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### An Analysis of Reinforcers Maintaining Caregiving Behaviors of Long-Term Care Facility Staff

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Running head: REINFORCERS OF LONG-TERM CARE STAFF

An Analysis of Reinforcers Maintaining Caregiving Behaviors of Long-Term Care  
Facility Staff

by

Sandra Garcia

A Thesis Submitted in Partial Fulfillment of the Requirements for the Degree of

Master's Degree

In

Clinical Psychology

Minnesota State University, Mankato

Mankato, Minnesota

May, 2016

# REINFORCERS OF LONG-TERM CARE STAFF

May 9, 2016

An Analysis of Reinforcers Maintaining Caregiving Behaviors of Long-Term Care Facility Staff

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This thesis has been examined and approved by the following members of the student's thesis committee.

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# REINFORCERS OF LONG-TERM CARE STAFF

## An Analysis of Reinforcers Maintaining Caregiving Behaviors of Long-Term Care

Facility Staff

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### Abstract

Traditionally, the medical model has been the standard level of care in long-term care facilities. However, many facilities are transitioning from the medical model to a person-centered approach. The core of person-centered care is the relationship between frontline staff and residents. Empirical research has found person-centered care to reduce depressive and behavioral symptoms, levels of loneliness, and increase quality of care in residents; person-centered care has increased job satisfaction in nursing staff.

Unfortunately, little is known about what motivates caregiving behavior in nursing staff and whether these motivators are consistent with principles of person-centered care. The current study attempted to assess what the motivators are and how often these motivators occur. A questionnaire was developed and included 43 experiences that nursing staff may or may not experience in their day-to-work. Participants were asked to rank how important each item was using a 4-point Likert scale (not at all important to very important) and to rank how often each item occurs using a 4-point Likert scale (never to always). Results indicated that items related to person-centered care were the highest ranked items for importance and frequency, while support from administrators was ranked as important, but was occurring infrequently. These results have implications in terms of staff selection and staff training related to person-centered care.

# REINFORCERS OF LONG-TERM CARE STAFF

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## An Analysis of Reinforcers Maintaining Caregiving Behaviors of Long-Term Care Facility Staff

In the past several decades, there has been significant growth in the older adult population in the United States. Currently, 43.1 million older adults comprise the United States population, and it is expected to increase to 83.7 million by 2050 (Ortman, Velkoff, & Hogan, 2014). This demographic shift is a result of several factors including longer life expectancies due to medical advances and the cohort known as the “baby boomers” are reaching their mid-sixties (Forstl, 2005; Meyer, 2001). As the number of older adults increases, the number of older adults who will require assistance in their activities of daily living (ADLs; e.g., bathing, toileting) will also increase.

Approximately, 8.3 million older adults seek care services from home health agencies, as it provides them with the opportunity to “age in place” (Harris-Kojetin, Sengupta, Park-Lee, & Valverde, 2013). However, older adults may need to move to long-term care facilities (i.e., skilled nursing, assisted living, independent living) because they may require more skilled care, engage in challenging behaviors (e.g., aggression) due to cognitive impairment, and/or they may require a general need for more assistance (Buhr, Kuchibhatla, & Clipp, 2006; Li & Porock, 2014). Reports indicate that between 1.5 and 1.8 million older adults currently reside in long-term care facilities to receive assistance with their ADLs (Kaye, Harrington, & LaPlante, 2010).

### **Care Models within Long-term Care Facilities**

The model of care that long-term care facilities implement is dependent on the preference of the facility. Typically, long-term facilities have operated from a medical model, which emphasizes the older adults’ illness and quality of care, as opposed to the

individual as a whole and quality of life. These facilities often mimic an environment similar to a hospital setting, and residents are required to follow a set schedule that determines when they sleep, eat, and bathe (Krasnausky, 2004). In settings that adopt the medical model of care, staff members tend to be task oriented and are more focused on meeting their own needs (e.g., getting things done on time) and not the needs of the residents (Bruck, 1996).

Although the medical model has been the standard of care in long-term care facilities, person-centered care is beginning to define the new gold standard of care (Brownie & Nancarrow, 2013). Person-centered care may be referred to as person-directed, resident-centered, patient-directed, or as person-focused care (Coleman & Medvene, 2013). Brummel-Smith et al. (2016) argue that the term “person-centered” is superior to the terms “patient-directed” or “patient-centered” because it emphasizes a holistic approach to care by including the individual’s social and cultural background, rather than a narrow focus on the individual’s medical needs.

There has been a trend over the past decade for long-term care facilities to make the transition from the medical model to the person-centered approach, also known as culture change. For instance, a national survey of 1435 nursing homes indicated that 31% of nursing homes have fully adopted person-centered care, 25% have few aspects of person-centered care, but management is committed to fully adopting this approach, and 43% reported that their facility and management is not interested in transitioning from the traditional model to person-centered care (Doty, Koren, & Sturla, 2008). As can be determined from this survey, more than half of the nursing homes in the United States are

transitioning to person-centered care. The desire to transition care models may be attributed to the characteristics of person-centered care.

### **Characteristics of Person-Centered Care**

There is no universal definition of person-centered care. However, characteristics indicative of person-centered care have been identified and may include, but are not limited to: communication, developing close relationships, getting to know the individual, maintaining autonomy and personhood, homelike environment, and providing comfort (Coleman & Medvene, 2013; Jones, 2011; Normann, Asplund, & Norberg, 1999; Talerico, O'Brien, & Swafford, 2003).

**Communication.** Communication between staff and residents is one of the key components of person-centered care (Adams & Grieder, 2005). The terminology consistent with the medical model often contains medical jargon, which can result in unclear communication. Words such as “person-centered,” “strengths-based,” “quality of life,” “community-based,” “preventative,” and “choices,” are often used in the person-centered approach whereas “practitioner-based,” “problem-focused,” “cure,” “facility-based,” “dependence,” and “reactive,” are used in the medical model (Adams & Grieder, 2005). A communicative style that incorporates the individual’s best interest demonstrates a greater level of sincerity, consideration, and respect, as well as a shift from focusing on the problems to a focus on developing resources and appropriate care plans for older adults.

**Close Relationships.** Incorporating person-centered communicative style allows for close relationships between staff members, residents, and family members. Establishing these relationships allows for staff members to individualize and to create



effective, appropriate care plans (Normann et al., 1999). Relationships with the family members and residents provides staff members with the opportunity to get to know the resident, and family members can help provide further insight about the resident, particularly if the resident has cognitive impairment. Close relationships between staff and residents are also supported through consistent assignment (same staff member(s) always care for the individual; Koren, 2010).

**Autonomy.** Autonomy is defined as an individual's right to self-determination, and the presence of physical and/or cognitive decline does not eliminate the ability or desire to make decisions for oneself (Welford, Murphy, Rodgers, & Frauenlob, 2011; Wulff et al., 2013). In conventional, long-term care facilities, it is not uncommon for older adults to lose their autonomy due to predetermined schedules set by administrators. Meanwhile, facilities that adopt a person-centered approach provide older adults with opportunities to make their own decisions about when they eat dinner, get dressed, or go to bed. Individuals are also provided with choices about what activities they prefer to engage in.

**Personhood.** As older adults move into long-term care facilities, they are likely to lose their previous roles and have to adapt to new roles. Although there is a shift in roles, they do not need to lose their identity. The development of close relationships between staff and older adults allows for individuals to maintain their personhood in person-centered care. Establishing these relationships provides staff with the opportunity to learn about the individual's preferences, and in turn, these preferences can be incorporated in activity programming and daily cares. It is typical for an older adult's

preferences to be included in the activities that are offered (LeBlanc, Cherup, Feliciano, & Sidener, 2006).

**Homelike Environment.** Person-centered care promotes an environment that incorporates features of the home, instead of features of a hospital or an institution. Typically, meals are prepared in the main kitchen, access to refrigerators is restricted to staff, and residents share bedrooms and bathrooms (Koren, 2010). The person-centered approach provides individual rooms and bathrooms, communal dining, resident and staff access to refrigerators, and meals are prepared on the unit. A homelike setting provides residents with greater opportunities to maintain their autonomy and personhood.

### **Models of Person-Centered Care**

Currently, there are five models, in which characteristics of person-centered care have been incorporated. Those models include the Eden Alternative, the Green House Project, the Wellspring Model, the Regenerative Community, and the Holistic Approach to Transformational Change (HATCH; Jones, 2011; White-Chu, Graves, Godfrey, Bonner, & Sloane, 2009).

**Eden Alternative.** Dr. William Thomas, a geriatrician, developed the Eden Alternative. The purpose of the Eden Alternative is to create an environment that is reminiscent of a home, to provide older adults opportunities to pursue meaningful lives in long-term care facilities, and to reduce feelings of helplessness, loneliness, and boredom (Brownie, 2011; Thomas, 1996). Ten principles were developed to help promote quality of life. Those principles include: 1) loneliness, helplessness, and boredom account for one's suffering in long-term care facilities, 2) a "human habitat" is created by providing older adults with contact to children, animals, and plants, 3) loving companionship

between the older adult and environment, 4) opportunities to give and receive care are provided during the daily activities, 5) creating a diverse, spontaneous environment to allow for unpredictable interactions to occur, 6) opportunities to engage in activities that are meaningful is essential to human health, 7) medical treatment is not the primary focus of care, 8) decision making is governed by the individual and by those closest to the individual, 9) growth is not separated from life and is a never-ending process, and 10) honoring and respecting older adults allows for wisdom to grow (Thomas, 1996).

**Green House Project.** In addition to the Eden Alternative, Dr. William Thomas developed the Green House, with the intention to de-institutionalize nursing homes (Sharkey, Hudak, Horn, James, & Howes, 2011). This project was designed to develop small communities (e.g., 9-12 residents) that fostered meaning and relationships between staff and older adults (Fishman, Lowe, & Ryan, 2016). In comparison to typical long-term care facilities, older adults are provided with individual rooms and bathrooms, while the remaining rooms are designed to reflect a home (e.g., living room with fireplace, walk-in kitchen, communal dining table; Sharkey et al., 2006). In addition to their nursing duties, certified nursing assistants are responsible to prepare meals on the unit, housekeeping, and providing activities (Kane, Lum, Cutler, Degenholtz, & Yu, 2007; Sharkey et al., 2011). Another component to the Green House includes consistent staffing assignments, which facilitates and fosters the development of relationships between staff and residents (Bowers, Esmond, & Jacobson, 2000; Zimmerman & Cohen, 2010).

**Wellspring Model.** The Wellspring Model was developed in Wisconsin, where 11 nursing homes created an alliance to enhance the quality of life among older adults in

long-term care (Reinhard & Stone, 2001). This model comprises of six key elements including: 1) an alliance of nursing homes committed to making quality of care a priority, 2) the geriatric nurse practitioner is responsible for developing and distributing training materials, 3) interdisciplinary teams that receive training are responsible for teaching staff at their respected facilities, 4) networking among departments within the facility, 5) nursing staff is encouraged to make decisions that impact the resident's quality of care, and 6) staff receives performance data on resident outcomes and environmental factors related to the nursing homes in the alliance (Reinhard & Stone, 2001; Stone et al., 2002).

**Regenerative Community.** Dr. Barry Barkan established the regenerative community and may be referred to as the Live Oak Regenerative Community or the Live Oak Institute (Barkan, 2003; White-Chu et al., 2009). The regenerative communities are based on Erikson's developmental model (Jones, 2011); Erikson's eight-stage model views the aging process as another stage in life, in which the individual continues to develop (Erikson, 1966). Thus, the center of these communities are the older adults, and older adults are defined as individuals who are still growing, learning, and continuing to contribute to society and future (White-Chu et al., 2009). The older adult's physical illness is minimized and strengths, instead of the declines, become of focus (Holzer, 2007).

**Holistic Approach to Transformational Change (HATCh).** The Quality Partners of Rhode Island created the HATCh model to aid long-term care facilities transition from a medical to a person-centered care model, and it is most often used in long-term care facilities providing services to veterans (Quality Partners of Rhode Island,

2007; Sullivan et al., 2013). In this model, the older adult is in the center, surrounded by six domains. The first domain, the environment, refers to the facility's homelike environment (similar to the homelike characteristics in the Green House). Activities and procedures, which are related to quality care and staff stability, create the workplace practices; these practices affect residents through their influence on staff (White-Chu et al., 2009). The third domain, care practices, refers to care (e.g., medical or clinical care) that the older adult receives in the facility. These three domains have the greatest impact on the older adult and are encompassed within the fourth domain – leadership (White-Chu et al., 2009). Leadership represents leadership at all levels of the facility (e.g., directors, supervisors). The fifth domain is family and community, and the leaders within the facility encourage relationships with the older adult's family and community. The final domain includes partnerships between the facility and government agencies to aid in the transition to a person-centered model (Quality Partners of Rhode Island, 2007).

### **Impact of Person-Centered Care on Residents**

Person-centered care has been found to have a significant impact on residents' psychological well-being, quality of life, and behavioral symptoms (Bergman-Evans, 2004; Chenoweth et al., 2009; Kane et al., 2007; Robinson & Rosher, 2006; Sloane et al., 2004).

**Psychological Symptoms.** Robinson and Rosher (2006) examined whether depression in older adults with and without cognitive impairment would be impacted by the implementation of the Eden Alternative. Prior to implementation, the Geriatric Depression Scale (GDS) was administered to individuals without cognitive impairment, and the Cornell Depression screen was administered to individuals with cognitive

impairment. After the Eden Alternative model was implemented, researchers found a significant decrease of depressive symptoms in older adults with and without dementia.

A further examination of person-centered care on depressive symptoms produced similar findings. Molony, Evans, Jeon, Rabig, and Straka (2011) compared depressive symptoms among individuals in a small home and standard nursing home. The GDS was administered prior and after the individual's move to the small home and to those who resided in the standard nursing home. Results demonstrated a decrease in depressive symptoms for those in the small home.

In addition to depression, Bergman-Evans (2004) used a quasi-experimental design to examine whether cognitively intact older adults living in an Eden Alternative facility (i.e., experimental condition) differ in levels of loneliness, helplessness, and boredom compared to those living in a facility operating from the medical model (i.e., control condition). Preceding the implementation of the Eden Alternative, baseline levels of boredom, helplessness, and loneliness were collected for participants in both conditions. These measures were also administered after the implementation of the Eden Alternative. Between pre and post-implementation, helplessness (38.1% to 23.8%) and boredom decreased (33.3% to 23.8%). Meanwhile, loneliness remained the same at 52.4%. In the control condition, there was an increase in helplessness (61.5% to 69.2%) and boredom (53.8% to 61.5%) between baseline and intervention; however, loneliness decreased to 69.2% from 76.9%. A one-year follow-up demonstrated significantly lower levels of boredom and helplessness for those in the experimental condition compared to the control. These results suggest that person-centered care has the potential to reduce the experience of boredom and helplessness.

**Quality of Life.** There is also empirical evidence to support greater quality of life among older adults living in long-term care facilities that adopt person-centered care. Kane et al. (2007) compared the quality of life among older adults living in a Green House to older adults living in conventional nursing homes. Quality of care was assessed in 11 domains including comfort, functional competence, privacy, dignity, meaningful activity, relationship, autonomy, food enjoyment, spiritual well-being, security, and individuality. In comparison to the conventional facilities, greater quality of life was reported for privacy, dignity, meaningful activity, relationship, autonomy, food enjoyment, and individuality. Older adults residing in a Green House also had a lower prevalence of bed rest, fewer individuals with little daily activity, lower incidence of decline in ADLs, and a lower prevalence of depression compared to more traditional nursing homes.

Furthermore, Grant (2008) investigated quality of life among residents living in a person-centered care facility and residents living in facility implementing the medical model. Quality of life was assessed in reference to choice, autonomy, and dignity. Results indicated that individuals living in person-centered care environments had more opportunities to make decisions and were treated with greater dignity by staff. These results suggest that person-centered care has the potential to increase one's quality life through autonomy.

**Behavioral Symptoms.** Older adults with cognitive impairment tend to engage in behaviors, such as aggression and agitation. The prevalence of aggression ranges from 13-86% (Buchanan, Christenson, Ostrom, & Hofman, 2007), and the prevalence of agitation ranges 55-90% depending on the setting (e.g., day center, nursing home; Spira

& Edelstein, 2006). Person-centered care has been found to help reduce symptoms of aggression and agitation. For example, Chenoweth and colleagues (2009) examined the impact of person-centered care on agitation in older adults with dementia. Long-term care facilities received training in person-centered care or continued with usual care. The Cohen-Mansfield Agitation Inventory (CMAI), which assesses the type and occurrence of agitated behaviors, was administered before, after, and during follow-up in both conditions. Higher scores on the CMAI indicate a greater number of agitated symptoms. After facilities received training in person-centered care, CMAI scores significantly decreased throughout the course of the study, and lower scores were obtained during the four-month follow-up when compared to facilities engaging in usual care.

Moreover, Sloane and colleagues (2004) assessed the frequency of agitation (e.g., crying, yelling, resistiveness) and aggression (e.g., hitting, verbal threats, biting) among older adults with cognitive impairment during bathing routines. Three conditions were examined – person-centered showers, person-centered towel-baths, and showers without person-centered characteristics (served as control condition). The person-centered bathing routines focused on the individual's comfort and preferences by providing the individual with choices and using bath products recommended by family. In addition to aggression and agitation, discomfort was measured by rating the negative vocalization, content facial expression, sad facial expression, and relaxed, tense, and fidgeting body language on a 4-point scale. All behavioral symptoms (i.e., agitation and aggression) were reduced, ranging from 32-38%, from baseline to the intervention phases. Results further demonstrated a decrease by 25.6% in discomfort during the towel-bath intervention and 13.7% in the person-centered shower.



**Characteristics of Long-Term Care Staff**

Nursing staff (e.g., certified nursing assistants, registered nurses) are on the frontlines of implementing person-centered care to residents, as they provide 80-90% of direct cares (Coleman & Medvene, 2012). Unfortunately, there are several challenges that may arise and serve as potential barriers to implementing this approach. One challenge includes high turnover rates. Castle and Engberg (2006) reported that 56.4% of certified nursing assistants, 39.7% of licensed practical nurses, and 35.8% of registered nurses quit their jobs within the first year. Consequently, there are often staffing shortages. Staff shortages may be due to the increasing number of older adults with cognitive impairment requiring intensive care in long-term care facilities (Fitzpatrick, 2002). High turnover rates and staff shortages significantly impact a critical component of person-centered care – consistency of staff members working with each individual. This could also result to insufficient time to complete tasks, which in turn, directs staff to task-oriented behaviors. Another challenge that nursing staff often face is burnout, which is related to emotional exhaustion, depersonalization, and decreased sense of personal accomplishment (Abrahamson, Sutor, & Pillemer, 2009). It is not uncommon for nursing staff to experience burnout, particularly because work demands increase due to staff shortage and turnover. When nursing staff experiences burnout, they are less likely to provide the care that the residents should receive.

**Impact of Person-Centered Care on Nursing Staff**

Person-centered care has also been found to have a significant effect on nursing staff. Van den Pol-Grevelink, Jukema, and Smits (2011) conducted a systematic review examining the impact of person-centered care on nursing staff. They found that feelings

of autonomy increased, job demands decreased, staff was less likely to be on sick leave, increased job satisfaction and personal accomplishment when working in a facility that promoted person-centered care compared to a traditional nursing home. Furthermore, Edvardsson, Fetherstonhaugh, McAuliffe, Nay, and Checno (2011) asked nursing staff to complete a measure of job satisfaction and a measure of person-centered care. It was found that staff members who perceived their care to be person-centered had higher job satisfaction in the following areas: personal satisfaction, balanced work load, support from colleagues, professional support, and satisfaction with training.

Findings from these studies suggest that person-centered care can increase job satisfaction, increase feelings sense of accomplishment, and increase one's ability to care for residents based on their preferences among nursing staff. This is especially important, as they are often barriers to staff implementing person-centered care in long-term care facilities.

### **Purpose of the Current Study**

It is well known that job satisfaction among nursing assistants is low and person-centered care is becoming standard in long-term care facilities. However, little is known about what motivates caregiving behavior in nursing staff and if these motivators are consistent with principles of person centered-care. For example, if a staff member is primarily motivated to complete caregiving tasks efficiently and quickly, this could be directly contrary to a person-centered care approach. Therefore, knowing more about what motivates staff could have implications for more effectively selecting staff that have values consistent with person-centered care and could also identify potential barriers to implementing person-centered care. Thus, the purpose of the current study was to: 1)

design a questionnaire that assesses what motivates caregiving behavior in nursing staff that work in long-term care facilities, 2) to understand how frequently staff members experience specific events that could be reinforcers, and 3) to understand potential barriers and facilitators of implementing person-centered care techniques.

## **Method**

### **Participants and Settings**

Twenty-nine participants (3 males and 26 females) were recruited from three local long-term care facilities in the Midwest. The average age was 40.75 years ( $SD = 14.59$ ) and participants had an average of 12.14 years ( $SD = 11.40$ ) of experience working with older adults in long-term care. See Table 1 for participant demographics. Among the three facilities, two facilities provided memory care, independent, and assisted living; the third facility was an assisted living community. Participants were recruited by contacting administrators at each facility. The researchers received permission from administration to attend staff meetings to briefly describe the study and to ask if nursing staff was interested in participating. Inclusion criteria included individuals who were nursing staff (e.g., certified nursing assistants, licensed practical nurses, registered nurses, nurse manager), have direct involvement in personal care tasks (e.g., dressing, bathing) with residents, and were at least 18 years old. The University's Institutional Review Board approved this study.

### **Materials**

**Demographics form.** Participants were asked to identify their gender, age, ethnicity, how long they have worked in long-term care and with the elderly, job title, and

the primary unit (i.e., assisted living, skilled nursing, memory care, or mixed units) in which they work. See Appendix A for a copy of the demographics form.

**Reinforcer Survey.** The Staff Reinforcer Survey is a 43-item questionnaire that was developed by the researchers. It includes a series of items that describe potential motivators/reinforcers for nursing staff in their day-to-day work. See Appendix B for survey. The researchers grouped the items into rationally-derived subscales (i.e., subscales were not created using empirical methods). Those subscales include intrinsic motivation (e.g., “opportunities to learn new caregiving skills”), extrinsic motivation (e.g., “not being reprimanded (written up) by a supervisor”), task-oriented behavior (e.g., “getting a personal care task done without being physically attacked by a resident”), support from administrators (e.g., “praise or statements of approval from supervisors or administrators”), working independently (e.g., “performing a caregiving task in my own way”), rule governed behavior (e.g., “following care plans”) relationships with co-workers (e.g., “having support from my colleagues”), relationships with residents (e.g., “hearing a resident tell stories about their past”), relationships with family (e.g., “interactions with resident family members or friends”), and collaboration (e.g., “collaborating with family members and my co-workers to develop care plans. These subscales were intended to measure different types of motivators for nursing staff. See Table 2 for a list of items in each subscale. For each item, participants were asked to use a 4-point Likert-type scale (1 = not at all important, 2 = somewhat important, 3 = important, 4 = very important) to rate how important they found each item. Participants were also asked to use a 4-point Likert scale (1 = never, 2 = rarely, 3 = sometimes, 4 = always) to rate how often each experience occurs.

**Procedure**

Individuals who agreed to participate had the option to complete a paper and pencil version of the survey or they could complete the survey online. Participants who chose to complete a hard copy of the questionnaire were provided with two copies of the consent form (one is signed and one is for their records), a demographics form, and a questionnaire at the staff meeting. Research staff reviewed the consent form with the participant and then allowed them to complete the questionnaire in a private area of the facility. To maintain confidentiality, all packets were assigned an alphanumeric code, and participants were provided with a large envelope to submit their completed forms.

The online version of the survey was available through the Qualtrics online survey system. This version of the survey is identical to the paper-pencil version. Participants completing the online version were presented with the consent form first, followed by the demographics form and survey. If a participant selected “I agree” to the online consent form, then this inferred consent to participate. If a participant selects “I disagree” to the consent form, then the participant is brought to a page thanking them for his/her time. No identifying information or IP addresses were collected to protect anonymity.

**Data Analysis**

Data analysis included an examination of means and standard deviations of the importance of each item and subscale. Additionally, the means and standard deviations of the frequency of each item and subscale were examined. Lastly, the relationship between years of experience working with older adults and items and subscales will be assessed with Pearson’s correlation.

## Results

### Descriptive Data

**Rankings of Items on Importance.** The means and standard deviations of each item were examined to determine the highest and lowest rated items in terms of how important they were to staff. The top 20% (i.e., top eight items) of items were categorized as the highest ranked items, while the bottom 20% (i.e., bottom eight items) were the lowest ranked items. See Table 3 for the means and standard deviations of all items. The items ranked the highest included: “meeting resident’s needs” ( $M = 4.00$ ,  $SD = .00$ ), “having a positive impact on the residents” ( $M = 4.00$ ,  $SD = .00$ ), “learning about what the resident likes and dislikes” ( $M = 4.00$ ,  $SD = .00$ ), “opportunities to learn new caregiving skills” ( $M = 3.97$ ,  $SD = .57$ ), “fostering trusting, caregiving relationships with residents and families” ( $M = 3.93$ ,  $SD = .26$ ), “commitment to do quality work” ( $M = 3.90$ ,  $SD = .31$ ), “following care plans” ( $M = 3.90$ ,  $SD = .31$ ), and “opportunities to work with a team” ( $M = 3.90$ ,  $SD = .31$ ).

The lowest ranked items in terms of importance consisted of “not getting negative feedback about my job performance” ( $M = 3.24$ ,  $SD = .79$ ), “engaging in tasks that will not affect my performance evaluation” ( $M = 3.24$ ,  $SD = .88$ ), “making mistakes and learning from them” ( $M = 3.21$ ,  $SD = .88$ ), “getting a personal care task done without being insulted or threatened by a resident” ( $M = 3.18$ ,  $SD = .91$ ), “being emotionally involved with residents” ( $M = 3.11$ ,  $SD = .97$ ), “engaging in tasks that will affect my performance evaluation” ( $M = 3.04$ ,  $SD = 1.17$ ), “performing a caregiving task in my own way” ( $M = 2.96$ ,  $SD = 1.04$ ), and “getting a personal care task done quickly” ( $M = 2.74$ ,  $SD = .94$ ).

**Rankings of Items on Frequency.** The means and standard deviations of each item were examined to determine the highest and lowest rated items in terms of frequency. As with the data concerning importance of each item, the top 20% (i.e., top eight items) of items were categorized as the highest ranked items, while the bottom 20% (i.e., bottom eight items) were the least ranked items. See Table 4 for the means and standard deviations of all items. “Having a positive impact on the residents” ( $M = 3.85$ ,  $SD = .36$ ), “getting paid” ( $M = 3.85$ ,  $SD = .46$ ), “commitment to doing quality work” ( $M = 3.78$ ,  $SD = .42$ ), “following care plans” ( $M = 3.74$ ,  $SD = .53$ ), “satisfaction helping older individuals” ( $M = 3.70$ ,  $SD = .54$ ), “doing what I am told to do by my supervisor” ( $M = 3.70$ ,  $SD = .54$ ), “resident(s) smiles at me” ( $M = 3.67$ ,  $SD = .62$ ), and “learning about what the resident likes and dislikes” ( $M = 3.63$ ,  $SD = .63$ ) appear to occur the most often.

Items that had the lowest frequency rating included: “performing a caregiving task in my own way” ( $M = 2.85$ ,  $SD = .88$ ), “having resources to pursue opportunities for professional growth” ( $M = 2.85$ ,  $SD = 1.06$ ), “praise or statements of approval from co-workers” ( $M = 2.78$ ,  $SD = 1.01$ ), “not getting negative feedback from supervisors about my job performance” ( $M = 2.74$ ,  $SD = .90$ ), “engaging in tasks that will not affect my performance evaluation” ( $M = 2.74$ ,  $SD = 1.01$ ), “breaks” ( $M = 2.64$ ,  $SD = .86$ ), “praise or statements of approval from supervisors and administrators” ( $M = 2.56$ ,  $SD = .92$ ), and “not being reprimanded (written up) by a supervisor” ( $M = 2.48$ ,  $SD = 1.12$ ).

**Rankings of Subscales on Importance.** See Table 5 for the means and standard deviations of each subscale. Results indicated that the rule governed behavior subscale ( $M = 3.84$ ,  $SD = .30$ ) had the highest ranking followed by support from administrators ( $M$

= 3.79,  $SD = .32$ ), intrinsic motivation ( $M = 3.77$ ,  $SD = .23$ ), relationships with residents ( $M = 3.75$ ,  $SD = .27$ ), collaboration ( $M = 3.69$ ,  $SD = .34$ ), relationships with co-workers ( $M = 3.64$ ,  $SD = .44$ ), relationships with families ( $M = 3.61$ ,  $SD = .45$ ), extrinsic motivation ( $M = 3.35$ ,  $SD = .43$ ), working independently ( $M = 3.33$ ,  $SD = .55$ ), and task-oriented ( $M = 3.12$ ,  $SD = .72$ ).

**Rankings of Subscales on Frequency.** See Table 5 for the means and standard deviations of each subscale. The subscale related to rule governed behavior ( $M = 3.72$ ,  $SD = .45$ ) had the highest ranking of frequency followed by relationships with residents ( $M = 3.46$ ,  $SD = .40$ ), intrinsic motivation ( $M = 3.40$ ,  $SD = .47$ ), relationships with families ( $M = 3.35$ ,  $SD = .52$ ), relationships with co-workers ( $M = 3.15$ ,  $SD = .56$ ), collaboration ( $M = 3.15$ ,  $SD = .65$ ), task oriented ( $M = 3.11$ ,  $SD = .45$ ), working independently ( $M = 3.08$ ,  $SD = .48$ ), extrinsic motivation ( $M = 2.90$ ,  $SD = .56$ ), and support from administrators ( $M = 2.84$ ,  $SD = .84$ ).

### Correlational Analyses

A series of correlational analyses were conducted to determine if years of work experience was related to the importance of particular items. Pearson's product-moment correlation indicated that years of experience working with older adults in long-term care facilities was significantly related to importance ratings on only one item, "engaging in tasks that will not affect my performance evaluation",  $r = -.51$ ,  $p = .009$ . No other significant correlations were found between years of work experience and ratings of importance.

In addition, a series of correlational analyses were conducted to determine if years of work experience was related to ratings of how frequently events occurred. A Pearson's



product-moment correlation also found years of experience working to be significantly correlated with ratings of frequency in “engaging in tasks that will not affect performance evaluation” ( $r = -.54, p = .009$ ), “opportunities to learn new caregiving skills” ( $r = -.39, p = .049$ ), “having a positive impact on residents” ( $r = -.41, p = .04$ ), “hearing stories about the resident’s past” ( $r = -.45, p = .02$ ), and “residents expressing appreciation” ( $r = -.48, p = .01$ ). No other significant correlations were found between years of work experience and ratings of frequency.

Lastly, a series of correlational analyses were conducted to determine if years of work experience was related to subscale scores in terms of importance and frequency. Pearson’s correlation found a significant relationship between years of experience and frequency scores on the extrinsic subscale ( $r = -.56, p = .008$ ) and scores on the relationships with residents subscale ( $r = -.44, p = .04$ ). No significant correlations between years of experience and subscale scores on ratings of importance were found.

### **Discussion**

Recently, long-term care facilities have begun to transition from a medical to a person-centered approach. Research has found person-centered care to decrease depressive symptoms (Molony et al., 2011), feelings of loneliness and boredom (Bergman-Evans, 2004), report fewer behavioral symptoms (Chenoweth et al., 2009; Sloane et al., 2004), and increase quality of life (Grant, 2008; Kane et al., 2007) in older adults with and without dementia. Increased feelings of autonomy, personal accomplishment, social support, and higher reports of job satisfaction (Edvardsson, Fetherstonhaugh, McAuliffe, Nay, & Chenco, 2011; van den Pol-Grevelink, Jukema, & Smits, 2011) in nursing staff have been associated with the implementation of person-

centered care. Unfortunately, there is a lack of research investigating what motivates caregiving behavior in nursing staff and whether these motivators are consistent with the characteristics of person-centered care. Therefore, the current study was the first to attempt to assess what motivates caregiving behavior among nursing staff and how often these motivators occur. Further, this study provided valuable insights into variables that might facilitate and/or impede the implementation of person-centered care.

### **Item/Subscale Importance**

The results provided preliminary data about the potential motivators of caregiving behaviors in nursing staff. Results indicated that nursing staff found some experiences to be more important than others. Specifically, experiences related to providing care to residents (i.e., “meeting resident’s needs,” “commitment to doing quality work,” and “having a positive impact on the residents”), communicating with the resident and family members (i.e., “fostering trusting, caregiving relationships with residents and families”), learning about the resident’s preferences (i.e., “learning about what the resident likes and dislikes”), enhancing one’s caregiving skills (i.e., “opportunities to learn new caregiving skills”), and considering the individual’s needs in care plans (i.e., “following care plans”) were the most important experiences and are potential motivators for staff in long-term care.

Meanwhile, experiences related to one’s job performance (i.e., “not getting negative feedback about my job performance,” “engaging in tasks that will not affect my performance evaluation,” and “engaging in tasks that will affect my performance evaluation”), completing a care task (i.e., “getting a personal care task done without being insulted or threatened by a resident,” “performing a caregiving task in my own

way,” and “getting a personal care task done quickly”), learning from mistakes (i.e., “making mistakes and learning from them”), and involving oneself with residents on an emotional level (i.e., “being emotionally involved with residents”) were less important to nursing staff.

In regards to the subscales, some importance rankings were consistent and some were more variable. For example, rule governed behavior was ranked as the most important subscale, but the item “following care plans” was the only item from this subscale that was ranked as important in terms of being in the top 20%. It seems that both items in the “rule governed” subscale are not individually ranked as important, but when they are grouped together, nursing staff views these items as important.

Interestingly, individual items grouped into the subscale, “support from administrators,” were not highly ranked items; however, when grouped together, they formed one of the highest ranked subscales in terms of importance. These results indicate that content related to any individual item in this subscale was not necessarily important, but when these items were combined, nursing staff perceives support from administration to be important.

The “intrinsic motivation” subscale was also highly ranked, and some of the items (i.e., “opportunities to learn new caregiving skills,” and “commitment to doing quality work”) within this subscale were also individually ranked as important. These results are very encouraging and indicate that nursing staff finds these caregiving experiences to be personally rewarding, perhaps by creating feelings of accomplishment, pride, or satisfaction from helping others as opposed rewarded by external events such as praise.

It is not surprising that the subscale, “relationships with residents,” was highly ranked because several items (i.e., “meeting resident’s needs,” “having a positive impact on the residents,” “learning about what the resident likes and dislikes,” and “fostering trusting, caregiving relationships with residents and families”) from this subscale were in the top 20%.

Overall, relationships with residents were the most important experiences nursing staff encounter in their day-to-day work. Further, intrinsic motivators were ranked as more important than the extrinsic motivators, suggesting that motivators that are personally rewarding are more important than rewards such as praise or performance evaluations. These results also demonstrate that experiences related to completing tasks quickly, working independently, and job performance were not as important compared to quality of care that is provided to residents in long-term care facilities.

### **Item/Subscale Frequency**

This study also provided preliminary data as to how often nursing staff experience various motivators. Results indicated that some experiences occur more frequently than other experiences. Experiences such as providing care to residents (i.e., “commitment to doing quality of work” “having a positive impact on the residents”), following care plans (i.e., “following care plans”), learning about the resident’s preferences (i.e., “learning about what the resident likes and dislikes”), aspects of one’s job (i.e., “getting paid” and “doing what I am told to do by my supervisor”), nonverbal responses from the residents (i.e., “resident(s) smiles at me”), and satisfaction of helping older adults (i.e., “satisfaction of helping older individuals”) occurred the most often.

Other experiences such as job performance (i.e., “not getting negative feedback from supervisors about my job performance,” “engaging in tasks that will not affect my performance evaluation,” and “not being reprimanded by a supervisor”), receiving praise (i.e., “praise or statements of approval from co-workers” and “praise or statements of approval from supervisors and administrators”), completing a task according to the staff member’s preference (i.e., “performing a caregiving task in my own way”), and enhancing one’s caregiving skills (i.e., “having resources to pursue opportunities for professional growth”) were least frequent.

When the items were grouped into subscales, nursing staff ranked rule-governed behaviors to occur the most frequently. This is consistent with the high frequency rankings of the individual items such as “following care plans” and “doing what I am told to do by my supervisor”. These results indicate that nursing staff is motivated to meet the expectations listed in their job descriptions and are doing what is necessary to meet the responsibilities of their job title.

The subscale, “relationships with residents,” was also ranked as occurring frequently. This was consistent with the individual rankings of items, as “having a positive impact on the residents,” “resident(s) smiles at me,” and “learning about what the resident likes and dislikes” frequently occurred. These results indicate that nursing staff is not only motivated to engage in caregiving behaviors that are focused on the resident, but that they frequently engage in these tasks and find satisfaction in them. This sample may also be more prone to engaging in such caregiving behaviors because they work in long-term care facilities that implement person-centered care.

When items related to intrinsic motivation were grouped together, frequency ratings were high, but only one item (i.e., “satisfaction of helping older individuals”) in this subscale was ranked in the top 20% of individual frequency items. These results indicate that single items of intrinsic motivation are not occurring as frequently, but when items related to intrinsic motivation are grouped together, nursing staff perceives these items to occur frequently.

In relation to scores on other subscales, frequency ratings on the “extrinsic motivation” subscale were relatively low. The items in this subscale, such as “not getting negative feedback from supervisors about my job performance,” “engaging in tasks that will not affect my performance evaluation,” “breaks,” and “not being reprimanded (written up) by a supervisor,” were also individually rated as rarely occurring. This suggests extrinsic motivation is not a common motivator among nursing staff in long-term care facilities.

The “support from administrators” subscale was ranked to occur the least often; however, only one item (i.e., “praise or statements of approval from supervisors and administrators”) from this subscale was individually ranked to rarely occur. These results indicate that administrative support is perceived to occur relatively infrequently.

These results suggest that motivators related to establishing relationships with residents and considering the resident’s needs and preferences are occurring frequently. In addition, motivators related to the duties of nursing staff (e.g., following instructions from the supervisor or care plans) also occur frequently. However, experiences that are driven by external rewards (e.g., breaks, performance evaluations) occur less frequently,

suggesting there is a greater focus placed on providing the greatest level of care to the residents.

### **Importance vs. Frequency**

When comparing and contrasting rankings of importance and frequency, interesting findings were revealed. One interesting trend is that the highly ranked experiences were generally also reported to occur frequently. For instance, “meeting resident’s needs,” “having a positive impact on the residents,” “learning about what the resident likes and dislikes,” “commitment to doing quality work,” and “following care plans” were items ranked in the top 20% for importance and for frequency. Experiences that were ranked as less important also generally occurred less frequently. Those experiences included “not getting negative feedback from supervisors about my job performance,” “engaging in tasks that will not affect my performance,” and “performing a care task in my own way.”

Another interesting finding is that some experiences were ranked as important, but these experiences were rarely occurring. For example, experiences such as “not getting negative feedback from supervisors about my job performance,” “not being reprimanded (written up) by a supervisor,” “engaging in tasks that will not affect my performance evaluation,” “getting a personal care task done without being physically attacked by a resident,” “breaks,” “having resources to pursue opportunities for professional growth,” “praise or statements of approval from supervisors or administrators,” and “praise or statements of approval from co-workers” were ranked as important and as rarely occurring. An examination of the subscale rankings revealed similar results. For instance, the “support from administrators” subscale was ranked as

important, but was found to occur the least often. This suggests that receiving praise and support from supervisors and administrators is a potential motivator for nursing staff, but nursing staff experience these motivators relatively infrequently compared to other motivators.

Conversely, one experience was ranked as less important, but ranked as sometimes occurring. This experience included “getting a personal care task done quickly.” This finding may be attributed to the challenges that nursing staff encounters - nursing staff experiences staff shortages, and as a result, staff members are assigned to a greater number of residents during a shift, and there may not a sufficient amount of time to meet each resident’s needs. Thus, nursing staff relies on getting care tasks done quickly to ensure that they have enough time to meet all resident’s needs.

### **Correlations**

A series of correlational analyses indicated that there were some significant relationships between years of experience working with older adults and questionnaire items. It appears that nursing staff with greater work experience rank “engaging in tasks that will not affect my performance evaluation” as less important and frequent. These results suggest that caregiving tasks that are unrelated to performance evaluation are not perceived as important or frequent among nursing staff who have greater work experience.

Results also demonstrated that experienced nursing staff rank “opportunities to learn new caregiving skills,” “having a positive impact on residents,” “hearing stories about the resident’s past,” and “residents expressing appreciation” as occurring less frequently. Additionally, nursing staff with greater work experience rank the subscales,



“extrinsic motivation” and “relationship with residents,” as less likely to occur. Because this sample included individuals who worked with older adults for a long period of time, they may be familiar with the resident(s) preferences and past stories and have already established a relationship with the resident(s). These findings may also be suggestive of burnout. As nursing staff works in long-term care facilities, they become more likely to encounter symptoms of burnout, and as a result they may not be emotionally present to provide care that is person centered.

### **Limitations/Future Directions**

Although some interesting findings were revealed, limitations of the current study need to be acknowledged. One limitation includes the size of the sample. There were only 29 participants included in this study. Due to the size of the sample, it is likely that responses to the questionnaire may not be a true representation of what motivates most nursing staff. Also, this sample was older and more experienced compared to many people who work in long-term care. Future research should include a larger sample to establish a greater understanding of what motivates caregiving behaviors. This sample was also predominately Caucasian and female. Although this sample fits the profile of nursing staff working in long-term care facilities, it limits the generalization to other populations, such as minorities or males. Generalizability of the results may also be limited by the fact that the sample was recruited from the Midwest. Thus, future research should include a more diverse and representative sample of the population of professional caregivers.

Consequently, a small sample size limits the statistical analyses that could be conducted. For instance, an exploratory factor analysis is warranted to determine if there

are statistically relevant subscales or themes among questionnaire items. A minimum sample size of 100 is recommended for conducting an exploratory factor analysis (Gorsuch, 1983), so one was not performed for this study. As a result a result, rationally-derived subscales were created as an alternative. However, whether these subscales have adequate internal consistency is unknown. Future research should aim to obtain a larger sample and conduct an exploratory factory analysis to determine what subscales or themes are statistically driven.

Another limitation is related to the recruitment procedures. Participants were recruited during staff meetings. At these meetings, nursing staff was provided with the opportunity to complete a hardcopy or online version of the survey. The researchers gave hard copies of the survey in the beginning of the staff meetings and did not require staff to complete the survey immediately. Future research should consider recruiting participants at the end of the staff meeting and asking staff members to stay a few minutes to complete the survey on site. Several potential participants also disclosed that they are interested in the online version; however, these individuals did not complete the online survey. The lack of response from the online version may be attributed to the fact that participants provided invalid email addresses, did not recognize the sender's name of the email, or participants changed their minds. Future research may want to examine other recruitment procedures, such as asking the nursing manager or administration to send an email enclosed with the link to the survey to provide familiarity with the sender.

Additionally, nursing staff was not consulted in the development of the questionnaire. Prior to data collection, the behavioral health team at one of the facilities was asked to review the questionnaire. The behavior health team consisted only of

psychologists and behavior analysts, not nursing staff. Therefore, it is possible that other items or content areas may have been included on the questionnaire had the researchers hosted focus groups with nursing staff. Future research should consider conducting focus groups with nursing staff to ensure the content validity of the instrument (i.e., that the items are relevant to their work experiences).

Questionnaire inherently require respondents to retrospectively report on their own behavior. Accurately estimating the frequency of certain events can be difficult and estimates are subject to cognitive biases (e.g., recency effect, availability heuristic), and memory distortions. Another disadvantage of self-report may include tendencies to respond to items in a socially desirable manner. For example, the items in the rule governed behavior subscale (e.g., “following care plans” or “doing what I am told to do by my supervisor”) could be answered in a favorable light regardless of the participant’s true opinions or beliefs. It is expected that participants would rank items in this subscale as “always” occurring because participants would not want to be viewed as individuals who do not follow the rules set by the facility, and potentially, by the law. Future research may incorporate live observations to assess the frequency of how often these experiences on the questionnaire occur.

Furthermore, this study did not administer the questionnaire to nursing staff working in long-term care facilities that operate from the medical model. Due to the differences between medical and person-centered approaches, it seems possible that nursing staff’s caregiving behaviors would be motivated by different experiences. Direct comparisons between the motivators of nursing staff in facilities implementing different models of care cannot be concluded from this study. Thus, future research should

administer the questionnaire to a facility using the medical model and to a facility using person-centered approach to examine if there are differences among nursing staff's rankings.

Moreover, this study also did not assess the reinforcing value of these motivators, which may provide further insights to why some experiences are ranked as more important or occurring more frequently. It may be possible that reinforcers with great value may be more difficult to provide and would occur less frequently. Future research should assess the reinforcing value of these motivators.

In addition, this study did not assess job satisfaction among nursing staff in long-term care facilities. Previous research demonstrated that nursing staff has higher levels of job satisfaction when implementing person-centered care (Edvardsson et al., 2011; van den Pol-Grevelink et al., 2011). Future research should examine whether the frequency of motivators are related to job satisfaction.

It is well known that nursing staff often experiences burnout, which is related to poor job satisfaction and high turnover rates among staff. Characteristics (e.g., emotional exhaustion, job demands) contributing to burn out may be suggestive of motivators that are lacking in long-term care facilities. Future research should investigate whether nursing staff who quit their jobs do so because of burnout, and if they do, then what careers do these individuals have after their job at the long-term care facility. This can help identify what motivators are lacking in long-term care facilities.

Lastly, future research should continue to examine the motivators among nursing staff. Because 8.3 million older adults are seeking home-care services (Ortman et al., 2014), it would be interesting to investigate whether home services are implementing

person-centered care, and if the same experiences that motivate caregiving behaviors among nursing staff in long-term care facilities upholds in home care. Such a study could provide further insight to the potential barriers of implementing person-centered care in the home.

### **Implications**

Understanding what motivates caregiving behaviors and how often these motivators occur in long-term care facilities has important implications for nursing staff, elder care, and the implementation of person-centered care. One significant implication is that some motivators may serve as facilitators of person-centered care. Experiences related to the characteristics, such as maintaining autonomy, personhood, and close relationships, of person-centered were the most important and most frequent experiences that nursing staff encountered. Thus, it would be easier to promote person-centered care in long-term facilities because nursing staff finds these experiences to be important. Fortunately, one common finding from the current study is that motivators consistent with person-centered care values (e.g., “meeting resident’s needs,” “learning about what the resident likes and dislikes”) were often reported as being important and occurring frequently.

This study also demonstrated that there are potential barriers to implementing person-centered care. One potential barrier relates to the minimal support received from administrators and supervisors. Nursing staff indicated that receiving praise and support from their authority figures are important, but this is occurring relatively infrequently. Empirical research has found that nursing staff manages challenges such as staff shortages and job demands better in a supportive work environment (Noelker, Ejaz,

Menne, & Jones, 2006). In supportive environments, nursing staff may be less likely to experience burnout, which in turn allows nursing staff to promote the greatest quality of care to the residents and to engage in the characteristics (e.g., establishing close relationships, getting to know the resident) indicative of person-centered care. Therefore, it can be recommended that supervisors and administrators be mindful of providing more support to their frontline nursing staff.

Another potential barrier relates to task oriented behaviors. Although the “task oriented” subscale had the lowest frequency ratings, nursing staff still viewed these behaviors to be important and occurring at least occasionally. This can impede the implementation of person-centered care because these experiences are representative of the medical model and the focus of care is not on the resident, but rather the task at hand. It is possible that these experiences are important because nursing staff must consider safety to themselves as well as the resident. The resident may have fewer opportunities to engage in physical or verbal aggression when staff members are completing a care task more quickly.

Furthermore, behavior analysts can use this data to help promote behavioral intervention protocols in long-term care facilities. Behavior analysts are helpful in creating interventions that address problem behavior in residents; however, even effective interventions are not always implemented once the behavior analyst stops working with the resident. It could be that implementing new caregiving strategies is not reinforced. If behavior analysts knew what motivated nursing staff, then they could potentially incorporate some of these motivators in the interventions. For example, a component of

an intervention could focus on meeting the resident's needs and asking the resident questions about his/her preferences.

Lastly, findings from this study can also have implications in the hiring process at long-term care facilities, especially for those facilities implementing person-centered care. Administrators or supervisors conducting interviews with applicants may use the staff reinforcer survey as a measure to supplement the hiring process. Incorporating this in the application or interview process can help administrators evaluate whether the applicant's motivators are consistent or inconsistent with those of person-centered care. For instance, an applicant may be primarily motivated to complete caregiving tasks efficiently and quickly, which is contrary to a person-centered care approach.

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Table 1  
*Participant Demographics*

Variables	Totals
Age (years)	
<i>M</i>	40.75
<i>SD</i>	14.59
Gender	
Females	26
Males	3
Work Experience (years)	
<i>M</i>	12.14
<i>SD</i>	11.40
Ethnicity	
Caucasian/White	18
Black/African American	8
Asian	1
Job Title	
Health Science Technician	4
Licensed Practical Nurse	9
Registered Nurse	4
Care Manager	6
Certified Nursing Assistant	1
Health Science Technician Senior	1
Nursing Assistant	1
Registered Nurse Supervisor	1
Lead Resident Assistant	1
Resident Assistant	1
Unit Worked On	
Assisted Living	5
Memory Care	9
Skilled Nursing	1
Mixed Units	14

Table 2  
*Items in Each Subscale*

Subscales	Items
Intrinsic Motivation	Opportunities to learn new caregiving skills Feeling accomplished Having resources to pursue opportunities for professional growth Satisfaction of helping older individuals Commitment to doing quality work Experiencing challenges of working with residents with cognitive impairment
Extrinsic Motivation	Not being reprimanded (written up) by a supervisor Getting paid Breaks Not getting negative feedback from supervisors about my job performance Engaging in tasks that will affect my performance evaluation Engaging in tasks that will not affect my performance evaluation
Task Oriented	Getting a personal care task done without being physically attacked by a resident Getting a personal care task done quickly Getting a personal care task done without being threatened or insulted by a resident
Support from Administrators	Praise or statements of approval from supervisors or administrators Having the support of my supervisor or administration
Working Independently	Correcting my mistakes Opportunities to work independently Performing a caregiving task in my own way Making mistakes and learning from them
Rule Governed Behavior	Following care plans Doing what I am told to do by my supervisor
Relationships with Residents	Having a positive impact on the residents Being emotionally involved with residents Hearing a resident tell stories about their past Resident(s) smiles at me Statements of appreciation (e.g., thank you) from the resident Learning about what the resident likes and dislikes Hearing a resident laugh Resident(s) expresses appreciation Fostering trusting, caregiving relationships with residents

	and families
	Meeting resident's needs
	Providing residents with opportunities to make decisions
Relationships with Families	Interactions with resident family members or friends
	Including family members in care decisions
	Praise or statements of approval from a resident's family member(s)
Relationships with Co-workers	Praise or statements of approval from co-workers
	Conversing with co-workers
	Opportunities to work with a team
	Having support from colleagues
Collaboration	Including family members in care decisions
	Collaborating with an interdisciplinary team
	Collaborating with family members and my co-workers to develop care plans

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Table 3  
*Means and Standard Deviations of Item Importance*

Questionnaire Items	<i>M</i>	<i>SD</i>
Meeting resident's needs	4.00	.000
Having a positive impact on the residents	4.00	.000
Learning about what the resident likes and dislikes	4.00	.000
Opportunities to learn new caregiving skills	3.97	.19
Fostering trusting, caregiving relationships with residents and families	3.93	.26
Commitment to doing quality work	3.90	.31
Following care plans	3.90	.31
Opportunities to work with a team	3.90	.31
Correcting my mistakes	3.90	.31
Satisfaction of helping older individuals	3.90	.31
Hearing a resident tell stories about their past	3.86	.35
Resident(s) smile at me	3.86	.35
Having the support of my supervisor or administration	3.86	.35
Hearing a resident laugh	3.83	.60
Providing residents with opportunities to make decisions	3.79	.57
Including family members in care decisions	3.79	.41
Doing what I am told to do by my supervisor	3.79	.41
Having resources to pursue opportunities for professional growth	3.76	.44
Getting paid	3.72	.65
Feeling accomplished	3.72	.59
Interaction with residents' family members or friends	3.69	.60
Having support from colleagues	3.69	.66
Praise or statements of approval from supervisors and administrators	3.68	.48
Collaborating with an interdisciplinary team	3.66	.48
Collaborating with family members and my co-workers to develop care plans	3.62	.73
Not being reprimanded (written up) by a supervisor	3.52	.63
Praise or statements of approval from co-workers	3.52	.74
Getting a personal care task done without being physically attacked by a resident	3.48	.74
Statements of appreciation from the resident	3.48	.83
Resident(s) expresses appreciation	3.45	.63
Experiencing challenges working with residents with cognitive impairment	3.43	.69
Breaks	3.41	.78
Conversing with co-workers	3.36	.73
Praise or statements of approval from a resident's family member	3.34	.81
Opportunities to work independently	3.31	.89
Not getting negative feedback about my job performance	3.24	.79

Engaging in tasks that will not affect my performance evaluation	3.24	.88
Making mistakes and learning from them	3.21	.88
Getting a personal care task done without being insulted or threatened by a resident	3.18	.91
Being emotionally involved with residents	3.11	.97
Engaging in tasks that will affect my performance evaluation	3.04	1.17
Performing a caregiving task in my own way	2.96	1.04
Getting a personal care task done quickly	2.74	.94

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Table 4  
*Means and Standard Deviations of Item Frequencies*

Questionnaire Items	<i>M</i>	<i>SD</i>
Having a positive impact on the residents	3.85	.36
Getting paid	3.85	.46
Commitment to doing quality work	3.78	.42
Following care plans	3.74	.53
Satisfaction of helping older individuals	3.70	.54
Doing what I am told to do by my supervisor	3.70	.54
Resident(s) smile at me	3.67	.62
Learning about what the resident likes and dislikes	3.63	.63
Meeting resident's needs	3.58	.58
Opportunities to work with a team	3.56	.70
Fostering trusting, caregiving relationships with residents and families	3.56	.70
Feeling accomplished	3.48	.64
Experiencing challenges working with residents with cognitive impairment	3.44	.70
Correcting my mistakes	3.44	.70
Interaction with residents' family members or friends	3.41	.75
Providing residents with opportunities to make decisions	3.38	.64
Praise or statements of approval from a resident's family member	3.31	.62
Hearing a resident laugh	3.30	.61
Statements of appreciation from the resident	3.30	.72
Including family members in care decisions	3.30	.87
Conversing with co-workers	3.27	.60
Hearing a resident tell stories about their past	3.26	.90
Opportunities to work independently	3.19	.88
Being emotionally involved with residents	3.15	.68
Resident(s) expresses appreciation	3.12	.65
Getting a personal care task done without being insulted or threatened	3.11	.70
Opportunities to learn new caregiving skills	3.11	.85
Having support from colleagues	3.11	.85
Getting a personal care task done quickly	3.08	.64
Engaging in tasks that will affect my performance evaluation	3.08	.98
Collaborating with family members and my co-workers to develop care plans	3.08	.95
Collaborating with an interdisciplinary team	3.07	.87
Having the support of my supervisor or administration	3.04	.94
Making mistakes and learning from them	3.00	.80
Getting a personal care task done without being physically attacked by a resident	2.96	.76
Performing a caregiving task in my own way	2.85	.88

Having resources to pursue opportunities for professional growth	2.85	1.06
Praise or statements of approval from co-workers	2.78	1.01
Not getting negative feedback from supervisors about my job performance	2.74	.90
Engaging in tasks that will not affect my performance evaluation	2.74	1.01
Breaks	2.64	.86
Praise or statements of approval from supervisors and administrators	2.56	.92
Not being reprimanded (written up) by a supervisor	2.48	1.12

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Table 5  
*Means and Standard Deviations for Subscales*

Subscales	Importance		Frequency	
	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>
Rule Governed Behavior	3.84	.30	3.72	.45
Support from Administrators	3.79	.32	2.84	.84
Intrinsic Motivation	3.77	.23	3.40	.47
Relationships with Residents	3.75	.27	3.46	.40
Collaboration	3.69	.34	3.15	.65
Relationships with Co-workers	3.64	.44	3.15	.56
Relationships with Families	3.61	.45	3.35	.52
Extrinsic Motivation	3.35	.43	2.90	.56
Working Independently	3.33	.55	3.08	.48
Task Oriented	3.12	.72	3.11	.45

## Appendix A

## Demographics Form

**Demographic Information:**

1. Gender:    M       F
2. Age: _____
3. Ethnicity: (Circle one)  Caucasian/non-Hispanic White Black African American Asian/Pacific Islander Hispanic or Latino/a Native American Other: _____
4. Job title: _____
5. Years of work experience caring for older adults & elderly: _____
6. Unit You Work On (Circle One):  Assisted Living                      Memory Care                      Skilled Nursing                      Mix of different units

## Appendix B

## Nursing Staff Reinforcer Survey

The items on this survey refer to experiences that might be important to you in doing your day-to-day work. There may also be some items on this survey that refer to experiences that are not important to you. Some items refer to “personal care tasks”, which include tasks such as dressing, bathing, grooming, feeding or toileting residents.

Please answer each item honestly, and if there are items you do not feel comfortable answering, you may skip those items. For each item listed, please indicate how important each item is and how often each item occurs using the following scales:

## IMPORTANCE RATINGS:

- 1 = not important at all
- 2 = somewhat important
- 3 = important
- 4 = very important

## OCCURRENCE RATINGS:

- 1 = never
- 2 = rarely
- 3 = sometimes
- 4 = always

	Importance	Occurrence
1. Meeting resident's needs	1 2 3 4	1 2 3 4
2. Getting a personal care task done quickly	1 2 3 4	1 2 3 4
3. Making mistakes and learning from them	1 2 3 4	1 2 3 4
4. Hearing a resident laugh	1 2 3 4	1 2 3 4
5. Getting a personal care task done without being insulted or threatened by a resident	1 2 3 4	1 2 3 4
6. Providing residents with opportunities to make decisions	1 2 3 4	1 2 3 4
7. Not getting negative feedback from supervisors about my job performance	1 2 3 4	1 2 3 4
8. Opportunities to learn new caregiving skills	1 2 3 4	1 2 3 4
9. Experiencing challenges of working with residents with cognitive impairment	1 2 3 4	1 2 3 4
10. Commitment to doing quality work	1 2 3 4	1 2 3 4
11. Interactions with resident family members or friends	1 2 3 4	1 2 3 4
12. Opportunities to work independently	1 2 3 4	1 2 3 4
13. Engaging in tasks that will affect my performance evaluation	1 2 3 4	1 2 3 4
14. Having a positive impact on the residents	1 2 3 4	1 2 3 4
15. Following care plans	1 2 3 4	1 2 3 4
16. Being emotionally involved with residents	1 2 3 4	1 2 3 4

	Importance	Occurrence
17. Getting a personal care task done without being physically attacked by a resident	1 2 3 4	1 2 3 4
18. Learning about what the resident likes and dislikes	1 2 3 4	1 2 3 4
19. Opportunities to work with a team	1 2 3 4	1 2 3 4
20. Conversing with co-workers	1 2 3 4	1 2 3 4
21. Praise or statements of approval from supervisors or administrators	1 2 3 4	1 2 3 4
22. Correcting my mistakes	1 2 3 4	1 2 3 4
23. Breaks	1 2 3 4	1 2 3 4
24. Not being reprimanded (written up) by a supervisor	1 2 3 4	1 2 3 4
25. Praise or statements of approval from co-workers	1 2 3 4	1 2 3 4
26. Hearing a resident tell stories about their past	1 2 3 4	1 2 3 4
27. Resident(s) smiles at me	1 2 3 4	1 2 3 4
28. Statements of appreciation (e.g., thank you) from the resident	1 2 3 4	1 2 3 4
29. Including family members in care decisions	1 2 3 4	1 2 3 4
30. Having the support of my supervisor or administration	1 2 3 4	1 2 3 4
31. Praise or statements of approval from a resident's family member(s)	1 2 3 4	1 2 3 4
32. Having support from colleagues	1 2 3 4	1 2 3 4
33. Collaborating with an interdisciplinary team	1 2 3 4	1 2 3 4
34. Engaging in tasks that will not affect my performance evaluation	1 2 3 4	1 2 3 4
35. Fostering trusting caregiving relationships with residents and families	1 2 3 4	1 2 3 4
36. The satisfaction of helping older individuals	1 2 3 4	1 2 3 4
37. Performing a caregiving task in my own way	1 2 3 4	1 2 3 4
38. Doing what I am told to do by my supervisor	1 2 3 4	1 2 3 4
39. Collaborating with family members and my co-workers to develop care plans	1 2 3 4	1 2 3 4
40. Resident(s) expresses appreciation	1 2 3 4	1 2 3 4
41. Getting paid	1 2 3 4	1 2 3 4
42. Feeling accomplished	1 2 3 4	1 2 3 4
43. Having resources to pursue opportunities for professional growth	1 2 3 4	1 2 3 4