Special Focus on
**Best Practices
Initiative**

Initiating Person-Centered
Care Practices
in Long-Term Care Facilities

ABSTRACT

Person-centered care is a key concept guiding efforts to improve long-term care. Elements of person-centered care include personhood, knowing the person, maximizing choice and autonomy, comfort, nurturing relationships, and a supportive physical and organizational environment. The Oregon Health & Science University Hartford Center of Geriatric Nursing Excellence and the state agency that oversees health care for older adults worked in partnership with 9 long-term care facilities. Each developed and implemented person-centered care practices, including those focused on bathing, dining, or gardening. This article describes the processes used to develop and support these practices. Three exemplary facilities made significant practice changes, 4 made important but more moderate changes, and 2 made minimal progress. These facilities differed in terms of existing culture, management practices, staff involvement, and attention to sustainability.

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Increasingly, health care providers, consumers, researchers, and advocates are working to develop and implement new models of care that fundamentally change the way we think about long-term care services and how they are delivered. Weiner and Ronch (2003) described this as a culture change process that makes "long-term care less about care tasks and more about caring for people and the relationships between people" (p. xiii).

Person-centered care is a key concept in the culture change movement. It is a global philosophy of care underpinning gerontological nursing (Nolan, 2001) and requires health care professionals to plan with the individuals who require daily assistance and to provide that assistance in such a way that clients are honored and valued and are not lost in the tasks of caregiving. The emphasis of care is on well-being and quality of life as defined by the individual. Elements of person-centered care include:

- Personhood (e.g., Epp, 2003; Harr & Kasayka, 2000; Kitwood, 1997; Sloane et al., 2004).
- Knowing the person (e.g., Morton, 2000; Talerico, O'Brien, & Swafford, 2003).
- Maximizing choice and autonomy (e.g., Mead & Bower, 2000; Ryden, 1992; Williams, 1990).
- Quality care (e.g., Kayser-Jones, 1996; Parley, 2001; Rader, Lavelle, Hoeffer, & McKenzie, 1996; Talerico et al., 2003; Werner, Koroknay, Braun, & Cohen-Mansfield, 1994).
- Nurturing relationships (e.g., Brooker, 2004; Epp, 2003; Happ, Williams, Strumpf, & Burger, 1996; Swafford, 2003; Williams et al., 1999).
- A supportive physical and organizational environment (e.g., Osborn Gould, 2001; Rader & Semradek, 2003; Tickle & Hull, 1995).

The Hartford Center of Geriatric Nursing Excellence (HCGNE) at Oregon Health & Science University and the state agency that oversees health care for older adults developed a partnership to promote culture change through the Best Practices Initiative (BPI). The goals of the BPI, described in this issue of the *Journal of Gerontological Nursing* by Harvath, Flaherty-Robb, White, Talerico, and Hayden (2007), were to address the gap between generating scientific evidence and translating that evidence into practice. The state was interested in partnering with the HCGNE to develop a statewide initiative designed to change the existing behavior management culture in state-licensed facilities to a culture that views behaviors as symptoms of unmet needs that can be addressed through person-centered care. The purpose of this article is to describe the project that emerged through the partnership, its results, and the lessons learned. The article concludes with suggestions for the next steps in person-centered care culture change practice and research.

PERSON-CENTERED CARE PROJECT

Initially, the focus of the BPI project was to move long-term care providers to a framework where all challenging behavior is viewed as meaningful. The emphasis was on determining the perspective of the person receiving care, identifying the need being communicated through behavior, and making this perspective central in planning and delivering care. A person-centered care approach was selected as the mechanism for introducing and implementing practice changes that would be required to work within this new framework. This framework represented a convergence of nursing research focusing on individualized dementia care (Swafford, 2003) and person-centered planning practices emerging from the developmental disability community (O'Brien & O'Brien, 2002). The BPI project was supported by a technical assistance firm with expertise in person-centered planning, with emphasis on developmental disabilities. The project was initially referred to as "the behavioral initiative" because of the partners' interests in dementia care; however, this focus soon broadened beyond issues of behavioral symptoms of individuals with dementia to include incorporating values, personal preferences, and meaningful activities into the care of all people served. The person-centered care project had multiple parts:

- A kick-off conference.
- An application and selection process to identify facilities that wished to participate in ongoing person-centered care work.
- Periodic educational retreats.
- Individualized coaching for each facility.

Kick-Off Conference

An educational summit on person-centered care was held in October 2002. To attend, long-term care facilities were required to identify and send teams that included a direct care provider (e.g., certified nursing assistant, health aide, personal assistant) and a person with organizational decision-making authority (e.g., administrator, director of nursing). The BPI team believed it was unfair to expose direct care providers to new and more satisfying ways of caring for and relating to their clients if they were not to be supported in implementing that care by those in authority. In addition, culture change is not possible without commitment at all levels of staff, particularly the administration and others in leadership positions. Similarly, effective practices cannot be sustained without systems in place to support them (Rader & Semradek, 2003; Richards & Beck, 2002). The conference was filled to capacity (39 facilities were represented), with other interested facility teams placed on a wait list.

The conference (**Table 1**) introduced person-centered thinking as a model of care that focuses on accommodating personal needs and using evidence-based interventions. Experiential learning and lectures were used to help attendees apply the principles

TABLE 1

OUTLINE OF PERSON-CENTERED CARE PROJECT KICK-OFF CONFERENCE

Speaker	Target Audience	Key Messages
Michael Smull, PhD, *Director of Support Development Associates, Annapolis, Maryland*	All participants	Advances in Person-Centered Planning • Important to/important for • Morning rituals • Partnerships in planning • Staff-centered versus person-centered care
Joanne Rader, RN, MN, FAAN, *Consultant and Associate Professor, Oregon Health & Science University, Portland, Oregon*	Direct care workers	Revolutionizing the Way We Keep People Clean • Focus on research and practical applications • Demonstration of technique
	Administrative decision makers	Revolutionizing the Way We Keep People Clean • Focus on research and systems needs • Supporting the direct care worker
Cornelia Beck, RN, PhD, FAAN, *Professor of Geriatrics, Psychiatry, and Nursing; Administrative Core Leader, University of Arkansas Medical Science Alzheimer's Disease Center, Little Rock, Arkansas*	Direct care workers	Person-Centered Approach to Dressing • Research findings • Emphasis on practical applications, video examples
	Administrative decision makers	Person-Centered Approach to Dressing • Research findings • Challenges to person-centered care • Methods to promote culture change

to their work. Those interested in receiving ongoing support from the BPI team to make culture changes in their facilities came back for a second day. At that time, facility teams began identifying the specific person-centered care projects they wished to pursue. Consistent with the BPI partnership philosophy and values (Harvath et al., 2007), each facility was encouraged to select an approach to person-centered care that fit its interests, passions, and needs and strengths. A BPI team member worked with each group as it began this process, seeking to support but not direct the group's efforts to change practice. It was at this point that the facility staff began to think about including residents other than those presenting behavioral challenges as a focus for this work. The BPI team completed a rating sheet for each facility team on the basis of their observations of teamwork (e.g., input encouraged from everyone, creativity, listening).

Facility Selection

Facility teams returned to their organizations to discuss projects with their coworkers and to further develop plans to initiate person-centered care. This was done to promote buy-in and support from all parts of the facility so the person-centered care endeavor would not be something imposed by select individuals or the BPI team. Sixteen facilities submitted detailed applications to receive ongoing education and coaching. Applicants described the projects they wished to pursue, staff who would be involved, potential barriers and how they would be addressed, planning processes, communication strategies, anticipated coaching support needs, and measurement indicators they expected to track.

BPI team members independently reviewed and rated the applications, identifying strengths and weaknesses. The BPI team met to discuss the applications and selected the top 10 facilities on the basis of the strength of their applications and the coaches' observations and ratings on day 2 of the conference (10 had previously been determined to be a manageable number of facilities to support given available coaching resources). Projects submitted by these facilities included five on dining, four on bathing, and one on gardening. Included were 5 nursing facilities, 3 residential care facilities, 1 assisted living facility, and 1 facility that offers both residential care and assisted living. Size ranged from 32 to 100 beds. Ownership included 1 governmental, 5 non-profit, and 4 for-profit facilities. They were geographically dispersed: 2 were located along the coast, 4 in central and southern Willamette Valley, 3 in the Portland metropolitan area, and 1 in eastern Oregon. One nursing facility, part of a wing of a rural hospital in eastern Oregon, had to drop out midway through the project when it closed due to low census.

Some applications from the selected facilities raised concerns at the time of selection. For example, some of the projects focused on changing the environment to make residents' lives more pleasant but did not address central person-centered care elements of identifying and accommodating resident choices and preferences, or nurturing relationships. Despite coaching and education, this apparent

lack of understanding about person-centered care remained a concern in some of these facilities throughout the project and may have contributed to less-than-optimal outcomes in those facilities.

Ongoing Education

During the 18 months following the kick-off conference, person-centered care facility teams participated in three educational 2-day retreats, where they received further training on person-centered care using a variety of experiential exercises led by staff from the technical assistance firm. Participants also received training in motivational interviewing as an approach to behavior change (Miller & Rollnick, 2002). Motivational interviewing typically is used to help guide and support individuals in making lifestyle changes by reinforcing the person's own self-motivational statements and helping that person develop a plan of action consistent with their values and priorities. The emphasis at the retreats was to use motivational interviewing approaches to work with staff who might be resistant to the organizational and practice changes required to support person-centered care.

Finally, content focused on sustainability. Time was provided for participants to learn from and support one another as they reported on their progress. No formal evaluations were conducted at these retreats, although the person-centered care teams were asked to respond to specific questions about their experiences at the final retreat (**Table 2**). Notes from the reports shared by the person-centered care teams at this last meeting were used to describe their programs and represented one indicator of success.

Coaching

Because educational approaches alone are often not effective in accomplishing change in institutional settings, a coaching consultation model was used. Research has demonstrated that the addition of advanced practice nurse consultation is important in effectively translating research knowledge into practice (Popejoy et al., 2000; Rantz et al., 2001; Wagner et al., 2007). The BPI team believed a multifaceted approach, including education, consultation, and development of research-based practice initiatives, would make a difference in quality of care; reduce caregiver injury, burnout, and turnover; and improve relationships among nursing facility residents, their caregivers, and families.

The BPI team members were the coaches for this project (4 from the state and 3 from the HCGNE). They included nurses, social workers, and gerontologists who had worked with older adult populations or in the field of aging for an average of 21 years. All of the coaches had worked in long-term care and, with one exception, had prior long-term care coaching or consultation experience. Coaching responsibilities were to:

• Help facilities develop a structure needed to make and implement decisions about change.
• Help facility teams respond appropriately to resistance from other staff.
• Help staff explore ambivalence related to change.
• Facilitate narrowing the gap between wishing to do something and actually doing something.

In addition to the seven BPI coaches, the state also contracted with the technical assistance firm for 1 day of consultation on person-centered care in each facility.

Coaches provided onsite consultation to project team leaders or team members an average of six times (range = two to nine visits), supplemented with telephone or e-mail contact with facility team leaders. Many of the coaches participated in or conducted

inservice training. Most provided evidence-based best practices and other resource materials specific to the projects (e.g., books, journal articles), and all assisted with person-centered care planning activities. On request, some coaches drafted or critiqued new assessment forms and other documents. In turn, these were shared with other facilities.

In addition to their work with the facilities, coaches met as a group monthly to discuss the projects and their roles as coaches. These meetings were used to chart progress, identify barriers, and strategize ways to overcome them. Coaches provided support to one another and helped identify resources beneficial to the participating facilities. At the end of the project, the coaches completed evaluation forms (**Table 2**). Information from the coaches (meeting notes and evaluation questions) and facility teams' presentations at retreats formed the basis for descriptions of the project results.

RESULTS

Each facility (including the one that closed) made progress in initiating new person-centered care practices. By the end, all recognized they were involved in an ongoing process. The extent to which person-centered care was implemented varied. Three exemplar facilities made significant practice changes, 4 made significant but more moderate changes, and 2 others made minimal progress. As reported above, one facility closed. The characteristics of the three groups and the lessons learned about successfully initiating culture change are identified below.

Facilities with Significant Practice Change

Three facilities made significant progress in initiating and implementing person-centered care practice change. To understand the basis of their success, it is useful to describe each of these exemplar facilities.

Facility #1. Facility #1 is a residential care facility that is part of a small chain of for-profit facilities devoted

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TABLE 3
STAFF ENTRY FROM PERSON-CENTERED CARE PROJECT NOTEBOOK

"What Person-Centered Care Means to Me"

I have been with Facility #1 for a year and a half. One of the first residents I had the pleasure to work with was Enid [pseudonym]. She is a wonderful, sweet lady, and I have learned so much from her. There was one aspect of her care that was a source of anxiety for all involved: Enid, her family, and the caregiver. The thing that no one ever wanted to mention was the word "shower." If Enid thought she was getting a shower, she would not go anywhere near the bathroom. If you were lucky enough to get her into the shower, she would cry, yell, kick, hit, whatever she could think to do to get away from the water. But she really likes to be clean and fresh. After the shower, while rubbing on lotion, getting dressed, and "primping," she will thank you and tell you how much better she feels.

When I first heard about person-centered care and the ideas of alternate bathing techniques, I thought Enid would be a perfect candidate for this project. The results have been amazing. You can now have a pleasant conversation with Enid throughout the entire bathing process. She smiles, laughs, and says that it feels good. Sometimes she will even choose to take a shower. I no longer walk in the door for work and think, "Oh no, it's Enid's shower day." I am positive Enid no longer wakes up and wonders, "Are they going to make me take a shower today?" What a difference this [has] made!

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to care of 75 people with dementia. Bathing was the focus of its person-centered care project. Staff at all levels were engaged, from planning and conducting education for all staff and family members to implementing new approaches to help residents be clean in a manner they chose.

Early in the project, staff realized that assessment and other forms used to document resident care needed to be changed to reflect person-centered language. In addition to changing these forms, new assessment tools were developed, enabling more individualized bathing plans. Policies and procedures were rewritten to support this new way of caring for residents. A "bathing success portfolio" was created for each resident in which the direct care worker recorded what was tried and what worked best. In this way, hard-won wisdom was not lost when new or different staff cared for the resident (although consistent assignments are the norm). Direct care staff were empowered to make bathing decisions.

The coach reported that "they realized early on that the experience for the client was more important than the outcome [getting a bath or shower]." At the end of the project, the coach reported that all but one of the bathing plans developed under this new approach were successful. Staff enthusiastically embraced the program. They created a notebook of photographs and staff entries recording "what [person-centered care] has meant for me" that is shared with family members and new employees (**Table 3**).

Facility #2. Facility #2 is a religion-affiliated nonprofit nursing facility serving 90 individuals and their families and is part of a continuing care community in rural Oregon. The project chosen by this facility focused on changing the dining experience for all residents. Beginning with a planning committee representing multiple disciplines, staff, and shifts, the team began to consider ways to build flexibility and choice into meals. The entire meal delivery system changed. First, breakfast service was extended to 2 hours so residents could wake up and eat according to their preferred schedules. Kitchen staff became wait staff, and when residents arrived in the dining room they chose from a

daily menu; meals were then cooked to order. The program was very successful and was soon extended to the noon hour, closely followed by the evening meal. In addition, a snack cart serves residents who choose to eat in their rooms, with continental breakfast options in the morning and soup, salad, sandwiches, and desserts available at noon, for the evening meal, and as snacks.

Residents now have much greater choice of when, where, and what to eat. Special diets were eliminated, with no detrimental effects on health. No unwanted weight gain or loss was noted, resident and family satisfaction has been high, and food waste has been eliminated almost entirely. Routine recording of nutrition intake ceased. The staff did recognize a need to monitor some residents, such as those with dementia, to ensure they are offered food throughout the day, and they reported that selective monitoring increased accuracy. Although job responsibilities changed, staffing levels did not. Job descriptions have been changed to reflect the new practice, which is well integrated into the nursing facility.

Facility #3. Facility #3 is a skilled nursing center, serving approximately 50 residents, within a private, nonprofit continuing care community. The person-centered care work here focused on bathing. Like the facilities described above, the initiative began with a planning group and inservice education. The planning group was composed mostly of direct care workers and a residential care manager. They began by focusing on assessment, using new tools, and enlisting family members to provide life histories. Direct care workers, with support from management, began taking more time to find out what was important to individual residents, giving special attention to those who were nonverbal. Bathing practices were changed to incorporate choice, privacy, and dignity.

Direct care workers soon reported less fighting with residents over bath-

ing, and work was completed in a manner that was more satisfying to staff and residents alike. The team reported that the mindset changed from telling residents what they were going to do to asking them what they wanted to do. They also found that identifying staff with a "knack" for working with an individual resident was more important than the bathing method the resident selected. As with the programs described above, changes were made in direct care worker job descriptions and all policies related to bathing, including new staff orientation. As behavioral symptoms decreased during bathing, all but one resident ceased needing take-as-needed psychiatric medications.

Summary. As all three facilities explored person-centered care and what it meant for their programs, they began to incorporate this approach into policies and procedures, job descriptions, assessment tools, and in some cases, care plans. They emphasized communication with individuals, even those who were nonverbal, in their care to better understand what was important to individual residents. Family members were enlisted to support this process. By understanding what was important to individual residents, facilities also began developing more flexibility in care to honor individual preferences over facility and staff routines. The two facilities that focused on bathing changed to a system where bathing could happen any time of the day or week and in a variety of ways. Maximizing control by the resident and nurturing staff relationships with residents were the paramount concerns.

Similarly, individual rituals and preferences were honored in the successful dining program. Changing the dining service also allowed for more relaxed waking and dressing routines. Person-centered care teams in all of these facilities reported that they became more aware of and began to focus on other aspects of their care environments that were not person

centered. Thus, changes in one part of the system were leading to other changes beyond the original project. For example, as staff began to honor bathing choices, they began to wake people up when they wanted to wake up rather than according to staff schedule, which in turn affected the timing of breakfast and the way it was served. Direct care staff, with support from their residential care manager, negotiated with dining staff to make this happen. Finally, these programs clearly supported the relationships between direct care workers and those for whom they care. Direct care workers were fully involved in planning the change, training other staff, designing tools, and providing feedback to the team about successes and failures.

Facilities with Moderate Practice Change

Four facilities made significant, but more modest changes. All reported important environmental changes supporting choice and creating more pleasant surroundings and experiences for residents. The strengths in these programs included supporting and enhancing relationships between residents and direct care workers. More choice in activities meant that staff could better honor rituals and preferences over staff routines. All facilities reported greater resident and staff satisfaction with the changes.

Compared with the exemplar facilities, however, less emphasis was given among this group to learning from residents or their families about individual values and preferences. For example, a variety of snacks or activities became more available to all residents but had not been tailored to meet any one person's specific preferences. Bathing choices were enhanced, but facility routines remained an emphasis for direct care workers (e.g., assigned shower days).

As a group, these facilities had a somewhat more hierarchical tenor; direct care workers did not appear to be as involved in creating the practice changes nor in decision making

TABLE 4
LESSONS LEARNED FROM THE BPI PERSON-CENTERED CARE PROJECT

Project Outcomes	Facility Culture	Management	Staff Involvement	Sustainability
Facilities with Significant Change (n = 3; bathing, dining) • Made significant practice and delivery system changes • Moved beyond initial project goals	• Existing culture compatible with person-centered care • Person-centered care core to mission (not just a project); remained a priority despite organizational stressors • Previous experience with innovation, practice change • Openness to doing things differently	• Understood and committed to person-centered care • Delegated project leadership to strong team leaders • Encouraged and supported creativity of team • Stayed engaged and served as sounding board, encourager	• Team members were committed champions for change • Representation from direct care workers, managers, nurses, other departments, all shifts • Regular, predictable meetings to plan and evaluate • Same staff consistently attended retreats • Direct care worker autonomy increased • Effective use of coaching resources	• Practice change became integrated: "This is the way we do things here." • Mission statements, job descriptions, policies and procedures, and training materials were rewritten • Staff reported person-centered care "bleeding" into other areas of practice • Became part of a subsequent funded project and continued development of person-centered care practices.
Facilities with Moderate Change (n = 4; bathing, dining, gardening) • Made significant practice changes to enhance choice • Reduced behavioral symptoms • Increased staff and resident satisfaction • Improved staff-client relationships • Did not honor individual rituals and preferences as much as did exemplar facilities.	• Interest in project, but person-centered care not yet considered core work • Project activities set aside during stressful times (e.g., staff shortages, budget reductions, state regulatory surveys)	• Understood choice and role of environment • Did not fully understand "what is important to" residents as person-centered care's central tenet • Maintained leadership role without time and ability to function effectively in this capacity, OR • Was not engaged • Tended to be more hierarchical in decision making	• Was variable; more likely to report intermittent meetings, changing memberships • Took longer to establish teams and identify specifics of the project • More dependent on manager approval in making decisions • Focused more on environmental changes than changing facility routines and practice • Variability in use of coaches	• Some, not all, made changes in policies and procedures, job descriptions, orientation • Many changes appear likely to continue, but fewer structural/system changes have been made • Most changes have focused on environmental, rather than deep practice, changes
Facilities with Minimal Change (n = 2; dining) • Made minor practice changes • Applied person-centered care inconsistently • Made some increases in choice • Made some improvements in staff-client relationships	• Project viewed as extra work by administration and staff • Person-centered care not a core value	• Had greater administrative turnover • Did not understand person-centered care principles and did not have strong commitment to the project • Gave little support to person-centered care team • Not engaged with project or staff; some undermining	• Greater staff turnover on team • Inconsistent attendance at retreats and team meetings • Poor follow through on team decisions • Considerable coaching time invested with little effect	• No system changes identified • Little change made after initial start-up, OR • Initial changes not maintained

Note. BPI = Best Practices Initiative.

1 Person-centered care is provided according to residents' needs, desires, and preferences, and staff are sufficiently flexible to accommodate these individual conditions.

2 To implement successful person-centered care practices, staff at all levels and from all departments must be engaged in the design and committed to success.

3 Person-centered care practices are viewed as part of the organization's core mission and not as a project that can be completed or set aside.

4 Systems to support and sustain practice changes should be in place, including ongoing education, policies and procedures, and job descriptions.

about implementation as were those in the facilities that made the most changes. Finally, these facilities were somewhat less likely to have made system changes to incorporate the language of person-centered care into job descriptions, assessment tools, or care plans. As a result, these changes are dependent on current staff for sustainability.

Facilities with Minimal Practice Change

Two facilities seemed to have made minimal changes toward person-centered care; both focused on dining. They varied from the other facilities in several ways. The scope of these programs was smaller, less emphasis was given to choice for individual residents, and direct care workers and other staff appeared to have less autonomy for suggesting changes or directing their own work. Both facilities experienced considerable turnover at all levels, including administrative and other leadership positions. Planning team membership varied, with enthusiasm and interest diminishing

over time. Participants seemed to have difficulty making decisions and continually revisited the same issues and concerns. Follow-through communication between meetings was inconsistent, and no new systems were in place to support the changes initiated. Most important, however, the language and spirit of person-centered care was not reflected in reporting by the facilities or coaches. In some cases, some of the staff understood person-centered care principles but did not have the authority to make the changes needed to support them.

LESSONS LEARNED

Several factors that differentiated the three facilities with significant practice changes from the others emerged (**Table 4**). These three facilities had cultures compatible with person-centered thinking that attracted them to the project in the beginning and had "warmed the soil" for person-centered care long before this endeavor began. The BPI project helped them to focus and enabled them to tackle person-centered care

as a core facet of their work. Each of the most successful facilities also had strong management and administrative support. Administrators, nursing directors, and other managers from these facilities attended the kick-off conference and were involved in the earliest planning activities and then delegated leadership to others. These administrators were not overly distressed by the difficult bumps in the road and the associated traumas that always occur with change. Instead, they had an open-door policy, helped teams problem solve, and encouraged forward movement. In programs that were the most successful, however, the primary team leadership role was assigned to someone else, such as a social worker, assistant administrator, or residential care manager. Organizations where administrators or directors of nursing were the designated or primary person-centered care team leaders suffered, perhaps because the high demands of their primary roles often meant that person-centered care activities were put on hold.

Wide representation by committed staff differentiated facilities. All of the successful programs actively engaged direct care workers from multiple shifts as well as management staff in their planning teams. One of the most successful nursing facilities reported that not having a staff nurse on the team in the beginning led to some undermining of the team's efforts, in part because nursing staff was not knowledgeable about nor fully committed to the practice changes identified to support person-centered care. As suggested by this example, it took some time for facilities to establish cohesive, focused teams. At the first retreat (which took place 3 months after the conference), most participants reported that they had been so enthusiastic after the conference that they had returned to their facilities and immediately began making changes. Participants reflected later that many of their first attempts at practice change were too ambitious, did not involve key people, and were otherwise ill considered. Most facili-

ties recovered from early missteps and were able to develop stable or growing team memberships following the first retreat. If one person left, someone else was invited to participate and made part of the team. In addition to planning and implementing activities related to person-centered care, these groups continued to expand the scope of their work into arenas beyond the original project, evaluate and monitor their efforts, provide training, and serve as role models to their peers.

Although the contribution of coaching in this project is not entirely clear (coaching time, focus, experience, and role varied), all facility representatives at the final retreat indicated that coaching had been an important component of the person-centered care project. According to the discussion, coaches helped facilities keep on track simply by checking in, participating in meetings, and providing inservices. Teams also appreciated coaches' availability and found them to be important sources of advice and support. Specifically, coaches provided a fresh perspective and made helpful suggestions as the teams struggled with change. Coaches also helped reduce feelings of isolation within the facility.

Use of coaching resources effectively distinguished the facilities. The trend was for the most successful groups to request more evidence-based resource materials for their teams' consideration than did other facilities. However, one of the coaches reported spending little time in one of the exemplar facilities because the team was progressing so well without her presence; much of her consultation was provided by telephone. Facilities that made fewer changes were not always able to effectively use the coaching resources, even when the coach devoted considerable time to the process. In fact, the coaches working with teams who made the least progress spent the greatest amount of time in those facilities. Barriers associated with less productive use of coaching included

management turnover, lack of or limited management support, and weak or ineffective teams.

One of the most striking differences between facilities that made the greatest changes and the others involved steps made to institutionalize practice change, as demonstrated by changes in mission statements, policies and procedures, job descriptions, and training materials. Although such documents do not guarantee sustainability of person-centered care, they do help reinforce the "this is the way we do things here" mentality and provide important structures to help ensure that practice changes are not lost when key staff leave the facility.

NURSING IMPLICATIONS

Nurses must be engaged in developing and supporting person-centered care practices at multiple levels. Nurses need to be knowledgeable about best practices and share this information with staff at all levels. Much of their involvement in promoting person-centered practice will include team building (i.e., working with other disciplines and empowering direct care staff to embrace and deliver person-centered care). Nurses can take an active role in ensuring that systems are in place to support these practices so facilities are not dependent on any one individual for sustainability.

SUMMARY

To date, lessons learned from the person-centered care project have contributed to a deeper understanding about what person-centered care is, the organizational characteristics needed to support it, and ways to help organizations achieve and sustain it. The next steps are to develop valid and reliable instruments to measure person-centered care from the perspectives of clients, family, and staff to be used in intervention studies. These lessons learned can be used to develop and test specific interventions that will prepare organizations to "warm the soil" so they can be

successful in the process of organizational change. In addition, these lessons must be used to develop and test specific interventions that will help organizations more quickly embrace person-centered care practices.

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