC using DCM or the VPM result in reduced agitation and better QoL for residents.	Sample size: 624 at baseline, 446 at 10 months, people with dementia living in 14 nursing homes. The homes were randomly sorted into a control group (5), DCM group (5) and VPM group (4). DC: Assessments were made at baseline and ten months later. Primary outcome measures using the Brief Agitation Rating Scale (BARS). Secondary outcomes measures from NPI-Q, CSDD and QUALID. DA: Descriptive statistical analysis, data assessed by independent t test and regression models for hierarchical data. Statistical analysis, using SAS version 9.2 and SPSS version 18with $p < 0.05$ were considered statistically significant.	Relevant Themes: No significant findings in the BARS primary outcome measure. Both models showed a decrease in neuropsychiatric symptoms. Both models of PCC showed statistically significant effects, DCM positive effect on residents' quality of Life whereas the VPM showed a change in depressive symptoms. Conclusion: Both models are appropriate for implementing PCC in nursing homes.	CASP tool for Randomised Control Trial research: 10/11. It was not possible to blind the participants, however the assessors did not know which group the participants belonged to. Outcome: include	Relevant as used VIPS framework for one intervention.

Data Extraction

PCC in Aged care	Value	Individualised Care	Perspective of the Person	Positive Social Psychology
Internal leaders to provide supervision and support to progress this change in practice.	Empower nursing home staff. Staff weekly meetings guided by the VIPS framework to analyse situation.	Assess the situation according the individual's impairment, life story and psychosocial needs.	VPM model could heighten the observation by nurses of the residents' mood and acting on this	Both models enable both the physical and social environment to address the residents' needs.

3. Citation of paper: Rosvik, J., Engedal, K., & Kirkevold, O. (2014). Factors to make the VIPS practice model more effective in the treatment of neuropsychiatric symptoms in nursing home residents with dementia. Dementia & Geriatric Cognitive Disorders, 37(5-6), 335-346.

Author Credibility	Journal & Year Of Publication	Context	Population	Type Of Paper
Author 1 - Rosvik, J. H index: 2 Author 2 - Engedal, K. H index: 31 Author 3 - Kirkevold, O. H index:11 Key Affiliation: University of	Dementia & Geriatric Cognitive Disorders 2014 Impact factor: 3.547 Rank: Q1, 10/50 (Geriatrics and Gerontology)	Country- Norway Same healthcare context	People with dementia with a mean age > 75 years. Setting: Nursing homes	Secondary research of an RCT.

Research Summary

Research Summary	Data Collection & Analysis	Research Findings	Quality Research Assessment	Topic Relevance
Research design: Sub study of an RCT (paper 13) *Research question:* Following the RCT- Which variables contribute to the successful implementation of VPM?	Sample size: 624 at baseline, 446 at 10 months, people with dementia living in 14 nursing homes DC: VPM data from the RCT DA: Statistical Analysis, multilevel linear regression model was developed to capture correlations between same clusters of units and to prevent false significant findings. This was a hierarchical model where the residents were on the 1st level variable and the unit on the 2nd level variable.	Relevant findings, variance of effect: That the organisational factors within a unit have a greater effect than the organisation wide factors. Leaders need to be in close proximity to the care providers to fulfil their role. Unit size can influence the empowerment of staff, as decision making processes are decentralised while being supported by leaders, function as per VPM. Conclusion: Further research about valuing staff and residents and their needs.	CASP tool for Randomised Control Trial research: 10/11. It was not possible to blind the participants, however the assessors did not know which group the participants belonged to. Outcome: include	Relevant as further assessed the VPM.

Data Extraction

PCC In Aged Care	Value
The organisational factors within a unit have a greater effect than the organisation wide factors which may be due to the local culture.	Empowerment of staff to make decisions. Leaders need to be in close proximity to care providers to provide support and praise as per the VPM.

4. Citation of paper: Rosvik, J., Kirkevold, M., Engedal, K., Brooker, D., & Kirkevold, O. (2011). A model for using the VIPS framework for person-centred care for persons with dementia in nursing homes: a qualitative evaluative study. International Journal of Older People Nursing, 6(3), 227-236.

Author Credibility	Journal & Year Of Publication	Context	Population	Type Of Paper
Author 1 - Rosvik, J. H index: 2 Author 2 - Kirkevold, M. H index : 20 Author 2 - M., Engedal H index: 31 Key Affiliation: University of Oslo, Norway	International Journal of Older People Nursing 2011 Impact factor: Not rated Rank; Not rated Peer Reviewed journal High quality researchers (H index)	Country- Norway Similar healthcare context: Nursing home setting with similar staffing skill mix.	Registered nurses (RNs) and Auxiliary nurses (ANs). Setting: two nursing homes, one having the wards split into 2-3 smaller units, and a nursing pool of 3 RNs. ANs were administrative managers. The other nursing home had a more traditional organisation.	Single study

Research Summary

Research Summary	Data Collection & Analysis	Research Findings	Quality Research Assessment	Topic Relevance
Research design Qualitative evaluative study Research question: Is the VIPS practice model applicable to facilitate the VIPS framework of PCC?	Sample size: Nursing home A - 7 RNs and 5 ANs. Nursing home B - 4 RNs and 7 ANs. All RNs and ANs were involved in the VIPS practice model pilot study. DC: method: Separate focus group interviews for RNs and ANs. DA: Qualitative inductive content analysis, a naturalistic enquiry to validate the VIPS conceptual framework	Relevant Themes: 1. Legitimacy of staff roles as per the model. 2. Facilitation of staff's use of knowledge about PCC. 3. Support of the resource person's facilitating role. 4. The leading RN's authority in support of legitimacy of this model. Conclusion: Specific facilitation roles and meetings to discuss sharing of knowledge and practical application of VIPS framework (criteria) for PCC are key for the successful application of this model. This model provides a way of translating PCC into practice.	CASP tool for qualitative research: 10/10. Outcome: include	Discussion of the applications of VIPS framework of PCC from the perspective of the staff. Thus staff roles and attributes required.

Data Extraction

Value
Teamwork is essential with facilitators to lead change. Valuing/ respecting everyone (lack of these led to a breakdown in facilitation of this model) Staff having knowledge of PCC but difficult to apply. The consensus meeting supported the transition/ change. What knowledge of PCC and the milieu is required prior to implementing the model?

5. Citation of paper: Rosvik, J., Brooker, D., Mjorud, M., & Kirkevold, O. (2013). What is person-centred care in dementia? Clinical reviews into practice: The development of the VIPS practice model. . Reviews in Clinical Gerontology, 23(2), 155-163.

Author Credibility	Journal & Year Of Publication	Context	Population	Type Of Paper
Author 1 - Rosvik, J., H index: 2 Author 2 - Brooker, D., H index: 13 Last Author - Kirkevold, O. H index: 11 Key Affiliation: University of Oslo, Norway and University of Worcester, UK	Clinical Gerontology 2004 Impact factor:0.94 Rank: Q4, 43/50 (Geriatrics and Gerontology)	Country- Norway Same healthcare context	People with dementia Setting: Nursing homes and home care.	Expert Opinion

Research Summary

Key Argument/Concern	Key Recommendations	Topic Relevance
The VIPS framework for implementing PCC was developed into the VIPS practice model (VPM) to achieve PCC in Norwegian nursing homes and home care. This model is evidenced based. The RCT showed positive results. This paper is a review of the VPM application for practice.	There remains a gap in the literature about the operationalisation of VIPS framework. The VPM can assist the achievement of PCC by addressing challenges such as having shared values and vision for PCC, seeing the perspective of the person and application of knowledge from PCC training through reflective practice meetings. Achievement of PCC is dependent on leadership to overcome the barriers thus provide authority for change and embedding PCC into the organisations culture. Ongoing review of the literature to strengthen the model and its practical application.	Relevant as it provides a framework for change and overcoming challenges to achieve PCC. Outcome: include

Data Extraction

PCC In Aged Care	Value	Individualised Care	Perspective Of The Person	Positive Social Psychology
Leadership to overcome the barriers VPM is embedded into the culture	Shared vision Valuing care providers, provision of coaching and supervision, and time for regular consensus meetings for collective reflection and problem solving.		Consensus meeting provides opportunity to further enhance understanding the perspective of the person through collaborative reflection and problem solving.	

6. Citation of paper: Passalacqua, S. A., & Harwood, J. (2012). VIPS Communication Skills Training for Paraprofessional Dementia Caregivers: An Intervention to Increase Person-Centered Dementia Care. Clinical Gerontologist, 35(5), 425-445.

Author Credibility	Journal & Year Of Publication	Context	Population	Type Of Paper
Author 1 - Passalacqua, S. A. H index: 3 Author 2 - Harwood, J. H index: 22 Key Affiliation: University of Arizona, USA	Clinical Gerontologist 2012 Impact factor: 0.94 Rank: Q3, 21/32 (Gerontology)	Country- US-southwest. Same healthcare context	Care providers Setting: LTC facility	Single study

Research Summary

Research Summary	Data Collection & Analysis	Research Findings	Quality Research Assessment	Topic Relevance
Research design Quasi-experimental study – One group pre-test post-test design. *Research question:* Will the VIPS communication skills training program for paraprofessionals increase PCC for people with dementia?	Sample size: 26 caregivers DC: Questionnaires that assessed the intervention outcome measures (pre-test and post-test) and the four workshops. DA: Comparison of the pre-test and post-test scores, paired *t*-tests and ANCOVA for time measure analysis. Evaluations of the workshops by the participants.	Relevant Themes: Increased hope for people with dementia. Decreased caregiver depersonalisation. Exploring new ways of communicating with people. Less time focused on routines. Conclusion: The VIPS communication skills training program required for non-professional care providers is successful in facilitating attitudes, behaviours and communication skills consistent with PCC.	CASP cohort 11/12. Unsure if questionnaire was tested. Outcome: include	Relevant as it uses the VIPS framework to guide the intervention.

Data Extraction

PCC In Aged Care	Value	Individualised Care	Perspective Of The Person	Positive Social Psychology
Honouring the Personhood	Hope for people with dementia	Depersonalisation decreased	Empathy	Leisure activities more important than routines.

7. Citation of paper: Brownie, S., & Nancarrow, S., (2013). Effects of person-centered care on residents and staff in aged-care facilities: a systematic review. Clinical Interventions in Aging, 8, 1-10.

Author Credibility	Journal & Year Of Publication	Context	Population	Type Of Paper
Author 1 - Brownie, S., H index: 8 Author 2 - Nancarrow, S., H index: 11 Key Affiliation: Southern Cross University, Australia	Clinical Interventions in Aging 2013 Impact factor: 2.077 Rank Q3, 27/55, Geriatrics and Gerontology	Countries- Australia, The Netherlands, UK and US. Same healthcare context	Residents and staff Setting: residential aged care facilities (RACF)	Systematic Review

Research Summary

Research Summary	Data Collection & Analysis	Research Findings	Quality Research Assessment	Topic Relevance
Research design Systematic Review *Research question:* What is the impact of PCC approaches on residents and staff in residential aged care facilities?	Sample size: 7 studies (presented in the 9 articles) DC: Literature search strategy with selection criteria and appraisal of study design using the JBI RCT and quasi-RCT appraisal tool. DA: The heterogeneity of the study designs meant that the findings were presented in a narrative form.	Relevant Themes: PCC studies: -challenges for study evaluation and transferability -need for uniform language -standardised study design Conclusion: The need for further research (homogeneity of studies) however PCC is associated with positive influences on staff outcomes, improved psychological status of residents and reduced levels of agitation. However, there may be an association with increased risk of falls.	CASP tool for assessing systematic reviews. 9/10 Unable to combine the results of studies due to the heterogeneity of the studies as disclosed by the authors. Outcome: include	Adds to the meaning and effectiveness of PCC and the varying models of PCC.

Data Extraction

PCC In Aged Care	Value	Individualised Care	Positive Social Psychology
Improved outcomes for residents and staff. Challenges: increased falls risk for older people in RACF. Further empirical research to evaluate the effectiveness of PCC is required.	PCC model study confirmed positive impacted on job satisfaction and work conditions.	PCC model study confirmed improved ability of staff to provide IC.	Staff being allocated to the same residents led to increased social interaction.

8. Citation of paper: Junxin, L., & Davina, P. (2014). Resident outcomes of person-centered care in long-term care: A narrative review of interventional research. International Journal of Nursing Studies, 51(10), 1395-1415.

Author Credibility	Journal & Year Of Publication	Context	Population	Type Of Paper
Author 1 - Junxin, L., H index: 1 Author 2 - Davina, P., H index: 18 Key Affiliation: University at Buffalo School of Nursing, US	International Journal of Nursing Studies 2014 Impact factor: 2.901 Rank: Q1, 1/110	Country- Australia, US and UK Same healthcare context	Residents (12 of the 24 studies involved older people, the remaining studies did not identify these characteristics) Setting: Long Term Care (LTC)	Narrative Review

Research Summary

Research Summary	Data Collection & Analysis	Research Findings	Quality Research Assessment	Topic Relevance
Research design Narrative review/synthesis *Research question:* What are the effects of different PCC models on resident outcomes in LTC?	Sample size: 24 studies (15 US LTC resident studies guided by culture change and 9 dementia LTC studies) DC: Literature search strategy with selection criteria and appraisal of study design using the Scottish Intercollegiate critical appraisal checklist (2012). DA: Synthesis of the findings were presented in a narrative form.	Relevant Themes: PCC is dependent on staff' belief and acceptance of PC philosophy. Ability of staff to develop relationships with residents that demonstrates empathy, kindness and patience. PCC led to a decrease in behavioural symptoms. Conclusion: The need for further research (homogeneity of studies) which are of highest quality, given limitations of population (ethics) and variance of settings.	CASP tool for assessing systematic reviews. 9/10, Unable to combine the results of studies due to the heterogeneity of the studies as disclosed by the authors. Outcome: include	Relevant to my study providing some evidence on the effects of PCC.

Data Extraction

PCC In Aged Care	Value	Individualised Care	Perspective Of The Person	Positive Social Psychology
Universal definition of PCC required. Further empirical research to evaluate the effectiveness of PCC is required. Understanding organisational support required for culture change.			Having empathy and understanding the person's perspective PCDC significant finding: Decrease in behavioural symptoms.	Ability of staff to develop relationships with residents that demonstrates kindness and patience

9. Citation of paper: McCormack, B., Karlsson, B., Dewing, J., & Lerdal, A., (2010). Exploring person-centredness: A qualitative meta-synthesis of four studies. Scandinavian Journal of Caring Sciences, 24(3), 620-634.

Author Credibility	Journal & Year Of Publication	Context	Population	Type Of Paper
Author 1 - McCormack, B., H index: 23 Author 2 - Karlsson, B., H index: 6 Author Last - Lerdal, A., H index: 15 Key Affiliation: University of Ulster, Northern Ireland. Monash University, Australia. Buskerud University, Norway	Scandinavian Journal of Caring Sciences 2010 Impact factor: 1.197 Rank: Q1, 35/108	Country- Republic of Ireland, England and Norway. Same and different healthcare context	People with long term health conditions. Settings Nursing home Private home Psychiatric hospital Community hospital	Qualitative meta-synthesis

Research Summary

Research Summary	Data Collection & Analysis	Research Findings	Quality Research Assessment	Topic Relevance
Research design Qualitative meta-synthesis *Research question:* Can the synthesis of 4 PCC studies using the PCNF provide a deeper and integrated understanding of PCC.	Sample size: 4 studies DC: 4 different and unrelated studies chosen because they are primary studies that had an aim to gain an understanding of 'being in the world', consistent with PC philosophy. DA: Qualitative meta-synthesis, inspired by hermeneutic approach, using 3 phases 1. Each researcher read each study several times to find related meaning to findings 2. Structural analysis 3. The PCNF constructs were used to develop a shared and comprehensive understanding.	Relevant Themes: Culture in the practice setting effects the impact of PCC. Importance of meaningful relationships, the requirement of being competent -interpersonal skill development. Two gaps in the PCNF the physical environment particularly the natural environment and perception of time. Conclusion: Important to have a broad and contextualised meaning of PCC. Further synthesis required to contribute to theory development.	CASP tool for qualitative research: 10/10. Outcome: include	Relevant as meaning of PCC is important for the operationalisation of PCC thus highlights the need to research the practice context to improve understanding.

Data Extraction

PCC In Aged Care	Value	Individualised Care	Perspective Of The Person	Positive Social Psychology
Nurses struggle to implement PCC, overcoming the pressure of completion of tasks and routine practice of daily work. Culture effects the impact of PCC. Not a one off change process	Effective functioning teamwork. Autonomy and leadership.		Autonomy and control of one's quality of life. Sympathetic presence 'Knowing self'- the importance of one's own beliefs and values,	Competent interpersonal skills Meaningful engaged relationships

10. Citation of paper: McCormack, B., Dewing, J., Breslin, L., Coyne-Nevin, A., Kennedy, K., Manning, M., Peelo-Kilroe, L., Tobin, C., & Slater, P. (2010). Developing person-centred practice: nursing outcomes arising from changes to the care environment in residential settings for older people. International Journal of Older People Nursing, 5(2), 93–107.

Author Credibility	Journal & Year Of Publication	Context	Population	Type Of Paper
Author 1 - McCormack, B., H index: 23 Author 2 - Dewing, J., H index: 10 Author Last - Slater, P. H index: 9 Key Affiliation: University of Ulster, Northern Ireland	International Journal of Older People Nursing 2010 Impact factor: Not rated Rank; Not rated Peer Reviewed journal High quality researchers (H index)	Country- Republic of Ireland (IRE) Similar healthcare context	Nurses working in residential care with older people. Setting: Residential care facilities for older people across IRE.	Single study

Research Summary

Research Summary	Data Collection & Analysis	Research Findings	Quality Research Assessment	Topic Relevance
Research design Multi method study *Research question:* What are the nursing outcomes from the development of a PCC environment in residential settings for older people?	Sample size: Time 1:614, Time 2: 498, Time 3: 439 DC: PCNI instrument pack for nurse participants consisting of the Nursing Context Index and the Caring Dimensions Inventory. DA: Descriptive statistics. PCNI were analysed after each data collection using SPSS. One-way ANOVA was used to compare the mean scores across the three collection points. Independent t-tests were used when only two sources of data collected. Statistically significant results were revealed. Following each survey the facilitators reported back to each site their results which informed their action plan.	Relevant Themes: Related to the Care Environment: Meaningful teamwork, Increased professional relationships Empowerment Organisational commitment Valuing highly relationships with older people and their families. Conclusion: The care environment is a crucial component of PCC. Thriving teams where learning and reflective practice is embraced, challenging traditional practice can support change in culture to PCC practice.	CASP tool for cohort study: 10/12. Confounding factors not really discussed. Some tables had unrelated results to the discussion which could have been due to typos. Outcome: include	Focusing on nursing outcomes when developing PCC provides an insight on changes required.

Data Extraction

PCC In Aged Care	Value	Positive Social Psychology
Developing PCC is a complex practice that requires a sustainable culture change program.	Effective Teamwork Collaborative learning Job satisfaction	Value relationships with residents and their families. Providing meaningful activities

11. Citation of paper: Chenoweth, L., Forbes, I., Fleming, R., King, M. T., Stein-Parbury, J., Luscombe, G., Kenny, P., Jeon, Y. H., Haas, M., & Brodaty, H. (2014). PerCEN: A cluster randomized controlled trial of person-centered residential care and environment for people with dementia. International Psychogeriatrics, 26(7), 1147-1160.

Author Credibility	Journal & Year Of Publication	Context	Population	Type Of Paper
Author 1 - Chenoweth, L H index: 15 Author 2 - Forbes, I. H index: 3 Last Author: Brodaty, H. H index: 56 Key Affiliation: University of Technology Sydney, Australia	International Psychogeriatrics 2014 Impact factor: 1.934 Rank: Q3, 29/50 (Geriatrics and Gerontology)	Country- Australia Same healthcare context	People with dementia> 60 years. Setting: Residential aged care homes (RACF)	RCT

Research Summary

Research Summary	Data Collection & Analysis	Research Findings	Quality Research Assessment	Topic Relevance
Research design Cohort RCT *Research question* Will the combination of PCC +PCE improve QOL and agitation, emotional responses and depression, and improve care interaction quality.	Sample size: 38 RCAFs (n=601) DC: Occurred 3 times: Pre, Post and FU (8 months). Staff and management agreed to not rotate staff to other nursing homes nor talk with colleagues outside of the home about the study to maintain study contamination or Hawthorne effect. DA: Differences between intervention groups using DemQOL, CMAI, CSDD, ERIC and QUIS	Relevant Themes: Small significant reduction in agitation with PCC and PCE interventions but not PCC + PCE. Significant and non-significant improvements in QOL with PCC and PCE respectively. PCC + PCE significant improvement in quality of care interactions and resident care responses. Limitations identified managers where not always supportive of changes therefore could have impacted the findings of this research. Conclusion: Future research required to address the limitations/ problems encountered within the study.	RCT CASP: 11/11 Outcome: Include	Relevant to my study.

Data Extraction

PCC In Aged Care	Value	Individualised Care	Perspective Of The Person	Positive Social Psychology
Limitations indicated that a system wide approach was not adopted.	Negative: Unsupportive managers		Decreased agitation was evidenced in PCC	QOL improvements with PCC. PCC + PCE significant improvement in quality of care interactions and resident care responses

12. Citation of paper: Jeon, Y. H., Luscombe, G., Chenoweth, L., Stein-Parbury, J., Brodaty, H., King, M., & Haas, M. (2012). Staff outcomes from the Caring for Aged Dementia Care REsident Study (CADRES): A cluster randomised trial. International Journal of Nursing Studies, 49(5), 508-518.

Author Credibility	Journal & Year Of Publication	Context	Population	Type Of Paper
Author 1 - Jeon, Y. H. H index: 15 Author 2: Luscombe, G. H index:24 Last Author: Haas, M. H index: 16 Key Affiliation: University of Sydney, Australia	International Journal of Nursing Studies 2012 Impact factor: 2.901 Rank: Q1, 1/110	Country- Australia Same healthcare context	Staff working in residential aged care. Setting: Residential Aged Care sites	RCT

Research Summary

Research Summary	Data Collection & Analysis	Research Findings	Quality Research Assessment	Topic Relevance
Research design Cluster RCT *Research question:* What is the impact of PCC and DCM interventions compared to each other and to usual dementia care on staff outcomes?	Sample size: 194 at baseline with 124 completed all assessments at 3 time points. DC: Questionnaires: the Maslach Burnout Inventory, General Health Questionnaire for primary outcomes. Neuropsychiatric Inventory for Nursing Home and Manager support (derived from the literature) and a validated observation tool to measure quality of care. These were completed prior to PCC and DCM interventions, post and 4 month follow-up. DA: Statistical Analysis using SPSSv.17 and descriptive analysis (chi-square tests for categorical data, the Kruskal-Willis chi-square for skewed continuous or ordinal data)	Relevant Themes: Results for both interventions showed a drop in depersonalisation however it was not statistically significant. Relationship between support of managers and staff personal achievement and reduction in exhaustion was identified. Conclusion: DCM can be an effective way of implementing PCC. Further research is needed to determine the acceptance, uptake and continuation of PCC.	RCT CASP: 10/11. Unable to blind the intervention groups due to the education program crossover. Statistical significant result for the DCM intervention whereas PCC and DCM demonstrated associations between outcomes at baseline. Outcome: Include	There are points of relevance.

Data Extraction

PCC In Aged Care	Value	Individualised Care	Perspective Of The Person	Positive Social Psychology
Commitment to a whole system approach.	Being listened to by managers to enhance personal achievement and reduce emotional exhaustion. Staff valuing residents and each other.			

13. Citation of paper: McCormack, B., Roberts, T., Meyer, J., Morgan, D., & Boscart, V. (2012). Appreciating the 'person' in long-term care. International Journal of Older People Nursing, 7(4), 284-294.

Author Credibility	Journal & Year Of Publication	Context	Population	Type Of Paper
Author 1 – McCormack, B., H index: 23 Author 2 - Roberts, T., H index: 3 Author Last - Boscart, V., H index: 9 Key Affiliation: University of Ulster, Northern Ireland	International Journal of Older People Nursing 2012 Impact factor: Not rated Rank; Not rated Peer Reviewed journal High quality researchers (H index)	Country- International perspective Same healthcare context	Registered Nurse Setting: Long term care	Expert Opinion. The author, McCormack is an expert in the philosophy and practice of PCC in long term care.

Research Summary

Key Argument/Concern	Key Recommendations	Topic Relevance
Aim: To understand the similarities and differences in the chosen 3 models of person-centredness and explore the implications for the role of the RN in long term care. 3 models of Person-centredness, chosen for their view of the person, thus the primacy of caring. Critique and discussion on how 'the person' is understood and how the positioning of 'the person' influences the way in which the model is constructed.	Relevant Themes: Understand the meaning of personhood. Regulators of LTC need to adopt a broader understanding of PCC to include staff training needs within the quality indicators. These PC practice models that have the philosophical underpinnings of personhood however, appear to be losing the original meaning, a humanistic approach, in an attempt to find the perfect model.	This is very relevant to the research question that I have raised. Outcome: include

Data Extraction

PCC In Aged Care	Value	Individualised Care	Perspective Of The Person	Positive Social Psychology
Personhood needs to be understood to ensure PCC does not lose its original humanistic emphasis. Differences in person-centred models therefore need to understand how personhood is applied to ensure person-centredness is preserved. Models and frameworks of PC are important for practice translation.	RNs to foster a culture that has a shared vision of person-centredness with older people, families and colleagues. Regulators of LTC need to include PCC indicators.			The importance of the RN in developing meaningful relationships with older people in long term care.

14. Citation of paper: Lynch, B. M., McCormack, B., & McCance, T. (2011). Development of a model of situational leadership in residential care for older people. Journal of Nursing Management, 19(8), 1058-1069

Author Credibility	Journal & Year Of Publication	Context	Population	Type Of Paper
Author 1 - Lynch, B. M. H index: 1 Author 2 - McCormack, B. H index: 23 Author 3 – McCance, T. H index: 13 Key Affiliation: University of Ulster, UK	Journal of Nursing Management 2011 Impact factor: 1.5 Rank: Q1, 19/110	Country- Not specified Same healthcare context	Older People Setting: Residential care	Expert Opinion. The author, McCormack is an expert in the philosophy and practice of PCC in long term care. This is part of a PhD and the model will be tested using action research.

Research Summary

Key Argument/Concern	Key Recommendations	Topic Relevance
The expectation that nurse leaders will bring about change from a traditional model to a PCC model therefore require a different set of skills to enable this culture change. Synthesis of two empirical models, PCNF and situational leadership to develop a conceptual model for change.	A model that integrates the PCNF and situational leadership to assist nurse leaders to follow the performance of care providers in a structured and supportive manner (directing, coaching, supporting, delegating), thus develop others to enable culture change and achieve PCC. Currently his model is being evaluated in an action research study.	Relevant as it provides a framework for change to achieve PCC. Outcome: include

Data Extraction

PCC In Aged Care	Value	Individualised Care	Perspective Of The Person	Positive Social Psychology
Culture change to achieve PCC. The model focuses on the developmental level of the care provider and their support (flexible/situational leadership) required by the nurse leader to achieve PCC. Supportive organisation.	Shared vision Knowing self- clarity of values and beliefs Professional competence Commitment Effective and collaborative teamwork		Working with the residents values and beliefs Sympathetic presence	Interpersonal skills Engagement Shared decision making Sharing of power Autonomy.

15. Citation of paper: Rokstad, A. M. M., Vatne, S., Engedal, K., & Selbæk, G. (2015). The role of leadership in the implementation of person-centred care using Dementia Care Mapping: a study in three nursing homes. Journal of Nursing Management, 23(1), 15-26.

Author Credibility	Journal & Year Of Publication	Context	Population	Type Of Paper
Author 1 - Rokstad, A. M. M. H index: 1 Author 2: Engedal, K. H index: 31 Last Author: Selbæk, G. H index: 13 Key Affiliation: Oslo University Hospital, Norway.	Journal of Nursing Management 2015 Impact factor:1.741 Rank: Q1, 10/110.	Country- Norway Same healthcare context	Nursing leaders Setting: NH	Single study

Research Summary

Research Summary	Data Collection & Analysis	Research Findings	Quality Research Assessment	Topic Relevance
Research design Qualitative descriptive study *Research question:* What is the role of leaders when implementing PCC in NH using DCM?	Sample size: 3 NH (18 care staff and 7 leaders) DC: Semi structured focus group interviews 6 months after the 2nd DCM observation and repeated at the end of implementation. DA: Qualitative content analysis using NVivo 8.	Relevant Themes: Leadership role is important for achieving PCC. The leader with a clear and integrated vision and long term focus on professional development was able to support and empower staff to implement PCC. Conclusion: Further research is required on the use and influence of different types of intervention leaders, the impact of funding models and organisational operation's.	CASP Qualitative Research 10/10 Outcome: include	Relevant to topic

Data Extraction

PCC In Aged Care	Value	Individualised Care	Perspective Of The Person	Positive Social Psychology
Leadership role/ style important. Integrated, clear and coherent vision	Empowerment of staff Long term focus on professional development. Leaders provided encouragement and role models.			Shared decision making

16. Citation of paper: Ericson-Lidman, E., Larsson L-l. F., & Norberg, A. (2014). Caring for people with dementia disease (DD) and working in a private not-for-profit residential care facility for people with DD. Scandinavian Journal of Caring Sciences, 28(2), 337-346.

Author Credibility	Journal & Year Of Publication	Context	Population	Type Of Paper
Author 1 - Ericson-Lidman, E. H index: 4 Author 2 - Larsson L-l. F. H index: 1 Author 2 - Norberg, A. H index: 41 Key Affiliation: Umea University, Sweden	Scandinavian Journal of Caring Sciences 2014 Impact factor: 1.197 Rank: Q2, 35/108	Country- Sweden Same or different healthcare context	People with Dementia Setting: Private Not-for-profit (NFP) residential care facility.	Secondary study: part of a larger study that also included municipal residential care for people with DD.

Research Summary

Research Summary	Data Collection & Analysis	Research Findings	Quality Research Assessment	Topic Relevance
Research design Qualitative descriptive study *Research question:* What are the experiences of care providers' caring for people with DD working in a Private NFP care facility?	Sample size: Purposive sampling, n=9, (7 ENs and 2 NAs). DC: Semi-structured FG interviews. DA: Qualitative Thematic Analysis	Relevant Themes: Revealed Challenges to achieve PCC and ambiguous work environment. Conclusion: To overcome these organisational and personal issues • Use troubled conscience as a driving force • Functional leadership • Shared value base Providing these as possibilities to achieve PCC.	CASP tool for qualitative research: 9/10. Limitations of this study not made clear, however was part of a larger study. Outcome: include	Provides information regarding challenges and possibilities to achieve PCC.

Data Extraction

PCC In Aged Care	Value	Individualised Care	Perspective Of The Person	Positive Social Psychology
	Shared value base Reflective, collaborative practice using the troubled conscience. Supportive leaders to empower staff and confirm the importance of their work			

17. Citation of paper: van den Pol-Grevelink, A., Jukema, J. S., & Smits, C. H. (2012). Person-centred care and job satisfaction of caregivers in nursing homes: a systematic review of the impact of different forms of person-centred care on various dimensions of job satisfaction. International Journal of Geriatric Psychiatry, 27(3), 219-229.

Author Credibility	Journal & Year Of Publication	Context	Population	Type Of Paper
Author 1 - van den Pol-Grevelink, A. H index: 1 Author 2: Jukema, J. S. H index: 1 Author 3 - Smits, C. H. H index: 15 Key Affiliation: Windesheim University of Applied Sciences, Netherlands.	International Journal of Geriatric Psychiatry 2012 Impact factor: 2.866 Rank: Q2, 23/50 (Geriatrics and Gerontology)	Country- Netherlands Same healthcare context	Caregivers Setting: Aged Care Nursing Homes	Systematic Review

Research Summary

Research Summary	Data Collection & Analysis	Research Findings	Quality Research Assessment	Topic Relevance
Research design Systematic Review *Research question:* Do various forms of PCC affect job satisfaction differently and if characteristics associated with PCC and job satisfaction been evaluated?	Sample size: 7 studies DC: Literature search strategy with selection criteria and appraisal of study design using the Dutch Cochrane Centre 2010. No studies received a Cochrane score rated as high. The seven intervention studies measured 42 individual dimensions of job satisfaction. The models included Emotion-orientated care, snoezelen, small scale, resident-orientated care and demand-orientated care. DA: The heterogeneity of the study designs meant that the findings were presented in a narrative form.	Relevant Themes: Emotion-orientated care, snoezelen and small scale care had a positive influence on job satisfaction. Emotional exhaustion was reduced by snoezelen and small scale care. Less unplanned leave with resident-orientated care and was also had a positive effect on contextual autonomy. Conclusion: Results of search only included Dutch studies as relevant. Further research that is of high quality is required. Qualitative research could provide more insight into the adaptation and implementation of PCC.	CASP Systematic Review 9/10, Unable to combine results.	Relevant as it explores the effect on caregivers, however, the studies reviewed were partially similar to the PCC model used in this study.

Data Extraction

PCC In Aged Care	Value	Individualised Care	Perspective Of The Person	Positive Social Psychology
	PCC was shown generally to have positive influence on job satisfaction.			

18. Edvardsson, D., Fetherstonhaugh, D., McAuliffe, L., Nay, R., & Chenco, C. (2011). Job satisfaction amongst aged care staff: exploring the influence of person-centered care provision. International Psychogeriatrics, 23(8), 1205-1212.

Author Credibility	Journal & Year Of Publication	Context	Population	Type Of Paper
Author 1 - Edvardsson, D. H index: 14 Author 2: Fetherstonhaugh, D. H index: 6 Last Author: Chenco, C. H index: 2 Key Affiliation: Umea University, Sweden. La Trobe University, Australia	International Psychogeriatrics 2011 Impact factor: 1.934 Rank: Q3, 29/50 (Geriatrics and Gerontology)	Country- Australia Same healthcare context	Aged care staff Setting: Residential Aged Care	Single study

Research Summary

Research Summary	Data Collection & Analysis	Research Findings	Quality Research Assessment	Topic Relevance
Research design Cross sectional study *Research question:* What is the association between PCC and job satisfaction for aged care staff?	Sample size: n = 297 DC: Survey: P-CAT and MJS. DA: Descriptive statistics separating the participants into high and low level PC. PASW v18.0.	Relevant Themes: PCC = increased job satisfaction. Personalising care and organisational support (flexible management) was important for achieving PCC and job satisfaction. Conclusion: The need to provide possibilities to enable PCC through support systems and reflective practice.	CASP cohort	Relevant to my study

Data Extraction

PCC In Aged Care	Value	Individualised Care	Perspective Of The Person	Positive Social Psychology
Organisational support Flexible management	PCC provides a higher incidence of team spirit. Professional support is evidenced in PCC. Satisfaction with training Valued work by colleagues	Increasingly being able to care for residents in their preferred way linked to job satisfaction. Life story to individualise care		PCC – focusing on residents a priority Residents preference for activities

19. Citation of paper: Willemse, B. M., De Jonge, J., Smit, D., Visser, Q., Depla, M. F. I. A., & Pot, A. M. (2015). Staff's person-centredness in dementia care in relation to job characteristics and job-related well-being: a cross-sectional survey in nursing homes. Journal of Advanced Nursing, 71(2), 404-416.

Author Credibility	Journal & Year Of Publication	Context	Population	Type Of Paper
Author 1 - Willemse, B. M. H index: 6 Author 2 - De Jonge, J. H index: 29 Last Author - Pot, A. M. H index: 26 Key Affiliation: VU University, Netherlands	Journal of Advanced Nursing 2015 Impact factor: 1.741 Rank: Q1, 10/110	Country- Netherlands Same healthcare context	Nursing Staff Setting: Nursing Homes	Single study

Research Summary

Research Summary	Data Collection & Analysis	Research Findings	Quality Research Assessment	Topic Relevance
Research design Cross-sectional study *Research question:* What is the impact of nursing staff's PC with people with dementia on job characteristics and job related well-being?	Sample size: 1093 nursing staff (RNs and NAs) DC: Self-report questionnaires DA: Statistical analysis, multilevel hierarchical regression. Two levels due to healthcare workers being nested within the nursing homes.	Relevant Themes: Staff with high PCC attitude were more satisfied and competent to perform their job however, more prone to exhaustion. Conclusion: Creating a positive work environment where staff members feel supported, thus develop a confident and stronger workforce to achieve PCC and quality of care.	CASP cohort 12/12. Outcome: Include	Relevant as it identifies what staff value to achieve PCC.

Data Extraction

PCC In Aged Care	Value	Individualised Care	Perspective Of The Person	Positive Social Psychology
	Supervisor support Empowered to do their job Job satisfaction			Positive environment

20. Citation of paper: Buckley, C., McCormack, B., & Ryan, A. (2014). Valuing narrative in the care of older people: a framework of narrative practice for older adult residential care settings. Journal of Clinical Nursing, 23(17/18), 2565-2577.

Author Credibility	Journal & Year Of Publication	Context	Population	Type Of Paper
Author 1 – Buckley, C., H index: 2 Author 2 – McCormack, B., H index: 23 Author 3 - Ryan, A., H index: 13 Key Affiliation: University of Ulster, Northern Ireland	Journal of Clinical Nursing 2014 Impact factor: 1.255 Rank: Q2, 35/110	Country- Republic of Ireland Same healthcare context	Older people living in residential care Setting: Publically funded residential care facility.	Secondary research

Research Summary

Research Summary	Data Collection & Analysis	Research Findings	Quality Research Assessment	Topic Relevance
Research design: Qualitative hermeneutic study *Research question:* Can a narrative-based approach to practice development facilitate person-centred practice with older people in residential care settings?	Sample size: 12 clinical nurse managers and 8 residents DC: focus groups, Clinical Nurse Managers (CNUs) attended 4 and residents attended 1. Interviews with 46 resident interviews from a previous study were used to initiate discussion DA: Secondary data analysis. Four phases: 1.Identification of 12 themes 2. Focus Group analysis with the CNUs 3.Transcripts analysed by two independent experts (researchers) 4. Focus group analysis with residents	Relevant Themes: Narrative being Narrative Knowing Narrative doing Conclusion: Development of a narrative framework, as part of PCNF.	CASP tool for qualitative research: 10/10. Outcome: include	Provides data that is relevant to VIPS framework of PCC

Data Extraction

PCC In Aged Care	Value	Individualised Care (IC)	Perspective Of The Person	Positive Social Psychology
Personhood, humanistic, person-centred approach	Person seen as important Values identity	Life story/ experiences Preferences	Working with the person's beliefs and values.	Narrative doing, meaningful activities. Enhancing relationships

21. Citation of paper: Hunter, S., & Levett-Jones, T. (2010). The practice of nurses working with older people in long term care: an Australian perspective. Journal of Clinical Nursing, 19(3-4), 527-536.

Author Credibility	Journal & Year Of Publication	Context	Population	Type Of Paper
Author 1 - Hunter, S., H index: 3 Author 2 - Levett-Jones, T. H index: 18 Key Affiliation: University of Newcastle, Australia	Journal of Clinical Nursing 2010 Impact factor: 1.255 Rank: Q2, 35/110	Country- Australia Same healthcare context	Gerontology Nurses Setting: Long Term Care (LTC)	Single study

Research Summary

Research Summary	Data Collection & Analysis	Research Findings	Quality Research Assessment	Topic Relevance
Research design Mixed methods study *Research question:* What do RNs working with older people in LTC perceive and understand about their practice?	Sample size: Questionnaires 48 RNs and 16 Nurse Managers (NMs). Focus group (FG) interviews: 21 RNs and 11 NMs. Purposive sampling. DC: Questionnaires: RNs differed from NM as NMs were asked to report the frequency of an RN activities as a group. FG: Devised from RN position descriptions and analysed using the Questionnaires. DA: Questionnaires: Descriptive statistics-comparisons of nursing activity used Wilcoxon t test, Bonferroni correction to limit Type 1 error and the Kruskal-Wallis test to compare RN and NM data. FG Content Analysis.	Relevant Themes: RN role changing Includes some elements of PCC Conclusion: Need to further develop and research PCC.	CASP tool for qualitative research: 10/10. Outcome: include	Provides some evidence to RN understanding of PCC.

Data Extraction

PCC In Aged Care	Value	Individualised Care	Perspective Of The Person	Positive Social Psychology
		Some elements of PCC. Individualised care plans, including social needs		

22. Citation of paper: Bedin, M. G., Droz-Mendelzweig, M., & Chappuis, M. (2013). Caring for elders: the role of registered nurses in nursing homes. Nursing Inquiry, 20(2), 111-120.

Author Credibility	Journal & Year Of Publication	Context	Population	Type Of Paper
Author 1 - Bedin, M. G., H index: 2 Author 2 - Droz-Mendelzweig, M. H index: not rated Author 3 - Chappuis, M. H index: 1 Key Affiliation: University of Applied Sciences, Lausanne, Switzerland.	Nursing Inquiry 2013 Impact factor:1.439 Rank: Q1, 21/110	Country- Switzerland Same healthcare context	Gerontology Nurses Setting: Nursing homes	Single study

Research Summary

Research Summary	Data Collection & Analysis	Research Findings	Quality Research Assessment	Topic Relevance
Research design Qualitative descriptive study *Research question:* What is the role of the RN in Gerontological care?	Sample size: 16 (9 nursing homes) DC: Observation to gain insight of daily work practices and relationships. Focus group (protagonist) interviews, 2 for each group. DA: Qualitative content analysis.	Relevant Themes: Autonomous person-centred activities • Developed interpersonal skills to build and maintain relationships • Knowing the person to inform clinical judgement • Adjusting care processes through collaboration and reflection. Conclusion: The role of the RN is pivotal in a nursing home to ensure the well-being of the older people can be met.	CASP tool for qualitative research: 10/10. Outcome: include	Relevant to my study.

Data Extraction

Perspective Of The Person	Positive Social Psychology
Understanding the resident as a person. Welcome other person's feelings- empathy. Working with older people's beliefs and values. Support people's self-determination. Redirection of a person's scope of care through collaboration and reflection. RN steers the care team to adapt the environment to meet the person's uniqueness.	Building and maintaining relationships to enable a continuation of self thus a meaningful life.

23. Citation of paper: Edvardsson, D., Varrailhon, P., & Edvardsson, K. (2014). Promoting person-centeredness in long-term care: An exploratory study. Journal of Gerontological Nursing, 40(4), 46-53.

Author Credibility	Journal & Year Of Publication	Context	Population	Type Of Paper
Author 1 - Edvardsson, D. H index: 14 Author 2 - Varrailhon, P. H index: 1 Author 3 - Edvardsson, K. H index: 4 Key Affiliation: La Trobe University, Australia. University of Umea, Sweden	Journal of Gerontological Nursing 2014 Impact factor:1.024 Rank: Q2, 50/110	Country- Sweden Same healthcare context	Nurses Setting: Long term care	Single study

Research Summary

Research Summary	Data Collection & Analysis	Research Findings	Quality Research Assessment	Topic Relevance
Research design Qualitative descriptive study *Research question:* How do nurses implement person-centredness into LTC settings?	Sample size: 436 (personal care workers, assistant nurses, RNs, unit managers and unspecified others from 26 LTC facilities). Convenience sample DC: Written self-reports DA: Qualitative content analysis	Relevant Themes: Promoting decision making Promoting meaningful living Promoting pleasurable living Promoting personhood Conclusion: Nurses and managers need to value and dedicate time to promoting PCC activities. Nurse leaders through reflective practice to change culture and promote PCC through small talk, facilitating a pleasurable and meaningful environment and promoting personhood.	CASP tool for qualitative research: 10/10. Outcome: include	This study is relevant to my research.

Data Extraction

PCC In Aged Care	Value	Individualised Care	Perspective Of The Person	Positive Social Psychology
Personhood is central for facilitating PCC	Valuing the resident as a person.	Listening to life stories Respect people's choices.		Matching activities that the resident is interested in and supporting functional capacity. Choices for residents Having meaningful experiences in everyday life. Non judgemental Creating festivities.

24. Citation of paper: Edvardsson, D., Fetherstonhaugh, D., & Nay, R. (2010). Promoting a continuation of self and normality: Person-centred care as described by people with dementia, their family members and aged care staff. Journal of Clinical Nursing, 19(17-18), 2611-2618.

Author Credibility	Journal & Year Of Publication	Context	Population	Type Of Paper
Author 1 - Edvardsson, D H index: 14 Author 2 - D. Fetherstonhaugh H index: 6 Author 3 - Nay, R. H index: 13 Key Affiliation: University of Umea, Sweden and La Trobe University, Victoria	Journal of Clinical Nursing 2010 Impact factor: 1.255 Rank: Q2, 35/110	Country- Australia (rural and metropolitan) Same healthcare context	Staff, people (residents) with early onset dementia and family members of people with dementia. Setting: Residential aged care	Single study

Research Summary

Research Summary	Data Collection & Analysis	Research Findings	Quality Research Assessment	Topic Relevance
Research design Qualitative explorative study *Research question:* What is understood and described by people with dementia, their family members and the staff who work in residential care about the meaning of PCC.	Sample size: 37 staff, 11 people with early onset dementia (respite care), 19 family carers of people with dementia, through convenience sampling. DC: method: Maximum variation to obtain multiple perspectives and from different contexts. Individual, focus group and telephone interviews. DA: Qualitative content analysis	Relevant Themes: Promoting a continuation of self and normality. Content subthemes 1. Knowing the person. 2. Welcoming the family. 3. Providing meaningful activities. 4. Being in a personalised environment. 5. Flexibility and continuity of care and activities. Conclusion: Themes clinically relevant and can be used to operationalise PCC.	CASP tool for qualitative research: 10/10. Outcome: include	Very relevant as it is relates PCC descriptions to VIPS framework.

Data Extraction

PCC In Aged Care	Value	Individualised Care (IC)	Perspective Of The Person	Positive Social Psychology
Defined with the overarching theme. Promoting a continuation of self and normality.	Welcoming the family, trust and respect, involving them in care and keeping them informed.	Knowing the person, life history and personalised environment was essential for meaningful communication and activities, address health needs, thus knowing their preferences.	Being in a personalised environment	Meaningful activities enabled the person to contribute to their own and other lives. Personalising the environment.

APPENDIX 3: MUHREC ETHICS APPROVAL

MONASH University

Monash University Human Research Ethics Committee (MUHREC)
Research Office

Human Ethics Certificate of Approval

This is to certify that the project below was considered by the Monash University Human Research Ethics Committee. The Committee was satisfied that the proposal meets the requirements of the *National Statement on Ethical Conduct in Human Research* and has granted approval.

Project Number:	CF14/3869 - 2014002016	
Project Title:	Moving Person-centred Philosophy into Practice with Older People in Residential Care	
Chief Investigator:	Assoc Prof Cheryle Moss	
Approved:	**From:** 22 December 2014	**To:** 22 December 2019

Terms of approval - ***Failure to comply with the terms below is in breach of your approval and the Australian Code for the Responsible Conduct of Research.***

1. The Chief investigator is responsible for ensuring that permission letters are obtained, if relevant, before any data collection can occur at the specified organisation.
2. Approval is only valid whilst you hold a position at Monash University.
3. It is the responsibility of the Chief Investigator to ensure that all investigators are aware of the terms of approval and to ensure the project is conducted as approved by MUHREC.
4. You should notify MUHREC immediately of any serious or unexpected adverse effects on participants or unforeseen events affecting the ethical acceptability of the project.
5. The Explanatory Statement must be on Monash University letterhead and the Monash University complaints clause must include your project number.
6. **Amendments to the approved project (including changes in personnel):** Require the submission of a Request for Amendment form to MUHREC and must not begin without written approval from MUHREC. Substantial variations may require a new application.
7. **Future correspondence:** Please quote the project number and project title above in any further correspondence.
8. **Annual reports:** Continued approval of this project is dependent on the submission of an Annual Report. This is determined by the date of your letter of approval.
9. **Final report:** A Final Report should be provided at the conclusion of the project. MUHREC should be notified if the project is discontinued before the expected date of completion.
10. **Monitoring:** Projects may be subject to an audit or any other form of monitoring by MUHREC at any time.
11. **Retention and storage of data:** The Chief Investigator is responsible for the storage and retention of original data pertaining to a project for a minimum period of five years.

[redacted]

Professor Nip Thomson
Chair, MUHREC

cc: Dr Georgina Willetts, Ms Catherine Wilson

Postal – Monash University, Vic 3800, Australia
Building 3E, Room 111, Clayton Campus, Wellington Road, Clayton
Telephone +61 3 9905 5490 Facsimile +61 3 9905 3831
Email muhrec@monash.edu http://www.monash.edu.au/researchoffice/human/
ABN 12 377 614 012 CRICOS Provider #00008C

APPENDIX 4: RESEARCH INFORMATION SESSION

INFORMATION SESSION

RESEARCH AT [redacted]

PERSON-CENTRED PRACTICE WITH RESIDENTS AT [redacted]

When

Wednesday 25th Feb
1pm – 2pm

Where

Education Centre

Discussion
Why get involved
What will this involve
What does this project mean

WHO SHOULD ATTEND

RNs, ENs AND PCAs

Involved in caring for residents and who have been employed at [redacted] **for more than two months.**

PRESENTER

Master of Nursing student
Catherine Wilson

The School of Nursing and Midwifery
Monash University

APPENDIX 5: FLYER FOR RESEARCH PROJECT

RESEARCH PROJECT

Person-centredness in Residential Care

Are **you interested** in talking about **Person-Centred Practice** with residents at [redacted]

We are **inviting** interested **Registered Nurses, Enrolled Nurses and Personal Care Workers** involved in caring for residents and have been employed at [redacted] for more than two months to participate.

What will this involve?

Attending two group interviews that will each take 60 minutes. These will occur at [redacted]

- 1st interview: Thursday 5th March 2015
- 2nd interview: Thursday 26th March 2015

How to participate:

If you are interested and would like to know more please contact:

Master of Nursing student: Catherine Wilson

[redacted]

This research project has been approved by the Monash University Human Research Ethics Committee.

MONASH University

APPENDIX 6: EXPLANATORY STATEMENT FOR PARTICIPANTS

MONASH University

EXPLANATORY STATEMENT

(Focus Groups)

Project: Moving Person-centred Philosophy into Practice with Older People in Residential Care.

Chief Investigator's name:
Associate Professor Cheryle Moss
School Of Nursing and Midwifery
[redacted]

Student's name: Catherine Wilson
[redacted]

Other investigator:
Dr Georgina Willetts, School Of Nursing and Midwifery, Monash University, email:
[redacted]

You are invited to take part in this study. Please read this Explanatory Statement in full before deciding whether or not to participate in this research. If you would like further information regarding any aspect of this project, you are encouraged to contact the researchers via the phone numbers or email addresses listed above.

What does the research involve?

- This research is being undertaken by Ms Catherine Wilson for her Master of Nursing Qualification. The research is being supervised by Associate Professor Cheryle Moss and Dr Georgina Willetts. Catherine is a registered nurse.
- Person-centred philosophy is where people are valued and respected, treated as individuals and therapeutic relationships and teamwork are seen as important attributes for practice. The operationalisation of person-centred practice is not well understood.
- We aim to recruit 12 participants. Six participants will attend each focus group interview, Nurses, either registered nurses (RN) or enrolled nurses (EN), in one group and Personal Care Assistants (PCAs) in the other group. Participants will be asked to attend two focus group interviews and asked about their experiences of operationalising person-centred practice.
- Interviews will occur three weeks apart at a mutually agreed time. They will be held in a private room within [redacted] to ensure confidentiality and convenience as it will be in the participants work time. Each focus group interview will take approximately sixty minutes.

Why were you chosen for this research?

- You have been invited to participate in this research because you are a RN, EN or PCA, you have had at least two months experience working in [redacted] and you are working with person-centred philosophy.

- We have advertised this research throughout [redacted] and we made a call for RN, EN or PCAs. You are receiving this information because you identified yourself as a potential participant.
- Your knowledge, experience and insights into working with person-centred philosophy will be invaluable to this research.

Consenting to participate in the project and withdrawing from the research

- The consent process will involve signing the consent form and returning the consent form in the self-addressed prepaid return envelope.
- Participants can withdraw themselves from the research up until the time and date of the data collection.
- All participants are required to maintain confidentiality about the focus group members and the content of the discussion.
- Data once shared in the group setting, cannot be withdrawn from the focus group as it involves all members of the group.

Possible benefits and risks to participants

- There is no assurance that you will benefit from participation in this research. However, you are likely to benefit through sharing with colleagues in the focus group.
- Your participation in this study, together with the other participants will provide important information about operationalising person-centred philosophy. The research will have implications for practice assisting other clinicians in residential care to implement a person-centred philosophy and for education and policy development.
- We are aware of no foreseeable physical or emotional risk to you as a participant.

Services on offer if adversely affected

- If you feel distressed after completing focus group interview (highly unlikely) we suggest accessing the lifeline service (please contact 13 11 14).

Payment

- No payment and no rewards are offered for your participation in this project.

Confidentiality

- The group interviews will be held in a private room within the residential care facility to ensure confidentiality.
- All participants after signing the consent will be given pseudonyms to use when contributing to the focus group interview.
- The data will be collected by Catherine Wilson, Master of Nursing student. One of the research supervisors will be present and assist with the interview process. All information collected will be de-identified

Storage of data

- Interviews will be digitally recorded. Electronic de-identified data and coded versions will be on each of the investigators' computers that are password protected.
- Consent forms with personal identification information will be stored separately in a locked filing cabinet in the chief investigator's office (Associate Professor Moss) at Monash University.
- Files will be destroyed after ten years.

Results

Results will be made available to participants. Please complete the contact details section on the consent form. The results will be sent to you when the research has been completed.

Complaints

Should you have any concerns or complaints about the conduct of the project, you are welcome to contact the Executive Officer, Monash University Human Research Ethics (MUHREC):

Executive Officer

Monash University Human Research Ethics Committee (MUHREC)

Room 111, Building 3e

Research Office

Monash University VIC 3800

[redacted]

Thank you,

[redacted]

Associate Professor Cheryle A. Moss

APPENDIX 7: C0NSENT FORM (NURSING GROUP)

CONSENT FORM

Nursing Group

Project: 'Moving Person-centred Philosophy into Practice with Older People in Residential Care'

Chief Investigator: **Associate Professor Cheryle Moss**
Other investigators: **Dr Georgina Willetts, Ms Catherine Wilson**

I have been asked to take part in the Monash University research project specified above. I have read and understood the Explanatory Statement and I hereby consent to participate in this project.

I consent to the following:	Yes	No
Audio recording during the interview / focus group	☐	☐
Taking part in a focus group of up to six people	☐	☐
I will maintain confidentiality and not reveal to other people the identity of focus group participants or share information that is disclosed during the focus groups	☐	☐
Receiving a summary report of the research findings when the study is completed	☐	☐
The data that I provide during this research may be used by the researchers in future research projects	☐	☐

Contact email or postal address (researchers will send the final report):

_____

Name of Participant_____

Participant Signature_____

Date_____

MONASH University

APPENDIX 8: CONSENT FORM (PERSONAL CARE ASSISTANT GROUP)

CONSENT FORM

Personal Care Assistant Group

Project: 'Moving Person-centred Philosophy into Practice with Older People in Residential Care'

Chief Investigator: **Associate Professor Cheryle Moss**
Other investigators: **Dr Georgina Willetts, Ms Catherine Wilson**

I have been asked to take part in the Monash University research project specified above. I have read and understood the Explanatory Statement and I hereby consent to participate in this project.

I consent to the following:	Yes	No
Audio recording during the interview / focus group	☐	☐
Taking part in a focus group of up to six people	☐	☐
I will maintain confidentiality and not reveal to other people the identity of focus group participants or share information that is disclosed during the focus groups	☐	☐
Receiving a summary report of the research findings when the study is completed	☐	☐
The data that I provide during this research may be used by the researchers in future research projects	☐	☐

Contact email or postal address (researchers will send the final report):

_____

Name of Participant_____

Participant Signature_____

Date_____

MONASH University

APPENDIX 9: FOCUS GROUP SCHEDULE

Focus Group Interviews

Thursday, March 05, 2015
Welcome and Signing Consent Forms
Introduction

- Person-Centred Care
- Purpose of Research

Interview Questions
A) Person-centred Care
What does person-centred care mean to you?
Example Trigger Questions

1. How do you interact with the people you care for and work with?
2. How do you include the people you care for in decisions about their own care?
3. How do find out what the people you care for like and dislike?
4. Do you know why the person is living in [redacted]?
5. What do you like about providing person-centred care?
6. What things you would like to do to promote more person-centred care?

B) Valuing People
We would like to find out about how you value people at [redacted].
Example Trigger Questions

7. What is the hardest part of valuing others?
8. What is the easiest part of valuing others?
9. At [redacted] how do you value the residents in your care?
10. What situations at work help you to be a functional member of a team?
11. Can you talk about how you value the people that you work with?

C) Individualised Care
We would like to find out about how about how individualised care works at [redacted]
Example Trigger Questions

12. What obstacles do you face when you try to provide individualised care?
13. What freedoms and support help you to provide individualised care?
14. Can you give some examples of excellent individualised care that happens at [redacted]?
15. Please give some examples of areas where individualised care could be improved at [redacted].

D) Seeing Other People's Perspectives
We would like to find out about ways of seeing other people's perspectives.
Example Trigger Questions

16. Please tell us about situations at work where you try to see other people's perspectives.
17. What is 'hardest' about seeing other people's perspectives?
18. What is 'easiest' about seeing other people's perspectives?

19. Can you give some examples of when seeing other people's perspectives commonly happens at [redacted]?
20. Please give some examples of situations where seeing other people's perspectives could be improved at [redacted].

E) 'Positive Social Psychology'

We would like to find out about how about how you use 'positive social psychology' at [redacted].

Example Trigger Questions

21. What situations trigger you to tell people they are doing well?
22. In what situations do you like to help people to learn?
23. What situations at work enable you to include people in their own care?
24. What situations at work enable you to include people in activities they value?
25. What are examples of situations at work where the reverse happens (e.g. Q20-24)?
26. What is the best thing about [redacted]?

Final Questions, comments, summary & closure
Thursday, February 26, 2015

Reflection

We are interested in what you do as a provider of person-centred care with residents at [redacted]
Prior to the next focus group interview could you reflect on your practice and provide examples of what you and your team do to promote person-centred care. When providing details please do not use any names or other identifiable information.

Thank you