Person-Centered Care Training in Long-Term Care Settings: Usefulness and Facility of Transfer into Practice*

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RÉSUMÉ

Les approches de soins centrées sur la personne sont de plus en plus recommandées en vue d'améliorer la qualité des soins de longue durée. Au Québec (Canada), l'approche relationnelle de soins a été implantée dans plusieurs établissements. Cette étude porte sur le point de vue des soignants formés sur l'utilité de cette approche ainsi que sur leur capacité à la transférer en pratique. Des questionnaires comportant des questions ouvertes ont été administrés un mois après la formation (n=392). Les réponses ont été catégorisées selon une approche qualitative. Les répondants perçoivent que certaines dimensions de l'approche sont hors de leur portée ou s'opposent à leurs croyances. Ils rapportent des pressions liées aux contraintes temporelles, à leurs collègues ainsi qu'aux familles des résidents. Ces résultats indiquent que la formation ne suffit pas à transformer les pratiques. Il faut également agir sur les croyances des individus ainsi que sur les situations de travail

ABSTRACT

The person-centered approach is increasingly recommended in long-term care facilities to increase quality of care. In Quebec, Canada,. caregivers were specifically trained in "relationship-based care. "This study analyzed caregivers' assessment of this approach's usefulness and their capacity, after training, to apply it to care practices. Questionnaires with open-ended questions were administered to caregivers ($n = 392$) one month after training. Caregivers' answers were categorized using a qualitative approach. Respondents perceive some features of this approach are beyond their reach or in opposition to their beliefs. They reported feeling pressure related to time constraints, their peers and the families of residents. These results indicate that training itself is insufficient to transform practice. Institutions wishing to implement such an approach must also act upon the beliefs of individuals, as well as upon work situations.

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Context

As the population ages, health care systems are striving to establish quality residential and long-term care services for seniors experiencing decreasing autonomy. In Quebec, residential and long-term care centers (CHSLDs) – known as nursing homes in the United States – must maintain high-quality services in a context characterized by serious difficulties recruiting and retaining staff and a gradual worsening of clients' conditions in terms of physical and cognitive autonomy (MSSS, 2003). Cognitive impairment often entails problem behaviors. For example, the prevalence of psychological and behavioral symptoms related to dementia among CHSLD residents is between 55 and 85 per cent (Beck et al., 2002). Moreover, dementia is often accompanied by aggressive behaviors, either physical or verbal. According to a study carried out in Quebec, more than one out of five residents exhibit disruptive aggressive physical or verbal behaviors, and approximately one out of ten residents exhibit both forms of aggressive behavior (Voyer et al., 2005). These behaviors affect not only the quality of life of the residents, but also that of their families, friends, and formal caregivers (Pitkala, Laurila, Strandberg, & Tilvis, 2004). Indeed, caregivers struggle with major physical and mental health problems. Because of the nature and context of the caregiving occupation, workers are confronted not only with stress, work overload, and a lack of time, resources, flexibility, and equipment, but also with the precariousness of life, the aggressive behaviors of residents and their families or co-workers, and their own limitations (Shields & Wilkins, 2006).

To meet the needs of aging persons living with dementia, health care professionals have developed new approaches to care, including the "person-centered care approach" (PCCA). This approach, which is based on a humanistic concept, suggests that, rather than focusing only on the disease of dementia, caregivers regard the whole life experience and capacities of persons living with dementia (Kitwood, 2008). From the perspective of long-term care, this concept entails a set of practices aimed at helping the person with dementia enter into a relationship (with formal and informal caregivers, and with other residents) – what we call "Being in a relationship" – and to be seen as having a life history and his/her own interests (what we call "Being in a social world"). The person-centered care approach also implies a favorable context, particularly in terms of the organization of the nursing staff's work ("Being in place"), and a desire to respect the values and preferences of persons when providing care ("Being with self") (McCormack, 2004). This approach has been widely studied in the extensive literature on long-term care (Edvardsson & Innes, 2010; McCormack, 2004). This approach can be an alternative or a complement to pharmacological treatments aimed at reducing the disruptive behaviors of persons with dementia (Cohen-Mansfield & Mintzer, 2005; Kong, Evans, & Guevara, 2009; Sloane et al., 2004).

The implementation of care models consistent with this approach implies a major change in culture in the long-term care setting (Miller et al., 2010; White-Chu, Graves, Godfrey, Bonner, & Sloane, 2009), and caregiver training is an essential facilitating factor for this change. The research presented here focuses on one model of person-centered practice called "relationship-based care" (RBC). The aim of this study, conducted one month following the RBC training, was to analyze trained formal caregivers' assessment of the usefulness of this approach and to analyze their capacity to transfer skills acquired during training to their care practices, as well as to identify facilitating and impeding factors in this regard.

The *Association pour la santé et la sécurité du secteur des affaires sociales* (ASSTSAS, association for health and safety in the social affairs sector)[1] has developed and widely disseminated RBC in Quebec since 2002, supporting long-term care institutions through training. Between 2005 and 2008, 35 long-term care institutions in Quebec implemented RBC in more than 73 facilities. The goal of RBC is to improve the quality of care provided to residents while contributing to greater job satisfaction and improving the occupational health and safety of caregivers, particularly by reducing the disruptive behaviors exhibited by residents. To this end, RBC training aims to teach caregivers theoretical knowledge and practical skills that are consistent with the four components of person-centered approaches. Specifically, as Table 1 shows, RBC content revolves around two main goals: (a) providing relationship-based care (initial contact, maintaining contact with the resident, and adapting to his/her feedback, using communication and touching techniques), and (b) selecting and implementing, individually and with the care team, care practices which foster the resident's autonomy and which respect his/her preferences.

RBC differs from other practice models based on the person-centered approach in two respects. First, RBC puts forward a technique that helps to relax muscle

Table 1: Elements of relationship-based care (RBC) training

Aim of the Training	Main Content of RBC Training

Providing relationship-based care	**Theoretical knowledge**
	■ Humanistic foundation for care (seeing the resident as a person, not only as a patient)
	■ Resident's processing of information (information input and response output, processing of tactile information, memory, etc.)
	■ Knowledge about communication (e.g., psychological effects of communication, paradoxical communication) and interaction (Pygmalion effect: influence of a person's expectations on the behavior of another person)
	
	Practical skills
	■ Focusing on initial contact: entering into a relationship right from the start of the care procedure (introducing yourself, touching the resident, looking the resident in the eye)
	■ Using communication techniques:
	  o Announcing the actions you are going to take and describing them as you are carrying them out; giving clear and positive instructions
	  o Referring to the resident's life story: for example, focusing the conversation on topics that are of interest to the resident or humming a tune that is familiar to the resident
	  o Avoiding paradoxical communication (e.g., offering a choice that cannot be respected)
	  o Encouraging the resident
	■ Being focused on the resident (maintaining eye contact, taking feedback into account), in particular during team care delivery
	■ Using touching techniques:
	  o Using gentle touch to move arms or legs (no pinching or grabbing)
	  o Using massage techniques to relax muscular contractions and gain access to various parts of the body
	■ Maintaining resident's comfort during care – for example:
	  o Starting with the least sensitive parts of the body
	  o Keeping the parts of the body warm that have already been washed or are waiting to be washed
	  o Using a washcloth to block and thus soften the spray from the showerhead

Selecting and implementing, individually and with the care team, care practices that foster the resident's autonomy and respect his/her preferences	**Theoretical knowledge** ■ Principle of adaptability: adapting to the specific needs and preferences of residents ■ Importance of vertical mobilization: developing or maintaining the capacity to stand up, even a few minutes per day **Practical skills** ■ Contributing to the attribution of care (i.e., the decision by the team regarding what care to provide according to the resident's capacities, needs, and preferences, based on a rehabilitation evaluation) ■ Carrying out care procedures: providing the care decided on by the team, including stand-up time (if possible) ■ Asking the residents to participate in their care, within their capacities (e.g., washing their own face) ■ Respecting resident's preferences

contractions, thus facilitating access to certain parts of the body for washing when that task is required. This technique involves massaging the antagonistic muscle and then massaging the tendons of the contracted muscle, until the contraction is relaxed. The second respect in which RBC differs is that RBC is characterized by the great importance it attaches to vertical mobilization. Thus, it requires developing and maintaining the capacity of all residents, depending on their limitations, to stand up (or at the very least to sit up), even just for a few minutes a day, until the end of their lives.

The ASSTSAS developed an entire RBC implementation process, which Table 2 summarizes. The process consists of a first phase focused on training a dozen or so caregivers (mostly patient care attendants and nurses' assistants), and ideally would include the person in the institution who is responsible for implementing the approach (this person becomes the project leader).

A later phase involves training the trainers. The latter are recruited among the first caregivers who receive the basic training and who then become peer trainers in their work setting. Subsequently, the ASSTSAS trainers provide follow-up for the trainers, on an as-needed basis. This training is provided mostly to patient care attendants and, in a smaller proportion, to other staff categories: nurses, nurses' assistants, occupational therapists, physiotherapists, and recreation technicians.

The basic training takes place over two days. Various teaching and learning strategies are used, including interactive presentations, experience sharing, videos, and demonstrations involving residents in care units. These activities allow the trainees to learn the theoretical foundations of RBC and to develop the practical skills required by this approach (see Table 2). This training is followed by a second stage involving a half-day of coaching, during which each participant carries out two

Table 2: RBC implementation process

Stages	Activities Involved	Actions of the ASSTSAS Trainer
Start-up	■ Appointing a project leader ■ Obtaining the support of local unions ■ Meeting, as needed, with the caregiving staff and managerial staff in charge of the project	■ Assists in project start-up ■ Checks eligibility conditions ■ Confirms that rehabilitation resources are available in the institution
Basic training (2 days)	■ Forming a group of voluntary participants (approx. 10 participants, including 5 future trainers and the project leader) ■ Freeing up and replacing staff	■ Provides basic training
Coaching (0.5 day)	■ Each participant carries out 2 care procedures under the trainer's supervision	■ Supervises care delivery and provides feedback to participants ■ Identifies issues to be discussed during the consolidation stage
Consolidation (3 hours)	■ Meeting with participants and managerial staff in the institution, 1 month after training ■ Assessing acquired knowledge and skills as well as prospects for RBC in the institution	■ Administers the training evaluation questionnaire* ■ Leads the meeting
Training the trainers	■ Classroom component (lecture style teaching, demonstrations, role plays): 3 days ■ Component involving experimentation supervised by the project leader ■ Consolidation and certification: 1 day	■ Trains the trainers ■ Provides support during the experimentation stage ■ Administers the training evaluation questionnaire to trainers ■ Certifies the trainers ■ Participates in a social activity with the new trainers to validate this stage
Dissemination in the work setting	■ Deployment of the basic training by the certified peer trainers ■ Peers monitoring (coaching)	■ Provides support as needed

* This questionnaire is the data source of this study

care procedures under the supervision of the trainer, who provides the trainee with personalized feedback. The last stage in the RBC training process is the consolidation stage (one half-day) in which all trained participants and their immediate supervisor are brought together to review the entire approach and discuss the issues involved in RBC implementation, four weeks after the training.

Current Knowledge

Studies conducted in the long-term care sector indicate that the knowledge acquired in a training situation does not always lead to the transposition of acquired skills to the work situation (Aylward, Stolee, Keat, & Johncox, 2003; Beck, Ortigara, Mercer, & Shue, 1999; Bourgeois, Dijkstra, Burgio, & Allen, 2004; Chao, 2005). From this perspective, current knowledge on the transfer to a work setting of skills developed in training among caregivers working in long-term care provides a number of possible avenues for investigation. According to numerous authors, to effectively change care practices in long-term care facilities, it is necessary to act on the skills of individuals and to ensure that the work situations facilitate the transfer of skills acquired in training. Moreover, these authors also point out the

need to plan for measures to reinforce and maintain these skills over time.

Acting on Skills and Individual Predispositions through Training

For a sustainable transformation of practices in long-term care, Aylward et al. (2003) suggested that training programs should aim not only at developing the skills of individuals (through knowledge and skills acquisition) but also at changing individuals' beliefs. According to these authors, this transformation appears to be fostered by the use of experiential active-learning strategies: role playing, simulations, group discussions, videos followed by a debate, case studies conducted in teams, and so on. These learning activities aim at both (a) the acquisition of concrete care strategies and (b) the development of a reflective position on one's care practices. Numerous studies indicate that such mechanisms generate learning processes that are richer and more easily transferable to practice situations (Beck et al., 1999; Braun, Cheang, & Shigeta, 2004; Kemeny, Boettcher, DeShon, & Stevens, 2006). Other conditions that are conducive to the success of training include, for example, reliance on prior analysis of the training needs expressed by the learners as well as on their individual

characteristics (different learning styles, cultural sensitivities, and initial educational level) (Aylward et al., 2003; Beck et al., 1999). According to Beck et al. (1999), adequate training of the trainer also constitutes an important condition for success.

Conceiving a Work Situation that Facilitates the Transfer of Acquired Skills

The successful implementation of person-centered care approaches cannot be limited to the acquisition of skills by caregivers. It also requires adapting the entire context of care (care practices, work organization, and physical environment) to the needs and preferences of both residents and caregivers, such as through flexibility in organizing meals, personal hygiene care, and rest (Cohen-Mansfield & Parpura-Gill, 2007; Kemeny et al., 2006). This flexibility also implies flexibility in work organization (e.g., work hours and time constraints). This adaptation should be based on a joint concern for continuity and quality of care, and for consideration of caregivers' needs (Cohen-Mansfield & Bester, 2006). Lastly, it is also necessary to adapt the physical environment (Glouberman, Richards, El Bestawi, Seidman-Carlson, & Teperman, 2007; Hoeffer et al., 2006). Living environment adaptations may involve the equipment used (e.g., use of shower stretchers or terry towels for bathing patients), normalizing decoration (for example by hiding medical devices and using domestic decoration items to create an environment as «home-like» as possible) or physical conditions (comfortable heat, subdued lighting, and so on). These changes may involve reviewing the architectural design of the building, such as the arrangement of rooms and units, and connections between the different areas (Cohen-Mansfield & Parpura-Gill, 2007). Moreover, for a sustainable transformation of care practices, PCCA implementation projects should involve favorable working conditions, including a reduction in time constraints and a work organization that is conducive to teamwork (Aylward et al., 2003; Burgio et al., 2002; Cohen-Mansfield et al., 2006; Emilsson, 2006). Organizational conditions must also be addressed, including the quality of supervision carried out by the immediate supervisors, the commitment of senior management, and the integration of this approach into the organization's mission (Buelow, Winburn, & Hutcherson, 1998; Emilsson, 2006; Kaskie, 2004; Shaller, 2007; Stolee et al., 2005).

Planning for Measures to Reinforce and Maintain Practices over Time

There appears to be a consensus that specific training, even when based on experiential learning mechanisms, is not enough to achieve meaningful and lasting results in terms of learning and transfer to practice (Aylward et al., 2003). Consequently, several studies have shown that mechanisms for follow-up, supervision, or reinforcement must be put in place (Bourgeois et al., 2004; Burgio et al., 2002; Hoeffer et al., 2006; Stolee et al., 2005). These mechanisms can take various forms: (a) continuous evaluation; (b) regular communication of progress to employees, residents, and their families and friends; (c) granting sufficient financial resources to maintain practices; and (d) exchanging knowledge with other services or agencies (Shaller, 2007; Stolee et al., 2005). This follow-up can also involve discussions of cases at work team meetings (Buelow et al., 1998) or can be based on observations of care procedures (Bourgeois et al., 2004; Burgio et al., 2002; Hoeffer et al., 2006).

Research Objectives

The general objective of this study was to document, shortly after training, the trainees' perceptions regarding the usefulness of RBC and the trainees' capacity to transfer the skills acquired in training to their actual care practices. More specifically, this study aimed to contribute in an exploratory way to the two following specific objectives:

(1) Identifying the dimensions of RBC deemed by the caregivers to be the most helpful and the easiest to integrate into their work and describing the caregivers' justifications for this, and

(2) identifying the dimensions of RBC deemed by the caregivers to be the most difficult to integrate into their work and describing the caregivers' justifications for this.

Methodology

Study Population

The population under study consisted of all workers – 420 people – who participated in the training provided by an ASSTSAS trainer between 2004 and 2008.

Study Variable, Study Design, and Data Source

The variable studied was the trainees' perception of their capacity to integrate RBC into their care practices, rather than its integration. The perception of individuals on a given subject is considered here as a construct related to their personal experience, potentially having multiple dimensions. This phenomenon was thus addressed according to a constructivist epistemology (Berger & Luckmann, 1966). In developing the RBC training, the ASSTSAS trainers devised their own in-house training evaluation questionnaire with the aim of continuously improving their practices. The study design we used is a descriptive study based on a survey designed for administrative evaluation purposes by the ASSTSAS. This study therefore presents a secondary analysis of data. The survey method used was a pencil-and-paper questionnaire with open-ended

questions (Roulston, 2008). We conducted a content analysis of the participants' responses (Krippendorff, 2003). Our rationale for the design selection follows: (1) the questionnaire was already developed and used by the ASSTSAS trainers, which allowed us to gather a large amount of data covering a five years' period; and (2) in questionnaires, open-ended questions are relevant to generate data about a participant's point of view, without influencing the responses or suggesting answers. Those questions allow participants to highlight the topics that are meaningful to them. Also, with those questions, the respondent must perform a cognitive task in order to answer; open questions also encourage more participation in the survey than closed questions only (Ballou, 2008).

The questionnaire was completed anonymously by all the trainees when they met during the consolidation stage, one month after the training. The open-ended questions, whose answers were analyzed as part of this study, are presented in Table 3. The data provided by the ASSTSAS were already grouped together for each training session as opposed to individual data. The numbers shown in parentheses in the tables of results (see Tables 4 through 7) thus refer to the groups rather than to individual participants. For example, G22 means the unit of meaning comes from data from the 22nd group.

Participants in the Study

Of all workers who participated in the training provided by an ASSTSAS trainer between 2004 and 2008, 392 participants (94%) completed the questionnaire. Since

Table 3: Number of coded units of meaning attributed to each question of the questionnaire (tables of results 4 to 7)

Tables and Questions of the Questionnaire	Number of Coded Units of Meaning
Table 4	
In your view, which component of the RBC training is the most helpful for your work?	848
In your view, which component of the RBC training is the easiest to integrate into your work?	663
Table 5	
Why is this component of the training the most helpful?	104
Why is this component of the training the easiest to integrate in your work?	309
Table 6	
In your view, which component of the RBC training is the most difficult to integrate into your work?	381
Table 7	
Why is this component of the RBC training difficult to integrate in your work?	434
Total	**2,739**

the questionnaire did not contain socio-demographic data, it was impossible to further specify the profile of participants. Nevertheless, a previous study [33] Poulin et al. (2004) focusing on the same training demonstrated that 75 per cent of participants in the training were patient care attendants or nurses' assistants. The other respondents were nurses (16%) or other health professionals (9%) such as physical rehabilitation therapists or psychologists. The ASSTSAS mentor-trainers were of the opinion that the profile of the respondents of all questionnaires was similar to that of the previous study. The respondents all belonged to one of 41 training groups made up of participants from 43 public and private long-term care facilities. These institutions were distributed among 14 regions of Quebec. Three of these regions – National Capital (03), Mauricie (04), and Montréal (06) – accounted for 51 per cent of participants. On average, the training groups included 9.8 participants, and 75 per cent of the groups included between 9 and 12 participants.

Data Analysis

The answers to the open-ended questions were subject to a systematic content (Krippendorff, 2003). Each open-ended question's answers were considered as a coding unit: that is, they were described (categorized) as separate units. For each open-ended question's answers, units were created with categorical distinction (i.e., because they had something in common). Those units could be a full respondent's answer, a single sentence, or a series of words. A total of 2,733 units of meaning were identified and then categorized. Some categories were created by referring to RBC aims and content as described in the participants' manual (ASSTSAS, 2007). Some other categories emerged from the participants' point of view, according to the grounded-theory perspective (Strauss & Corbin, 1990). The categories of meaning were first determined based on four questionnaires selected at random. These categories were subsequently tested with other questionnaires and then enriched and refined based on the companion training documents developed by the ASSTSAS and through discussions with one of the training developers. The coding was subject to interjudge agreement within the research team (two persons). Table 3 presents the number of coded units for each of the questions analyzed and shows how those units were grouped together in the results tables.

The results obtained in this way were then interpreted and discussed in light of the existing literature on the person-centered care approach. We also presented the results to a group of about 30 caregivers – in the context of a knowledge transfer event that was organized by the ASSTSAS (Viau-Guay & Feillou, 2011) – as well as to the ASSTSAS trainers. This validation process enabled

Table 4: Categorization, weighting of units of meaning, and examples of units about the components of the RBC training deemed to be most helpful and the easiest to integrate into the work setting

Component	Subcategories	Weighting of Units (%) Most Helpful	Weighting of Units (%) Easiest	Examples of Units of Meaning
Practical skills to provide relationship-based care	Initial contact	21.1	24.4	*I think everything hinges on the first contact we make with the person (looking at them, touching them). Everything happens at the beginning when we first enter a room. I didn't used to do this very often but now it has become a priority. (G22)**
	Communication	15.5	21.1	*Sometimes in the work routine, we forget to tell the person what we are about to do; the training has helped me do that. (G03)* *I became aware of paradoxical communication: I'm careful now, I think twice before giving instructions to the client. That's been helpful. (G39)*
	Touch	15.5	16.3	*Applying the method to relax muscular contractions. (G08, G11)* *Remembering not to pinch or grab. (G29) Touching the residents gently. (G24)*
	Eye contact	4.3	2.7	*Positioning ourselves in such a way that the patient always has eye contact with us. (G09)* *Maintaining eye contact. (G24)*
	Subtotal	56.4	64.5	
Practical skills to foster the resident's autonomy	Mobilizing the resident's capacities	9.0	9.1	*Avoiding doing things for the residents that they can do for themselves. (G01, G27)* *Letting the residents do what they can: for example, combing their own hair, washing their own face, etc. (G13)* *The easiest would be encouraging residents to perform activities. (G04)*
	Being responsive to the resident's feedback	6	3.8	*Adapting to the client according to their capacity and preferences: for example, washing a client in bed instead of going to the bathtub because they're tired today. (G28)* *Analyzing good feedback and less-positive feedback. (G20)*
	Care procedures and attribution of care	3.3	5.9	*Evaluating the level of assistance a client needs (it's surprising what the clients can do). (G37)* *Using the body protocol as a tool in my interventions with the clients. (G24) Trying new things. (G15)*
	Vertical mobilization	3.2	3.0	*Making the residents who can, walk. Often, when a resident is installed in a geriatric chair, we tend to forget that they can still be mobile. (G15)* *Helping residents stay on their feet or get back up, and helping them to walk. (G6)*
	Subtotal	21.5	21.8	
Others	Humanistic foundation for care	11.3	11.6	*Humanitude, respect for our seniors. (G20)* *I put myself in the client's shoes and try to understand her/his needs. It's easier to make others understand that respect for the individual is important since you just have to put yourself in the other person's shoes. (G24)*
	Overall approach	6.7	0.8	*All the components that make up relationship-based care help us to focus better on the client. The task itself necessarily becomes less central because otherwise it becomes detrimental to the client. (G13)*
	Knowledge about residents' cognitive functioning and memory	2.2	0.9	*Working with the resident's procedural memory. (G30)* *The one about cognitive functioning, about using the different types of memory a person has – that opens up a whole bunch of alternatives for carrying out a care procedure. (G24)*
	Teamwork techniques	1.8	0.4	*Using diversion when we can work as a team, with one person carrying out a task while the other gets the client's attention and talks to him. (G10)* *The training helped improve teamwork. (G09)*
	Subtotal	22	13.7	
TOTAL		99.9	100	

* Since data were pooled and cannot be linked to individual participants, units of meaning sources indicate the example's source referring to the group (e.g., G24 meaning the example comes from the group 24 data).

Table 5: Categorization, weighting of units of meaning, and examples of justifications regarding the components of the RBC training deemed to be the most helpful and the easiest to integrate into work setting

Categories	Subcategories	Weighting of Units (%)	Weighting of Units (%)	Examples of Units of Meaning
		Most Helpful	Easiest to Integrate	
Perceived positive effects of RBC	On occupational health and safety	18.2	3.2	*When we use the right techniques, it's much less strenuous. (G05)* *There are no surprises and they (i.e., the patients) don't get agitated (aggressive). (G27)*
	On the quality of the relationship	17.3	6.8	*These (techniques) are beneficial for both them and us. (G11)*
	On the ease of providing care	16.4	16.2	*(It) helps us provide better care because, when we get their attention, they listen to instructions better, and it gives us more time. (G9)*
	On the well-being of residents	16.4	11	*(These methods) help patients trust us more and understand better what's happening around them. (G27)* *It reduces the residents' pain and makes it easier to provide care. (G23)*
	On the job satisfaction of caregivers	15.4	6.8	*I'm more relaxed; the residents come to me more freely. (G09)*
	Subtotal	**83.7**	**44**	
Personal and professional factors	Consistent with caregivers' current practices and easy to understand/put into practice	0	26.2	*I already tend to do it naturally. (G24)* *I feel like I already apply this approach pretty regularly in my everyday practices, encouraging them. (G11)* *These are simple things. (G08)* *Because it's easy to grasp the importance of this, and it's easy to remember. (G30)*
	Consistent with caregivers' capacities and values	0	15.6	*Contact with others is pretty easy for me, and I enjoy applying this way of doing things. (G31)* *For me, these are basic principles or values. (G27)* *Because I like working with older people, and I really appreciate having the chance to connect with them. (G10)*
	Consistent with caregivers' professional identity	0	4.5	*Vertical mobilization because I work in rehabilitation .... (G21)*
	Subtotal	0	**46.3**	
Compatibility with actual work setting	RBC applied by all staff/Institutional project	11.8	0	*We are currently adapting the living environment so this goal is a main focus right now. (G15)*
	RBC is within their power to implement	0	5.2	*Any approach that involves just me in the sense that I work alone, nobody else interferes and, especially, whatever I say and think is for the good of the client. (G21)* *Anything we do on our own with the client as part of our regular work. (G40)*
	RBC does not take longer	0	2.9	*It doesn't take me longer; I just have to use my time better. (G19)* *When we take the time to describe what we're doing, we actually save time. (G13)*
	Enough resources: time, staff, and equipment	2.7	0	*Avoiding doing things for clients that they can do for themselves: this would be more helpful if we weren't always tight for time. (G17)* *In an ideal world (!!), all the aspects of this training would be really, really helpful, even necessary, for my job. But since we don't live in that world, I will use as much of the content as possible depending on the schedule, the time I have, and the physical environment I'm working in. (G2)*
	Organizational conditions	1.8	1.6	*Because this approach is already promoted by most of the staff in the institution. (G23)* *It's the easiest because it doesn't require … any extra equipment and if everyone does it, it will create a momentum. (G31)*
	Subtotal	**16.3**	**9.7**	
Total		**100**	**100**	

Table 6: Categorization, weighting of units of meaning, and examples about the components of the training deemed to be the most difficult to integrate into the work setting

Categories	Subcategories	Weighting of Units (%)	Examples of Units of Meaning
Practical skills to foster the resident's autonomy	Mobilizing the resident's capacities	22.6	Taking the time to let the residents do what they can do on their own and at their own pace. (G27) Avoiding doing things for the residents that they can do for themselves. (G38)
	Care procedures and attribution of care	17.3	Choosing care actions based on the client's needs. (G25) The attribution of care. (G23)
	Vertical mobilization	14.4	Helping residents get back on their feet. (G12)
	Being responsive to the resident's feedback	7.6	Adapting to the patient, for example, regarding bath time. (G05)
	Subtotal	**61.9**	
Practical skills to provide relationship-based care	Communication	11.0	Announcing what I'm going to do. (G11) Not using pat phrases like "don't be afraid" our "this won't take long" which have just become a reflex. (G37)
	Touch	10.3	Relaxing muscular contractions. (G30) Integrating the approach into our gestures (paying more attention to the client). (G39) Muscular contractions and the techniques involved aren't completely integrated into my work. (G21).
	Initial contact	3.4	During a care procedure, if you lose contact with the client, it can be hard sometimes to re-establish communication. (G12)
	Eye contact	0.8	For people with cognitive impairment, establishing and maintaining eye contact during their care. (G14)
	Subtotal	**25.5**	
Others	Teamwork	6.6	Everything that involves team decisions: keeping residents on their feet, the attribution of care and choices regarding personal hygiene care. (G38) The difficulty of follow-up, making sure there's continuity on the part of the whole staff. (G24)
	Overall approach	6	They [RBC principles] are all difficult. (G10) Making the right choices: not just focussing on what you have to get done but rather putting the emphasis on maintaining a harmonious relationship vs. getting the task done at all costs. (G11)
	Subtotal	**12.6**	
Total		**100**	

us to ensure that the results met constructivist paradigm scientific criteria, that is, trustworthiness and credibility for the community (caregivers and trainers) as well as transferability to other long-term setting contexts (Denzin & Lincoln, 2011).

Findings

The findings are presented here according to each of our two aforementioned objectives.

> *Objective 1: Identifying the dimensions of RBC deemed by the caregivers to be the most helpful and the easiest to integrate into their work and describing the caregivers' justifications for this.*

As Table 4 shows, the practical skills used to provide relationship-based care (initial contact, communication skills, touching techniques, and eye contact strategies) emerged from the respondents' discourse as being the RBC training components that were the most helpful

and the easiest to integrate into their work (between 56.4 and 64.5% of the coded units of meaning). The practical skills related to developing residents' autonomy were also mentioned by the caregivers but in a smaller proportion (approximately 20% of coded units). Finally, between 13.7 and 22 per cent of coded units referred to other RBC components, such as general principles (for example, a humanistic view of the residents), overall approach, knowledge about resident's cognitive functioning, and teamwork techniques.

As Table 5 shows, the great majority (83.7%) of the coded units – linked to the caregivers' justifications regarding the RBC training components they considered to be the most helpful – referred to the positive effects of RBC that the caregivers experienced post-implementation. These effects were for the resident (in terms of well-being and quality of the relationship) as well as for the caregivers themselves (in terms of occupational health and safety, job satisfaction, and ease of providing care).

Table 7: Categorization, weighting of units of meaning, and examples of justifications regarding the components of the RBC training deemed to be the most difficult to integrate into the work setting

Categories	Subcategories	Weighting of Units (%)	Examples of Units of Meaning
Incompatibility with actual work setting	Lack of time	32.5	*When we're overloaded with work, it's harder. (G5)* *Because we want to and have to work very quickly. We've developed a very fast routine. (G20)* *I will have trouble letting the clients do everything they can do, for lack of time. (G10)*
	Organization of work and care	9.9	*Because sometimes they [the residents] don't have good balance or even [any] at all. Sometimes, there needs to be two of us to make sure the resident will be safe when he or she is standing up, and the work organization doesn't always make this possible. (G30)* *The fact that the residents are evaluated by people who are not really involved in their day-to-day care and who don't know them as well as we on the floor do – this often complicates things. (G24)*
	Lack of staff, equipment, and space	8.9	*There are architectural barriers and not much openness on the part of management with regard to buying the equipment needed or changing the schedule for the use of the specially equipped bathrooms. (G23)* *Lack of equipment and staff. (G03)*
	Subtotal	51.3	
Professional issues	Co-workers do not believe in/are not trained in the approach	11.1	*Among the nursing staff, there's a firmly rooted false belief that walking leads to aggressive behavior, falls, and death. (G23)* *For it to work properly, the whole staff needs to adopt the same approach, so it should be a little easier once everyone has had the training. (G15)*
	Requires team consensus	7.9	*I think it's mainly a question of teamwork. All the caregivers have to want to [apply the approach] or else the client will be confused. For each client, there are at least 4 direct caregivers and just as many indirect ones …. (G30)* *It all depends on cooperation with other members of the care team and on everyone's willingness. We need good communication so that there will be proper follow-up. We need to discuss things and share ideas and tips to make our work easier and more satisfying. That way, it will be more pleasant for everyone. (G15)*
	Fear of peers' judgment	2.5	*Avoiding leaving things for the next shift and being blamed for not doing them. (G24)*
	Subtotal	21.5	
Personal factors	Requires deconstructing some firmly rooted habits	8.1	*Because they are typical phrases that we have to make a conscious effort to stop repeating, like not saying "OK". (G33)* *Deeply embedded work routine. (G05)* *[We have a] really set routine. (G5)* *It's hard (for many caregivers) to break old habits. (G16)*
	Need for learning time/practice	4.6	*Because of a lack of practice. (G10)* *With practice and time, we'll get there. (G17)*
	Inconsistent with existing strategies for maintaining caregivers' own health	3	*Saying ahead of time what we're going to do and then describing what we're doing as we go along: I feel like I'm talking for no reason and that I'm constantly repeating myself. (G22)* *Because sometimes, with the limited time we have, we don't want to have to come back to something. At those times, we're focusing more on our own needs as caregivers than on the resident's needs. (G11)*
	Professional ethics	1.8	*We need the job to be well done. I know myself, [that] if I haven't shaved a client properly, for example, I'll do it over again, unless the client doesn't cooperate. (G10)*
	Subtotal	17.5	
Characteristics of residents and relatives	Cognitive impairment and other residents' characteristics	9.0	*Eye contact with people with cognitive impairment. It's harder to get their attention. (G06)* *Vertical mobilization, because in the evening the residents are tired and have less stamina, and it's harder for them to stay on their feet. (G27)*
	Families and visitors	0.7	*Some visitors get involved on behalf of our clients and tell us what to do. That bothers me. (G03)* *Relationship-based care is sometimes harder to apply when there are several people in the house (children, a spouse) who come in and interrupt our contact with the client (in the context of home care). (G02)*
	Subtotal	9.7	
Total		100	

The caregivers' positive perception of the effects of the approach also emerged from the analysis of justifications related to the RBC training components that were deemed to be the easiest to integrate into the work setting (44% of coded units). The effects mentioned by the caregivers were related to the resident's well-being but also strongly to the caregivers themselves (ease of providing care, job satisfaction, and occupational health and safety).

When questioned why some RBC training components were deemed to be easy to integrate into their work, many caregivers cited personal and professional factors (46.3% of units). More specifically, the caregivers' discourse indicated that RBC was consistent with their current practices and easy to understand or to put into practice (26.2%). Some units also referred to the fact that RBC was consistent with the caregivers' capacities, values, and professional identity. Finally, a smaller number of coded units (from 9.7 to 16.3%) referred to RBC's compatibility with the actual work setting. Subcategories referred to (a) RBC's being applied by all staff or being an institutional project, (b) RBC's not taking longer or being within the respondent's power to implement, (c) having enough resources (time, staff, and equipment), and (d) relying on organizational conditions favorable to RBC implementation (e.g., having time to exchange information about residents between shift changes).

> Objective 2: Identifying the dimensions of RBC deemed by the caregivers to be the most difficult to integrate into their work and their justifications for this.

As highlighted in Table 6, the practical skills aimed at fostering the resident's autonomy and the means used to achieve this objective, such as vertical mobilization and the attribution of care (i.e., the decision by the team regarding what care to provide according to the residents' capacities and needs, based on a rehabilitation evaluation), emerged as being the component of RBC training considered by the caregivers to be the most difficult to integrate into their work (61.9% of units). Other components related to the practical skills involved in providing relationship-based care were also mentioned, such as communication (11% of units) and touch techniques (especially techniques for relaxing muscular contractions). Finally, some caregivers also described other components of RBC training, such as the recommended teamwork, and the overall approach as being difficult to integrate into their work.

The analysis of the caregivers' justifications concerning this question (see Table 7) shows that, for many of them, the incompatibility of RBC with the actual work setting constituted a major impeding factor for integrating RBC into their practices (51.3% of coded units). More specifically, approximately one third of the coded units (32.5%) referred to the perceived lack of time to apply the approach adequately. Professional issues were also cited (21.5% of units): (a) co-workers who had not been trained in the approach or who did not believe in it, (b) the need for team consensus to implement RBC, and (c) the fear of peers' judgment.

Another important category of the caregivers' justifications concerning the dimensions of RBC deemed to be the most difficult to integrate into their work was related to personal factors (17.5% of units). The caregivers mentioned that the approach required deconstructing some habits, in particular with regard to communication (e.g., not offering false choices such as asking "Do you want to take a bath?" if it is going to happen anyway, or describing their actions as they were carrying them out). Other respondents mentioned that RBC could be inconsistent with strategies (not repeating the same things over and over again; focusing on their own needs) for maintaining their own health or with their conception of a job well done (as they saw it, fostering the residents' autonomy could result, in some cases, in less hygienic care). Finally, some coded units (9.7%) referred to the characteristics of residents (such as cognitive impairment or fatigue) or to the presence of families or visitors who, as perceived by some caregivers, could make RBC more difficult to apply in their day-to-day care practice.

Interpretation and Discussion

The findings reveal that, one month following the end of the training, the caregivers perceived RBC to be generally helpful, overall, and that they intended to continue integrating this approach into their care activities. However, when questioned more specifically on which RBC components they considered helpful, easy, or difficult to integrate into their work, nuances appeared and brought to light factors that could impede the transfer of this approach into the work setting. More specifically, we discuss the findings here on the basis of a social ecological model (Bronfenbrenner, 1977), wherein individual behavior is examined in light of the multiple systems in which the person interacts. As Figure 1 illustrates, the integration of RBC can be described as the interaction between two individuals – the caregiver and the resident – each of whom is part of a microsystem: that is, for caregivers, the microsystem is their work group, and for residents, it is their families. The interaction between these two microsystems takes place in a mesosystem: the long-term care facility itself.

Caregivers

The findings indicate that RBC fostered strong support among many participants, in particular because it was based on the values of dignity and maintaining autonomy – values consistent with their personal and
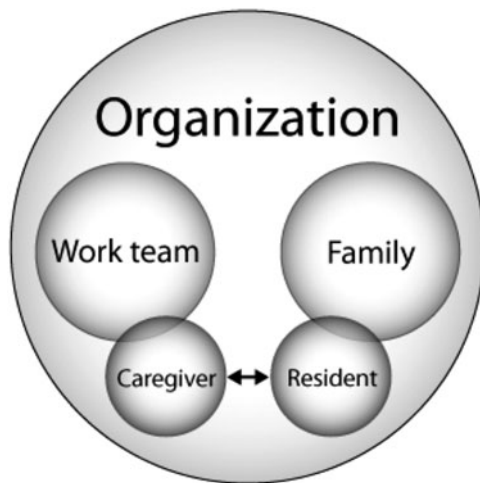
Figure 1: The implementation of relationship-based care is based on a social ecological model (Bronfenbrenner, 1977)

professional identity. Many participants considered that they could integrate RBC because it was consistent with their current practices. The respondents' answers indicated that receiving training in this approach and/or experimenting with it in real-life situations led them to believe in the positive effects of the approach for themselves, the residents, and the quality of the care relationship. However, several respondents pointed out that integrating these new skills involved breaking firmly rooted habits, which they perceived as being difficult to do. They also found the ease of integrating these skills to be potentially compromised by the caregiver's degree of fatigue. Moreover, a number of respondents reported feeling conflicted between the values linked to maintaining the resident's autonomy, values that are advocated by RBC, and the professional ethics linked to "a job well done".

These observations are in line with those found in studies reviewed by Aylward et al. (2003), according to which transforming care practices requires acting not only on individuals' knowledge and skills but also on individuals' beliefs. These findings also show that, even though participants generally shared the value of dignity on which RBC is based, the more specific dimensions of this approach, such as the value of autonomy and the suggestion that "relationship-based" care can help save time, may go against the previously held beliefs of participants, which could constitute an impeding factor for the transformation of work practices. This finding can be interpreted based on transformational learning theory (Mezirow, 2000) or on experiential learning theory (Fenwick, 2003). According to the conception of learning grounded in these theories, any process that involves major change begins with the destabilization of beliefs or governing variables (Schön, 1983) which are the foundation of action. Then, through

a process of searching for and constructing meaning, the individual will gradually arrive at a new conception and new beliefs, which will be tested in real-life situations. Depending on how pertinent the individual finds this new conception for action, the change might become stabilized, or it might be subject to a new cycle of searching for, then construction, meaning. This process can be iterative, and can take place over a relatively long period of time.

Caregiver's Microsystem: The Care Team

The care team – the caregivers who share common tasks and share the care provided to a particular group of residents – is a dimension of RBC that clearly emerged from the caregivers' discourse. This dimension, however, is less well documented in the literature on training in long-term care settings, and is not explicitly present in Aywlard et al.'s literature review (2003). Many of the study respondents perceived the care team's support to be a facilitating factor for integrating the approach into their work practices. This finding is consistent with studies that underline the positive impact of team empowerment on caregivers' performance as well as quality of care (Yeatts & Cready, 2007). Examples of team empowerment include providing certified nurse aides with more information on the special needs of residents and more opportunities to be involved in decision making. However, some respondents reported fearing judgment by their peers if they implemented the approach because they felt that it would slow down their work pace while increasing the workload of their co-workers.

These findings also bring to light tensions that can arise between the different professions, in particular with the nursing staff. In the caregivers' view, these tensions impede the opportunities to transfer the techniques learned – especially those linked with maintaining and developing residents' autonomy – because they require consensus among the care team. These findings are also in line, more broadly, with the literature on the service relationship, according to which all relations involving service are fundamentally characterized by the existence of various concerns (related to the employee status, the work group, the client, and the self) which can sometimes clash (Caroly & Weil-Fassina, 2004; Schoot, Proot, Legius, ter Meulen, & de Witte, 2006). The potential strength of relationship-based care is that it benefits both "client-based" concerns (such as the well-being of the resident and improved quality of care) and the "self-based" concerns (improved occupational health and safety, feeling of job satisfaction, and so on). Thus, it is reasonable to consider that an RBC implementation which is essentially limited to the transformation of individuals is likely, in the end, to generate tension between the self-based concerns and those concerns inherent to the work activity, in particular

those linked to the work group (care team). These findings are also consistent with a historical-cultural perspective of such activity. In that perspective, the interaction between a subject (the caregiver) and an object (relationship-based care) is mediated by the rules and values shared by the subject's community of practice (Engestrom, 2001; Lave & Wenger, 1991).

Residents and Their Families as Microsystems

Some caregivers mentioned the difficulties related to the lack of support from residents' families. Although this interpretation is not coherent with person-centered care, some caregivers seem to think that the presence of a family member can interfere with the caregiver-resident relationship. This highlights the fact that the interaction between the microsystems involving the "work group" and "families of residents" may not always be harmonious in relation to RBC. This finding is consistent with the affirmation that the involvement of residents' families is likely to facilitate the implementation of person-centered care approaches (Shaller, 2007). According to this principle, RBC's training could be enriched by advocating more clearly the importance for the caregivers to establish a relationship not only with residents, but also with their families and with other significant persons.

Organization as a Mesosystem for RBC

According to the literature, the successful implementation of person-centered care approaches requires that the entire context of care be adapted to result in, for example, more-flexible care practices, less constraining work organizations, and a modified physical environment (Buelow et al., 1998; Emilsson, 2006; Grossman et al., 2009; Kaskie, 2004; Matthews, Farrell, & Blackmore, 1996; Shaller, 2007; Stolee et al., 2005). The current findings indicate that, from the caregivers' perspective, these conditions are not always present in those care settings which have implemented RBC. In particular, the study participants emphasized that the training should be part of an institutional project, that there should be enough staff for care units, and that the work should be organized to be more conducive to collaboration between caregivers when providing care.

The analysis of the caregivers' comments demonstrates more particularly that several of the caregivers wished to see training in RBC extended to the entire caregiving staff as well as to other categories of staff, so that the approach could be applied by all. Some caregivers also felt that the training, beyond the specific training sessions, should include more-frequent opportunities to practice the approach, with feedback provided on some of its dimensions over the weeks or months following the training. These findings are in line with the idea that maintaining a change in care practices, beyond the training period, requires implementing mechanisms for follow-up, supervision, or reinforcing the practices (Aylward et al., 2003). These mechanisms have been found to lead to the achievement of the most meaningful and lasting results of training and transfer to practice (Bourgeois et al., 2004; Burgio et al., 2002; Sloane et al., 2004; Stolee et al., 2005). They become even more necessary in light of the concerns we have already expressed (on changing habits and beliefs, regulating work in the team, etc.), which imply a long-term process is required to foster sustainable implementation.

Study Strengths and Limitations

As reported by Edvardsson and Innes (2010), a common approach in studies of person-centered interventions in dementia has been to use outcome measures such as (a) the prevalence of behavioral and psychological symptoms of dementia (BPSD), (b) the use of neuroleptic medications, and/or (c) the quality of life. Tools attempting to measure person-centered care use different perspectives, mainly care staff and family caregivers, and, more rarely, cognitively unimpaired care recipients. As opposed to the many tools reviewed by Edvardsson and Innes (2010), this secondary analysis does not aim to evaluate person-centered care's results or outcomes. With this analysis, our interest is to examine the person-centered care implementation process from the caregivers' point of view. From our perspective, findings of this study add a complementary insight on how person-centered care might be difficult to implement for some caregivers, and how this implementation could be more successful, especially by a greater involvement of the care team. Those findings are consistent with the idea that implementing person-care approaches require major change in culture in the long-term care setting (Miller et al., 2010; White-Chu et al., 2009) and might help health professionals managers to understand why many person-care trainings do not generate long-term effects on caregivers' work practices (Aylward et al., 2003). More specifically, the open-ended nature of the questions in the study questionnaire made it possible to examine the perception of a great number of caregivers regarding the transfer of this approach to the work setting. In particular, the subquestions "Why" allowed us to enrich the knowledge on the facilitating or impeding factors for this transfer. The clear opposition between the answers to the questions regarding the dimensions of RBC that the caregivers found most helpful/easiest (practical skills related to resident and caregiver relationship) and most difficult (principles and practical skills linked with the aim of fostering the residents' autonomy) to integrate into their work shed interesting light on the RBC components that are more susceptible to being transferred into practice.

The methodology used nevertheless presents some limitations. Participants answered the questionnaire in the trainer's presence. Thus, there might have been a social desirability bias: that is, the respondents might have tended to answer more positively to please the trainer. However, in our view, since a self-administered paper-and-pencil questionnaire was used instead of an interview, for example, the social desirability bias was reduced. Another limitation of the questionnaire was the lack of socio-demographic data on the respondents and the fact that the data had already been grouped together. More-detailed data would have made it possible to highlight the differences between the various subgroups: men/women, novices/experts, and patient care attendants/other categories of staff. Moreover, because the ASSTSAS-provided data were already pooled for each training group, links could not be made between the answers of the same individual.

Furthermore, since the questionnaire was distributed only one month after the end of the basic RBC training, it was not possible to ascertain whether the implementation of the approach was sustained over time. The caregivers' perceptions documented in this study indicate that adequate longer-term follow-up could positively influence the sustainability of the approach. Therefore, subsequent research is needed to examine the effective role of such follow up. Some studies suggest that the degree to which practices are maintained over time should be evaluated at least two months, or even six months, after the training (Burgio et al., 2002). In addition, the methods used for this evaluation should go beyond the use of questionnaires. Thus, in future studies investigating the RBC approach, it will be important to not only use paper-and-pencil questionnaires but also to record the verbal comments made at the consolidation meeting by those trained in RBC.

Another limitation of the methodology involves the well-documented difference between the *discourse* of actors regarding their work activity and their *actual* work activity. It can be hypothesized that this discourse is associated with the work activity; however, the nature of this association is not clear. The data are liable to tell us more about the standards of the work group than the actual activity itself (Sannino, 2008; Theureau, 2003). This is why the broader research project of which this study is a part provides for other investigations involving a survey of all institutions that have implemented RBC, focus-group discussions with key actors, and case studies of RBC implementation projects that are already completed or under way, including observations of the individual and collective care actions of caregivers. All these activities will make it possible to draw a more detailed portrait of the factors that facilitate or impede the transfer of RBC skills from the training situation to the work situation.

Conclusions

The findings of this study demonstrate that, when it comes to a complex caregiving organization, a person-centered approach to care such as RBC constitutes a challenge in terms of training but also, and mainly, in terms of implementation (Verkade et al., 2010). The analysis of the respondents' discourse shows that, one month after training, they generally supported the approach and saw the benefits of it. However, some respondents felt that the approach clashed with some of their firmly rooted beliefs or values. The participants also stated that some – mostly organizational – constraints hampered the integration of the approach into their work situation. Support from the caregivers' institution thus becomes essential in this regard.

This study adds to the evidence suggesting that, in order to transform care practices in a sustainable way, training in person-centered approaches such as RBC must be consistent with the values and beliefs of participants. They must also take into account the difficulty of breaking old habits, as well as the influence of the work group, which can act as a driving force or as a brake to implementation. It is therefore necessary to plan for sufficient learning time and opportunities to practice and hold group discussions about the reorganizations and compromises that must be made in order to foster the sustainable implementation of the approach. These findings also indicate that it is not enough to act on the individual skills of caregivers through training but that the entire care situation and work organization must also be dealt with. To obtain lasting effects, this training should be integrated into an institutional project that addresses working conditions, work organization, the work group, and the support of residents and their families.

Note

[1]   The ASSTSAS is a non-profit sector-based association, managed by a joint executive board and funded by employers of institutions in the health and social services sector, whose mission is to provide employers and workers in this sector with training, information, and professional advice in occupational health and safety, directly to institutions.

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