# Exploring Interrelations Between Person-Centred Care and Quality of Life Following a Transition into Long-Term Residential Care: A Meta-Ethnography

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**Conflict of Interest**
None.

**Abstract**

**Background and Objectives**: Globally, a culture change in long-term residential care (LTRC) moving towards person-centred care (PCC) has occurred in an attempt to improve resident quality of life (QoL). However, a clear understanding of how different aspects contributing to a PCC approach are interrelated with resident QoL is still lacking. This review explores interrelating aspects between PCC and QoL in LTRC using qualitative synthesis.

**Research Design and Methods**: Ten relevant primary studies were identified from a search of interdisciplinary research databases providing qualitative information. Studies were critically reviewed for key themes and concepts by the research team. We used a meta-ethnography approach to inductively interpret findings across multiple studies and reinterpreted the information using a constructivist approach.

**Results**: We identified 5 second order constructs sharing commonalities suggesting interrelations between PCC and QoL: (1) Maintaining dignity, autonomy and independence. (2) Knowing the whole person. (3) Creating a 'homelike' environment. (4) Establishing a caring culture. (5) Integrating families and nurturing internal and external relationships. Synthesis translation led to the following third order constructs: (1) Personalising care within routines (2) Optimising resident environments (3) Giving residents a voice.

**Discussion and Implications**: There are many interrelating aspects of PCC and QoL following a permanent transition into LTRC, but successful implementation of PCC, which enhances QoL presents challenges due to organisational routines and constraints. However, by prioritising resident voices to include their needs and preferences in care, QoL can be supported following a transition into LTRC.

**Keywords**: Aged Care; Care Home; Well-being

**Background and Objectives**

Levels of daily healthcare requirements for the older population due to worsening chronic illness, multi-morbidities, acute illness or deterioration of mental health have increased in an aging population (Leichsenring, 2004; World Health Organization, 2015). This often requires constant and complex care, increasing the necessity of long-term residential care in later life (Johri, Beland, & Bergman, 2003; Robison et al., 2012). For the purpose of this review, long-term residential care (LTRC) is used as an umbrella term for institutional environments providing care to older adults residing in this setting on a permanent (24/7) basis. This includes, for example, nursing homes and care homes; as outlined by Moore, Keegan, Dunleavy, and Froggatt (2019). Older people show a preference to remain in their own homes, among other things due to negative views of care in LTRC. A culture change movement in LTRC over the last decades has aimed to alter such negative perceptions of a permanent transition into LTRC (Meyer & Owen, 2008). A key element of this culture change movement was a move towards person-centred care (PCC) in an attempt to focus more on individual quality of life (QoL) than biomedical markers of health as a key measure to determine a successful move into LTRC (Musich et al., 2018).

*A Culture Change in LTRC*

LTRC facilities provide both medical services and a home environment for older adults (World Health Organization, 2015). By using a more social model of care, residents become the central focus of care and services provided rather than using a 'one size fits all' strategy, which promotes resident autonomy and QoL (Crandall et al., 2007; Zimmerman, Shier, & Saliba, 2014). By adjusting care provisions, the requirements of each resident's specific circumstances are met during a transition from home to a new LTRC environment (Kane. et al., 2004). As a result, a key concept in this change in culture is PCC, which emphasises the

importance of resident well-being and QoL rather than focussing on more medically driven outcome measures previously used in healthcare for the older population (McCance, McCormack, & Dewing, 2011; Nolan, 2001) .

*PCC as a concept in LTRC*

PCC is an overarching term, which takes a holistic approach to care, 'whole well-being', which includes the context, preferences, beliefs, and experiences of an individual and emphasises living well now above living longer. As a concept, PCC has been outlined using various terms depending on the researcher and with the context in mind, for example 'patient-centred care', 'integrated care', 'resident-centred care' or 'relationship-centred care'. However, despite the varied terms used, the general concept intends on placing core values and resident choice at the centre of the care structure (McCance et al., 2011). McCance et al. (2011) define PCC as "an approach to practice established through the formation and fostering of therapeutic relationships between all care providers, patients and others significant to them in their lives" (McCance et al., 2011). A successful PCC culture is developed through strong collaboration between multiple actors, including LTRC staff, external medical professionals such as GPs and family members (Dewing & McCormack, 2017; Koren, 2010; Tsakitzidis et al., 2017). A person-centred organisational culture creates a more positive experience for residents following a transition into LTRC, improving self-efficacy and resilience (Bradshaw, Playford, & Riazi, 2012; Poey et al., 2017; Terada et al., 2013). Although the need for PCC is acknowledged, a lack of clarity on how to put PCC elements into practice and how it works in different contexts and for different individuals has been reported; therefore a gap between "the rhetoric and the reality" of PCC largely remains (Berntsen et al., 2019).

*QoL in LTRC*

Resident QoL has been acknowledged as an overall outcome of 'healthy aging' in LTRC (Hughes & Moore, 2012). QoL is defined by the World Health Organization (WHO) using four domains: (a) physical health; (b) social relationships; (c) psychological health; and (d) environment (World Health Organization, 2015, 2019). While QoL has previously focussed on physical health, the importance of individual perceptions based on context, social situations, and spiritual needs are now acknowledged (Pinto, Fumincelli, Mazzo, Caldeira, & Martins, 2017). Despite definitions, QoL means different things to different people, and is hard to quantify; particularly in the older population where each lived experience is different depending on environment, physical health and cognitive state (Halvorsrud & Kalfoss, 2007; Levasseur, Tribble, & Desrosiers, 2009). QoL should itself be considered a person-centred concept (Halvorsrud & Kalfoss, 2007).

LTRC research increasingly aims to understand resident QoL (Post, 2014), focussing on organisational and cultural factors influencing resident experiences (Rahman & Schnelle, 2008; White-Chu, Graves, Godfrey, Bonner, & Sloane, 2009). QoL in LTRC should be addressed during the whole trajectory of a resident's stay, from point of entry onwards (Hjaltadóttir & Gustafsdottir, 2007; Moore et al., 2019). Adjustments, such as facilitating personalisation of resident rooms for continuity, must therefore be made within LTRC depending on individual circumstances to improve resident QoL and ease the transition into LTRC (Bradshaw et al., 2012; Kane. et al., 2004).

LTRC facilities are working to assure practices enhancing QoL, however, resident QoL in LTRC still fails to be adequately measured with a focus on avoiding adverse events rather than accounting for individual experiences to promote resident well-being and QoL (Carr & Higginson, 2001; McGilton et al., 2012). This is particularly the case in residents

with cognitive decline or those living with dementia, who are often represented in studies by a proxy, such as staff members (Usman et al., 2019; Wilhelmson, 2005).

*Aims and Objectives*

Although PCC as an overall concept is understood to enhance resident QoL, there is not yet a clear understanding of how different aspects contributing to a PCC approach are interrelated with resident QoL. Furthermore, additional insight from the perspectives and experiences of residents is required to fully understand potential interrelations between PCC and QoL (Edvardsson. et al., 2019; Kane, 2003; Klapwijk, Caljouw, Pieper, van der Steen, & Achterberg, 2016; Roberts & Ishler, 2017). This review paper therefore aims to explore interrelations between PCC and QoL following a permanent transition into LTRC from resident perspectives using qualitative synthesis.

**Research Design and Methods**

A meta-ethnography was undertaken as outlined by Noblit and Hare (1988), which synthesises qualitative information to explore a phenomenon within a real-life context; in this case LTRC. Meta-ethnography allows inductive and interpretive synthesis. This in-depth analysis explores and explains collectively shared understandings as well as contradictions between studies, providing new insights and offering a single wider conclusion based on the multiple conclusions observed by the author (Tong, Flemming, McInnes, Oliver, & Craig, 2012). The meta-ethnography followed seven phases from inception to completion (Noblit & Hare, 1988).

*Search Strategy*

*Phase 1 and 2*:  Based on a gap identified concerning how PCC and QoL are interrelated where a qualitative synthesis of information would support further understanding, a systematic literature search was conducted in January 2020 and again in March 2021 using the following databases: CINAHL (EBSCO); PubMed (EBSCO) and PsycINFO (Proquest), SCOPUS. The searches comprised three search blocks including variants of: (1) Long-term Residential Care, (2) Quality of Life/Well-being and (3) Person-Centred Care. Boolean operators AND and OR were used to combine search terms. Phrase searches, proximity operators and truncation were also used. All terms were searched by title and abstract. Controlled vocabulary terms were used when provided by the database. Search terms were decided using suggestions from current literature, Cochrane published reviews, pilot searches and discussions among the research team. Studies were eligible for inclusion if they included insight into QoL or well-being in LTRC, or any aspects professing to contribute to QoL, such as personhood in LTRC. LTRC had to offer PCC, or a variant of PCC to be included. The transition into LTRC could be finalised or ongoing to be eligible for inclusion, with no restriction on length of stay where the transition had been finalised. Primary studies using qualitative or mixed-methods designs were included in the final selection. Where mixed-methods designs were used, only qualitative results were included. Studies had a target population of LTRC residents aged 65 or over, which could also include those living with cognitive decline or dementia. The information reporting on QoL, experiences of QoL or any aspect of health-related QoL could have been self-reported, reported by proxy or observed by a third party, for example relatives or staff members. All inclusion criteria were agreed among the research team ahead of the screening process. All screening (title/abstract and full text) was undertaken independently by two reviewers (100% dual screened, first and last

author), and any discrepancies reviewed by two independent reviewers. See table 1 for included study characteristics.

*Data Extraction and Analysis*

*Phase 3*: Each included study was read in full multiple times to obtain a full picture of the phenomenon. During this time, definitions of PCC were determined from each study and tabulated (see table 2) and a list of potential themes and potential relationships between studies were established. This list was reduced into relevant categories. Minor discrepancies in paper or theme inclusion were resolved during discussion within the research team. During analysis, outcomes were discussed within the review team. Line of argument synthesis was developed during reflective discussion of each construct using perspectives of the whole review team; a constructivist approach as shown in the phases outlined below was used to achieve this (Atkins et al., 2008; Britten et al., 2002; Noblit & Hare, 1988). The review structure follows the guideline Enhancing Transparency in Reporting the Synthesis of Qualitative Research (ENTREQ) (Tong et al., 2012).

*Meta-Synthesis and Analysis*

*Phase 4*: Identifying Relationships Across the Studies

Using information presented in the results, discussion and conclusion sections of the included papers, we were able to establish author interpretations relating to PCC and QoL. During this time, we constructed themes, which were then used to determine relationships across the studies, which formed our second order constructs (see table 3).

*Phase 5*: Translating Papers Into Each Other

Following tabulation of second order constructs, reciprocal translation was used to identify 'commonalities and contradictions' in the included studies to synthesise the information and build on it from the perspectives of the research team (Dixon-Woods & Fitzpatrick, 2001; France et al., 2019). Themes concluded from this meta-synthesis were constructed from synonymous concepts found across the included studies to help determine potential interrelations existing between PCC and QoL following a permanent transition into LTRC, which were discussed in the research team in order to be reinterpreted (Grant & Booth, 2009; Ring, Ritchie, Mandava, & Jepson, 2011).

*Phase 6*: Synthesising Translations

Themes were reinterpreted in a second level of synthesis to provide explanation, forming the third order constructs presented in the results section. The second order constructs were discussed within the research team and, using our different backgrounds, were elaborated on to form a new conceptual understanding and arguments for the interrelating factors between PCC and QoL in LTRC and demonstrated new interpretations of the second order constructs.

*Phase 7:* Presenting the Synthesis

The synthesised translations were presented as: (1) *Personalising care within routines* (2) *Optimising resident environments* (3) *Giving residents a voice*.

**Results**

969 potentially relevant studies were identified following database and hand searches. 61 studies were screened by full text, of which 10 met the inclusion criteria for this review.

*Second Order Constructs*

Qualitative data from 7 countries was found in the 10 primary studies included, which indicated the following second order constructs: (1) Maintaining independence, dignity and autonomy, (2) Knowing the whole person, (3) Creating a 'homelike' environment, (4) Establishing a caring culture, (5) Integrating families and nurturing internal and external relationships. Table 3 shows the occurrence of the second order constructs in each study, the detail of which is discussed fully below.

*Maintaining Independence, Dignity and Autonomy*

Ordinarily, a move into LTRC follows a need for additional care or support. However, regardless of the level of dependence of a person, they remain a person of value and should be respected and treated with dignity. In order to provide continuity during a move, residents should be provided with choice, and the need for care should be balanced with supporting independence. This is integral not only to achieving PCC in LTRC, but also in maintaining resident QoL (Barnes, Wasielewska, Raiswell, & Drummond, 2013; Baxter, Sandman, Björk, Lood, & Edvardsson, 2019; Edvardsson, Fetherstonhaugh, & Nay, 2010; Hennelly & O'Shea, 2021).

Provision of care and support in LTRC creates a feeling of safety and ensures physical/functional needs are addressed; however, support should go beyond physical care to provide residents with a level of choice to maintain a sense of self and increase personhood and QoL (Barnes et al., 2013; Baxter et al., 2019; Williams, Hadjistavropoulos, Ghandehari, Yao, & Lix, 2015). Individualising care and considering both physical and behavioural resident needs could better maintain independence, which promotes resident QoL (Donnelly & MacEntee, 2016; Williams et al., 2015). It is important for staff to understand individual

resident limitations and needs to simultaneously provide adequate care and create an environment where residents feel comfortable asking for additional help; while also encouraging residents to take charge of their own care/activities where possible to support independence (Barnes et al., 2013; Donnelly & MacEntee, 2016). Overestimating a resident's ability could put the resident at risk, for example of falls, therefore the level of support required by each resident must be acknowledged while encouraging independence (Edvardsson et al., 2010; Williams et al., 2015). Staff limitations and time constraints should also be recognised, as organisational needs can dictate staff behaviours and put pressure on staff. This can reduce the possibility of staff-resident interactions, making it difficult for staff to promote resident independence (Adra, Hopton, & Keady, 2015).

Sensitivity to privacy and dignity is at times overlooked in residents requiring more assistance with daily living activity. Resident interviews emphasised this, discussing times when they were 'wheeled down the hall half dressed' or when they felt their voice was overlooked, impacting dignity (Donnelly & MacEntee, 2016). Resident's expressed a desire to be listened to rather than being 'talked over', particularly during activities or when relatives were present to improve personhood and prevent them feeling they were being treated like children; which is how some residents recounted the experience (Adra et al., 2015; Hennelly & O'Shea, 2021).

Organisational needs, policies and staff demands often cause rigid routines within LTRC, which residents felt meant they were all subject to the same routine, reducing the possibility of resident choice and QoL (Barnes et al., 2013; Baxter et al., 2019; Donnelly & MacEntee, 2016; Nakrem, 2015). Regardless of staff limitations or the level of dependency of individual residents, it is important to provide flexibility and choice in care wherever possible in order to

successfully achieve PCC, maintain resident QoL and allow residents to thrive in LTRC rather than simply surviving (Barnes et al., 2013; Baxter et al., 2019; Hennelly & O'Shea, 2021).

### *Knowing the Whole Person*

Following a move to LTRC, there is a risk that a resident will lose their sense of self; therefore, a comprehensive history of the resident should be taken, which includes medical and biographical information as well as likes and dislikes of the resident. This assists with a smoother transition into care and promotes resident QoL (Adra et al., 2015; Edvardsson et al., 2010; Williams et al., 2015).

Getting to know a new resident as a 'whole' person should incorporate information from the resident as well as family members or close friends who know the person best, which follows the concept of PCC (Adra et al., 2015). Taking time to learn resident histories, needs, interests and preferences is important to be able to engage residents in meaningful conversations and activities and personalise routines; all of which contribute to resident QoL (Barnes et al., 2013; Donnelly & MacEntee, 2016; Edvardsson et al., 2010; Hartmann et al., 2018; Williams et al., 2015). The difficulty is that presence and availability of staff is key in facilitating informal conversations with residents outside of a care routine (Edvardsson et al., 2010). In an intervention to spend more one to one time with residents, staff immediately found getting to know residents better to be a positive experience (Helgesen, Fagerli, & Grøndahl, 2020).

Increased staff-resident engagement enables staff to get to know residents better, allowing them to have better quality interactions and adapt activities to suit different residents, making

them more meaningful (Edvardsson et al., 2010; Hartmann et al., 2018; Nakrem, 2015). This was found to not only help maintain resident sense of self, but staff also found this made the working day easier as such quality interactions had a calming influence on residents, and the setting as a whole; including for persons living with dementia (Hartmann et al., 2018). Times when staff were viewed by residents as preoccupied or burdened was described by residents as making them feel less engaged with the care team (Adra et al., 2015; Donnelly & MacEntee, 2016; Edvardsson et al., 2010; Hartmann et al., 2018).

Getting to know a resident well and including them in the care planning process enables PCC. Regular one to one contact with residents beyond care delivery was integral to achieving PCC (Helgesen et al., 2020). Highlighting the need for such interactions helped staff become more aware of low activity and encouraged them to provide additional stimulation for residents (Hartmann et al., 2018). In fact, they found that this culture change spread beyond those involved in the intervention and uptake was seen in the majority of staff, which was seen as a positive step. However, Donnelly and MacEntee (2016) found that according to residents, imposing activities on residents under the assumption they should be stimulated led to a loss of autonomy, which reduced QoL.

### *Creating a 'Homelike' Environment*

Residents, staff and family members mutually agree that the ability to personalise resident living space following a move into LTRC is integral to PCC and resident QoL. Allowing the resident to create an environment reminiscent of the home they moved from, provides familiarity and continuity during a transition to LTRC, which is particularly important to maintain QoL for persons living with dementia (Adra et al., 2015; Baxter et al., 2019; Edvardsson et al., 2010; Nakrem, 2015).

Residents felt it important to have 'normal' things around them to remind them of their life before moving into LTRC and to provide them with a personalised space. Personalising a space with 'homelike' items, such as photos, pictures, plants and furniture allows the resident to show their personality as well as providing continuation of self and a sense of normality for the resident, which is key to achieving PCC (Adra et al., 2015; Edvardsson et al., 2010). In addition to enriching the environment, personalising resident space facilitates staff-resident contact by providing conversation topics, which provides content for more meaningful conversations leading to improved resident QoL (Edvardsson et al., 2010; Hartmann et al., 2018; Helgesen et al., 2020).

In addition to individual resident rooms, it is important to consider the aesthetics in open communal spaces providing access to mutual activities, such as gardening. Creating a welcoming atmosphere can encourage social relationships between residents and encourage residents to continue a past hobby (Adra et al., 2015; Edvardsson et al., 2010). Continuation of self is enhanced when in flexible surroundings, which goes beyond resident bedrooms. A sense of 'home' is enhanced by providing views of and easy access to outside space (Edvardsson et al., 2010). The whole environment and overall aesthetics in LTRC should be welcoming and comfortable for residents, providing an open but safe atmosphere (Baxter et al., 2019). Clear and calming decoration in particular helps persons living with dementia to settle into life in LTRC (Edvardsson et al., 2010).

*Establishing a Caring Culture*

Culture change in LTRC is a 'continuous learning process', which is dependent on adequate communication and training among staff. Even with training, what PCC should entail can look differently across teams, with each individual focusing on different core elements of PCC (Nakrem, 2015; Williams et al., 2015).

Successful PCC should centralise resident needs and prioritise residents over tasks. Baxter et al. (2019) explored the possibility for a resident to 'thrive' in LTRC, and found that each aspect contributing to this proved a 'one size fits all' approach does not work. However, data in other included papers suggests that structural and cultural differences between LTRC homes mean this isn't always possible (Edvardsson et al., 2010; Nakrem, 2015). In interviews, residents occasionally observed staff as being too task focussed, which residents expressed as causing dissatisfaction with their care (Barnes et al., 2013; Donnelly & MacEntee, 2016). Observed instances of staff able to interact more freely with residents during tasks seemingly improved resident experience and QoL, and staff expressed a reduction in guilt (Barnes et al., 2013; Helgesen et al., 2020). In interview data presented, residents praised the level of support offered by staff during these prolonged interactions; although the same data also demonstrated that simply knowing someone is there and feeling able to ask for help, even someone external to the LTRC home such as a family member, GP or volunteers increases feeling of support (Baxter et al., 2019; Donnelly & MacEntee, 2016). Occasionally, organisational needs and rigid structures in place could not be changed and acted as a barrier to achieving PCC, causing residents to express dissatisfaction (Helgesen et al., 2020; Nakrem, 2015). Although Nakrem (2015) actually found that a certain level of routine or some rhythm to the day provided residents with a feeling of safety and being well cared for.

Good communication across all actors is key to successfully implementing PCC. It has been found that differing views among the care team or between family and LTRC staff, particularly involving persons living with dementia, can create a barrier to supporting personhood and providing PCC (Donnelly & MacEntee, 2016; Hennelly & O'Shea, 2021). Differing opinions between staff and relatives surrounding care can impact resident personhood and creates an additional barrier for PCC (Hennelly & O'Shea, 2021).

### *Integrating Families and Nurturing Internal and External Relationships*

A common ground among different variants of PCC in LTRC in the included studies is the involvement of multiple actors; including family members, various staff, volunteers from the local community and the resident themselves.

Often, care provided before a permanent move into LTRC is provided by family members or close friends, which Adra et al. (2015) found did not immediately end following a move into LTRC. In addition, the involvement of family in care positively impacted outcomes for both residents and family members. Family members interviewed felt their inclusion in the life and care of their resident was an integral part of achieving PCC, which staff agreed with as knowledge provided by family members assisted with care planning and supported resident QoL (Adra et al., 2015; Edvardsson et al., 2010). For residents and family members, this integration also helped with adjusting to change. Family members could remain a significant part of the resident's life, while resident's value continuation of 'normal life' during the transition into LTRC; both of which are particularly important for persons living with dementia (Adra et al., 2015; Edvardsson et al., 2010).

Family involvement following a move into LTRC could be a positive experience, providing continuity and support, or a negative experience, creating anxiety for persons living with dementia and staff depending on how the relationship was prior to the move and the understanding of dementia (Hennelly & O'Shea, 2021). Family members emphasised the importance of communication, which reduces their own anxiety about a resident, where staff described the opportunities for teamwork between staff and family members. Poor communication between staff members and relatives can create interpersonal barriers, which prevents personhood in persons living with dementia (Hennelly & O'Shea, 2021). Overall, family input is regarded in the studies as beneficial, however residents highlighted that it should not cause them to feel like they are being 'overlooked' (Donnelly & MacEntee, 2016). Encouraging and incorporating family in care provides additional support for residents, while reducing burden on family members, which helps achieve PCC and maintain resident QoL (Adra et al., 2015; Barnes et al., 2013; Hennelly & O'Shea, 2021). Interview data demonstrated that creating opportunities for interactions with family members is integral to 'thriving' in LTRC. In addition, interactions with friends and the wider community was also found to provide 'a sense of social support and connection' (Edvardsson et al., 2010).

Resident interactions with relatives, staff and other residents are important to create a feeling of connectedness and support for residents, but should be led by the resident. However, interactions can be encouraged by all parties within the LTRC environment, and are important to achieve PCC and maintain resident QoL (Barnes et al., 2013; Baxter et al., 2019; Edvardsson et al., 2010). New relationships between residents within LTRC were seen by residents as providing continuity between past and present circumstances; however, encouraging resident interactions was not always welcome, with residents expressing and observed as sometimes preferring solitude (Adra et al., 2015; Baxter et al., 2019). In addition

to resident interactions, informal interactions with staff were also described in interview data as improving resident moods (Baxter et al., 2019). Staff interviewed echoed the value of this one-to-one interaction in a different study (Helgesen et al., 2020). In general, residents felt opportunities for informal interactions were important; although it is important that the level of interaction be decided by the resident (Baxter et al., 2019).

### *Synthesising Translations*

After synthesis of the second order constructs, the following third order constructs emerged and were developed: (1) *Personalising care within routines* (2) *Optimising resident environments* (3) *Giving residents a voice*.

### *Personalising Care within Routines*

It is clear from the included papers that an understanding around the importance of personalised care in achieving PCC exists to provide continuity for residents and more control over their daily lives in LTRC. The difficulty is, while the included papers agree that personalised care is optimal, they also demonstrate clear barriers to implementing it. Unavoidable routines and restrictions imposed on LTRC staff are eluded to, preventing personalised care from being carried out in the way it is fully intended. These routines are discussed throughout included papers as a significant barrier to PCC, as they prevent shared decision making, restrict resident autonomy and create a focus on task completion rather than residents. If this is the case, LTRC risks feeling less personalised, which threatens resident QoL. It must be recognised that perceptions of routines within the included papers largely come from LTRC staff, so it is difficult to know whether the routines are as rigid as described or whether this is perceived organisational control.

In addition to preventing PCC, imposed routines are said to reduce staff-resident engagement beyond daily care needs, which makes it more difficult to promote resident autonomy and independence. Some residents' found routines provided structure resulting in a sense of safety, although mostly the inability to change routines within LTRC was negatively discussed or residents were resigned to it, but not happy about it. It should be stressed that routines were imposed from an organisational stand point and were simply implemented by staff, who in most interview extracts also saw this as a negative element of the care provided.

Residents moving into LTRC must adapt from independent living to a regulated community environment, which will undoubtedly alter their usual routine. There will always be restrictions to providing a fully personalised routine, for example, it is difficult to serve meals at staggered times when catering to a large number. However, by providing lunch options including different portion sizes for residents to choose from begins to recentralise residents in the activity. Small steps such as discussing with a resident whether they prefer to shower in the morning or evening, what time they like to get up and go to bed and how they prefer to structure their day around activities that are difficult to change immediately increases resident autonomy and eases the transition into LTRC.

*Optimising Resident Environments*

Personalising resident environments is discussed as a key element in PCC; with staff and resident interviews in the included studies showing that moving with personal items such as furniture and photographs, as well as tailoring the general aesthetics to each resident eases the transition into LTRC and improves resident QoL. This is considered to be particularly important for people living with either cognitive decline or dementia, for whom this familiarity can provide continuity, comfort and an identity following a transition into LTRC.

However, potential limitations such as physical needs of a resident or organisational policy can make implementation of all desired personalised changes more difficult. For example, if a resident moves into LTRC needing specialist equipment, it may not be feasible to bring furniture they previously used when living in the community. Although, providing equipment to meet the individual needs of a resident is also integral to PCC. Within resident rooms, it should be possible to provide a blank canvas other than required specialist equipment so that a resident can personalise them as much as they wish.

It is clear from included papers that optimising resident environments goes beyond individual rooms. The whole environment should be considered a resident's home as would be the case in any communal living environment. Personalising communal spaces to suit the preferences of each resident is challenging, however discussing design with residents can give an idea of preferred aesthetics and includes residents in the decision-making process. Providing spaces that residents can contribute to, such as gardens or wall art could allow residents to feel more at home and part of the community as well as encouraging independence and personhood. Having the right aesthetics can contribute to residents feeling welcome and at ease following a transition into LTRC.

Creating space for residents to continue hobbies outside of pre-arranged activity groups, such as gardening could improve personhood and act as a conversational focus between residents or residents and staff, therefore increasing interaction. This provides a space to explore shared hobbies in a less structured way. In addition, communal spaces, such as dining areas could increase opportunity for resident interaction depending on the layout.

### *Giving Residents a Voice*

Knowing the resident, including a biographical history, their likes and dislikes (past and present) as well as their medical and daily care needs enables PCC and creates continuity during a transition into LTRC. It is important that resident histories, likes and dislikes come primarily from residents. While family members can provide valuable insights into who the resident was and who they are now, it is important that a resident is also able to share this information. In fact, some studies in this review show that the focus of information given often differs depending on whether it comes from family or the resident; for example, family will focus more on physical aspects such as diet where residents focus on social aspects such as likes and dislikes. There is a risk of overlooking the resident in favour of relative viewpoints and wishes, which should be avoided to achieve PCC.

Knowing the person should incorporate who the resident is today as well as their history. This is particularly important for persons living with dementia, who in some cases have forgotten what their past preferences were, but may be able to communicate what they enjoy today. This concept is often overlooked and an importance tends to be placed on knowing who the person 'was' rather than seeing them as the person they are today. In this case, it is important that perspectives of both residents and family are brought in to listen to the resident preferences today, as well as those expressed in the past to create a whole picture.

In order to really 'know the person', it is also important to consider how they feel following a transition into LTRC. It is common for older people to experience a sense of loss during such a transition, whether this is a result of leaving people, or the environment they have been used to living in. It is important for staff to understand and help residents to navigate this by talking and listening to residents. Information obtained to get to know the resident should be

translated into shared decision making relating to care and routines wherever possible in order to facilitate PCC and improve QoL. A focus on resident experiences makes it possible to understand necessary changes in care or routines, implement PCC and improve QoL.

**Discussion and Implications**

The results of this review indicate that implementing a person-centred model of care enhances resident QoL, although exactly what PCC means differs across the included studies. The synthesised data suggests that enabling the personalisation of care and resident environments as well as ensuring resident voices are heard are strong interrelating factors between PCC and QoL. Lack of adaptability within LTRC creates a barrier to implementing PCC, compromising resident autonomy and independence, which ultimately reduces resident QoL. Simple changes within LTRC applied to routines and the environment considering the voice of the residents facilitates PCC and improves QoL.

A major barrier to achieving PCC in LTRC observed in this review is restrictions imposed by organisationally influenced routines. This is not a new concept, with previous studies hearing from staff that even when PCC is there, time forces a task-orientated approach to care (Oppert, O'Keeffe, & Duong, 2018). It is therefore important to focus on flexibility in routines to support resident independence and autonomy, which is beneficial to people with cognitive decline (Kane. et al., 2004; Oppert et al., 2018). The difficulty is that PCC is being implemented alongside a number of barriers, such as lack of time, staff or money, or even too many residents (Kong, Kim, & Kim, 2021). It is this attempt to implement PCC without understanding local contexts, which was outlined by Berntsen et al. (2019) as a gap in clearly understanding how elements of PCC can be put into practice. It is important therefore to look at how organisational and personalised routines can complement each other to benefit

resident QoL, for example by altering serving styles at mealtimes as indicated by Barnes et al. (2013) rather than adding further pressure to staff by suggesting fully moving to personalised care for all. Manageable personalisation of routines, such as individual wake up times and providing choice of times for daily care can introduce elements of PCC, while respecting necessary organisational routines such as meal times, which are more challenging to alter. It is important to consider such organisational factors while also working to improve resident experiences (Rahman & Schnelle, 2008). By doing this, the physical health, environmental and psychological health elements of the WHO QoL domains could be achieved.

Staff-resident interaction, allowing staff to get to know residents better, can be facilitated or obstructed by the LTRC home environment according to Helgesen et al. (2020). This, according to World Health Organization (2019) is an important QoL domain 'social relationships'. Providing personalised resident environments has been suggested as a key element in achieving PCC in previous research, as it provides continuity during a transition to LTRC (Bradshaw et al., 2012). The findings of this review support this, showing that familiar and flexible surroundings support a continuation of self for the resident, which improves personhood and QoL (Edvardsson. et al., 2017). Furthermore, the results of this review indicate that environment goes beyond resident bedrooms and should include communal spaces, which are key to encouraging resident-resident and resident-staff social interactions by providing talking points and access to shared interests (Adra et al., 2015; Edvardsson. et al., 2017).

Getting to know residents well as they move into LTRC helps staff to understand personal preferences that can be met, which helps to achieve PCC by individualising routines as much

as possible within organisational constraints (Baxter et al., 2019; Hennelly & O'Shea, 2021; Nakrem, 2015). Previous quantitative research has found that within LTRC that has fully implemented PCC, resident choice and staff knowledge of resident preferences are associated with resident satisfaction and higher resident QoL (Poey et al., 2017). The qualitative data within this review supports this, and additionally suggests that when staff are able to get to know residents well, it is possible to make activities more meaningful. This not only increases resident sense of self, but also makes things easier for staff, who also commented on the benefits of knowing their residents (Edvardsson et al., 2010; Hartmann et al., 2018; Helgesen et al., 2020).

Integrating family into LTRC was suggested in this review as a way of getting to know the resident further and enabling the implementation of PCC. The results of this review particularly highlighted the importance of integrating family members into both the care planning process and the LTRC environment to facilitate PCC (Adra et al., 2015; Barnes et al., 2013; Edvardsson et al., 2010; Hennelly & O'Shea, 2021). Past quantitative research exploring perceived resident QoL from the perspective of family members found that resident QoL was perceived as higher when communication between family members and staff was strong (Roberts & Ishler, 2017). Furthermore, Dewing and McCormack (2017) stated that a strong collaboration between multiple actors, which includes family members is key to a successful PCC culture in LTRC. However, results in this review from a resident perspective suggest that staff-family communication can at times overshadow the voice of the resident, causing them to feel overlooked and risking their autonomy (Donnelly & MacEntee, 2016). Supporting resident autonomy is key in providing PCC and maintaining resident QoL, therefore residents should have a voice in how family are integrated to LTRC. Although, it is important to explore what integrating family members into LTRC could mean for the resident

and how best to achieve this from the perspective of the resident as well as the family

member.

The findings of this review indicate that there are still barriers to implementing PCC, which

has previously been said to risk the belief that PCC has been fully implemented, when it in

fact has not (Dewing & McCormack, 2017). At an organisational level, perceived barriers,

such as time constraints prevent PCC from being implemented in full, which Dewing and

McCormack (2017) explain can create feelings of guilt and failure among staff. At an

individual level, the key interrelating factor between PCC and QoL is the resident feeling like

they have a voice and choice, which includes adding personalised elements to routines and

allowing them to feel at home within the environment. Therefore, in reality, there are aspects

of PCC that can be implemented around organisational constraints, which would maintain

resident QoL without being so complex that extra pressure is put on staff. However,

organisational constraints within each LTRC home need to be considered that change

depending on context. Culture, physical building design and governing bodies alter which

PCC elements can be implemented within each LTRC home. By creating a realistic PCC

culture in LTRC, which puts emphasis on strengthening communication with residents and

family members and recognises the elements of routine and environment that can be

personalised, the key interrelating factors contributing to PCC and QoL can be achieved.

*Strengths and Limitations*

The applied meta-ethnographical approach enabled previous findings based on inductive

qualitative research relating to PCC and QoL from heterogenous contexts not only to be

synthesized, but to be reinterpreted with insight from each member of the interdisciplinary

team. This procedure gave additional value to individual qualitative studies by translating

them into each other, therefore allowing us to go beyond a comparison to fully explore relevant interrelating factors in varying cultural contexts of LTRC.

A limitation in this review is that without access to the original data analysed within each study, any reinterpretation of data was limited to what was presented in each paper, allowing only selected data to be discussed and reinterpreted. The final number of papers eligible for inclusion in this review was small in number, so we were unable to filter papers based on richness of data, which has been suggested by France et al. (2019) as a method to improve meta-ethnographic reporting. Therefore, the data included in this review is not equally rich across all studies. Furthermore, the background of each study has not been included in detail when creating the second or third order constructs, which means that the detailed description of context normally important in qualitative studies had to be somewhat overlooked. However, the use of reciprocal translation within this review allowed us to focus on commonalities and differences across studies to provide novel and inductively grounded insights to develop a consistent interpretive synthesis (Dixon-Woods & Fitzpatrick, 2001; Noblit & Hare, 1988).

*Conclusion*

There are many interrelating aspects of PCC and QoL following a permanent transition into LTRC, but how PCC can be and is performed still presents challenges. There is a clear need for good communication across multiple actors to successfully implement PCC, but it is important to prioritise resident voices to get to know residents well so that their needs and preferences can be factored into care planning and organisational routines. In doing this, QoL will be supported and the transition into LTRC will be a more positive experience. Future research should seek to understand how these key interrelating factors can be implemented while considering context to understand exactly what is possible.

**References**

Adra, M. G., Hopton, J., & Keady, J. (2015). Constructing the meaning of quality of life for residents in care homes in the Lebanon: Perspectives of residents, staff and family. *International Journal of Older People Nursing*, 10(4), 306-318. https://doi.org/10.1111/opn.12094

Atkins, S., Lewin, S., Smith, H., Engel, M., Fretheim, A., & Volmink, J. (2008). Conducting a meta-ethnography of qualitative literature: Lessons learnt. *BMC Medical Research Methodology*, 8(1), 21. https://doi.org/10.1186/1471-2288-8-21

Barnes, S., Wasielewska, A., Raiswell, C., & Drummond, B. (2013). Exploring the mealtime experience in residential care settings for older people: An observational study. *Health & Social Care in the Community*, 21(4), 442-450. https://doi.org/10.1111/hsc.12033

Baxter, R., Sandman, P. O., Björk, S., Lood, Q., & Edvardsson, D. (2019). Illuminating Meanings of Thriving for Persons Living in Nursing Homes. *Gerontologist*. https://doi.org/10.1093/geront/gnz142

Berntsen, G., Dalbakk, M., Hurley, J. S., Bergmo, T., Solbakken, B., Spansvoll, L., Bellika, J. G., Skrøvseth, S. O., Brattland, T., & Rumpsfeld, M. (2019). Person-centred, integrated and pro-active care for multi-morbid elderly with advanced care needs: A propensity score-matched controlled trial. BMC health services research, 19(1), 682. https://doi.org/10.1186/s12913-019-4397-2

Bradshaw, S. A., Playford, E. D., & Riazi, A. (2012). Living well in care homes: A systematic review of qualitative studies. *Age and Ageing*, 41(4), 429-440. https://doi.org/10.1093/ageing/afs069

Britten, N., Campbell, R., Pope, C., Donovan, J., Morgan, M., & Pill, R. (2002). Using meta ethnography to synthesise qualitative research: A worked example. *Journal of Health Services Research & Policy*, 7(4), 209-215. https://doi.org/10.1258/135581902320432732

Carr, A. J., & Higginson, I. J. (2001). Are quality of life measures patient centred? *BMJ*, 322(7298), 1357-1360. https://doi.org/10.1136/bmj.322.7298.1357

Crandall, L. G., White, D. L., Schuldheis, S., & Talerico, K. A. (2007). Initiating person-centered care practices in long-term care facilities. *Journal of Gerontological Nursing*, 33(11), 47-56. https://doi.org/10.3928/00989134-20071101-08.

Dewing, J., & McCormack, B. (2017). Editorial: Tell me, how do you define person-centredness?.*Journal of Clinical Nursing*, 26(17-18), 2509–2510. https://doi.org/10.1111/jocn.13681

Dixon-Woods, M., & Fitzpatrick, R. (2001). Qualitative research in systematic reviews. Has established a place for itself. *BMJ*, 323(7316), 765–766. https://doi.org/10.1136/bmj.323.7316.765

Donnelly, L., & MacEntee, M. I. (2016). Care perceptions among residents of LTC facilities purporting to offer person-centred care. *Canadian Journal on Aging/La Revue canadienne du vieillissement*, 35(2), 149-160. https://doi.org/10.1017/S0714980816000167

Edvardsson, D., Fetherstonhaugh, D., & Nay, R. (2010). Promoting a continuation of self and normality: person-centred care as described by people with dementia, their family members and aged care staff. *Journal of Clinical Nursing*, 19(17-18), 2611-2618. https://doi.org/10.1111/j.1365-2702.2009.03143.x

Edvardsson, D., Baxter, R., Corneliusson, L., Anderson, R. A., Beeber, A., Boas, P. V., Corazzini, K., Gordon, A. L., Hanratty, B., Jacinto, A., Lepore, M., Leung, A., McGilton, K. S., Meyer, J., Schols, J., Schwartz, L., Shepherd, V., Skoldunger, A., Thompson, R., Toles, M., … Zúñiga, F. (2019). Advancing long-term care science

through using common data elements: Candidate measures for care outcomes of personhood, well-being, and quality of life. *Gerontology and Geriatric Medicine*, 5, 2333721419842672. https://doi.org/10.1177/2333721419842672

Edvardsson., Sjögren, K., Lood, Q., Bergland, Å., Kirkevold, M., & Sandman, P.-O. (2017). A person-centred and thriving-promoting intervention in nursing homes - study protocol for the U-Age nursing home multi-centre, non-equivalent controlled group before-after trial. BMC geriatrics, 17, 1-9. https://doi.org/10.1186/s12877-016-0404-1

France, E. F., Uny, I., Ring, N., Turley, R. L., Maxwell, M., Duncan, E., Jepson, R. G., Roberts, R. J., & Noyes, J. (2019). A methodological systematic review of meta-ethnography conduct to articulate the complex analytical phases. *BMC Medical Research Methodology*, 19, 35(1), 1-18. https://doi.org/10.1186/s12874-019-0670-7

Grant, M. J., & Booth, A. (2009). A typology of reviews: an analysis of 14 review types and associated methodologies. *Health Information & Libraries Journal,* 26(2), 91-108. https://doi.org/10.1111/j.1471-1842.2009.00848.x

Halvorsrud, L., & Kalfoss, M. (2007). The conceptualization and measurement of quality of life in older adults: A review of empirical studies published during 1994–2006. *European Journal of Ageing,* 4(4), 229-246. https://doi.org/10.1007/s10433-007-0063-3

Hartmann, C. W., Mills, W. L., Pimentel, C. B., Palmer, J. A., Allen, R. S., Zhao, S., Wewiorski, N. J., Sullivan, J. L., Dillon, K., Clark, V., Berlowitz, D. R., & Snow, A. L. (2018). Impact of intervention to improve nursing home resident-staff interactions and engagement. *Gerontologist*, 58(4), e291-e301. https://doi.org/10.1093/geront/gny039

Helgesen, A. K., Fagerli, L. B., & Grøndahl, V. A. (2020). Healthcare staff's experiences of implementing one to one contact in nursing homes. *Nursing Ethics*, 27(2), 505-513. https://doi.org/10.1177/0969733019857775

Hennelly, N., & O'Shea, E. (2021). A multiple perspective view of personhood in dementia. *Ageing and Society*. Advance online publication. https://doi.org/10.1017/S0144686X20002007

Hjaltadóttir, I., & Gustafsdottir, M. (2007). Quality of life in nursing homes: Perception of physically frail elderly residents. *Scandinavian Journal of Caring Sciences*, 21(1), 48-55. https://doi.org/10.1111/j.1471-6712.2007.00434.x

Hughes, K., & Moore, S. (2012). Quality of life versus quality of care: Elderly people and their experience of care in South Australian residential facilities. *Practice: Social Work in Action*, 24(5), 275-285. https://doi.org/10.1080/09503153.2012.740451

Johri, M., Beland, F., & Bergman, H. (2003). International experiments in integrated care for the elderly: A synthesis of the evidence. *International Journal of Geriatric Psychiatry,* 18(3), 222-235. https://doi.org/10.1002/gps.819

Kane, R. A. (2003). Definition, measurement, and correlates of quality of life in nursing homes: Toward a reasonable practice, research, and policy agenda. *The Gerontologist, 43*(suppl_2), 28-36. https://doi.org/10.1093/geront/43.suppl_2.28

Kane., Bershadsky, B., Kane, R. A., Degenholtz, H. H., Liu, J., Giles, K., & Kling, K. C. (2004). Using resident reports of quality of life to distinguish among nursing homes. *The Gerontologist,* 44(5), 624-632. https://doi.org/10.1093/geront/44.5.624

Klapwijk, M. S., Caljouw, M. A., Pieper, M. J., van der Steen, J. T., & Achterberg, W. P. (2016). Characteristics associated with quality of life in long-term care residents with dementia: A cross-sectional study. *Dementia and geriatric cognitive disorders, 42*(3-4), 186-197. https://doi.org/10.1159/000448806

Kong, E. H., Kim, H., & Kim, H. (2021). Nursing home staff's perceptions of barriers and needs in implementing person- centred care for people living with dementia: A qualitative study. *Journal of Clinical Nursing*. https://doi.org/10.1111/jocn.15729

Koren, M. J. (2010). Person-centered care for nursing home residents: The culture-change movement. *Health Affairs, 29*(2), 312-317. https://doi.org/10.1377/hlthaff.2009.0966

Leichsenring, K. (2004). Developing integrated health and social care services for older persons in Europe. *International Journal of Integrated Care, 4, e10*. https://doi.org/10.5334/ijic.107

Levasseur, M., Tribble, D. S.-C., & Desrosiers, J. (2009). Meaning of quality of life for older adults: importance of human functioning components. *Archives of Gerontology and Geriatrics, 49*(2), e91-e100. https://doi.org/10.1016/j.archger.2008.08.013

McCance, T., McCormack, B., & Dewing, J. (2011). An exploration of person-centredness in practice. *Online Journal of Issues in Nursing*, 16(2), 1.

McGilton, K. S., Heath, H., Chu, C. H., Boström, A. M., Mueller, C., Boscart, V. M., McKenzie-Green, B., Moghabghab, R., & Bowers, B. (2012). Moving the agenda forward: a person-centred framework in long-term care. *International Journal of Older People Nursing, 7*(4), 303-309. https://doi.org/10.1111/opn.12010

Meyer, J., & Owen, T. (2008). Calling for an international dialogue on quality of life in care homes. *International Journal of Older People Nursing, 3*(4), 291-294. https://doi.org/10.1111/j.1748-3743.2008.00144.x

Moore, D. C., Keegan, T. J., Dunleavy, L., & Froggatt, K. (2019). Factors associated with length of stay in care homes: a systematic review of international literature. *Systematic Reviews, 8*(1), 56. https://doi.org/10.1186/s13643-019-0973-0

Musich, S., Wang, S. S., Kraemer, S., Hawkins, K., & Wicker, E. (2018). Purpose in life and positive health outcomes among older adults. *Population Health Management, 21*(2), 139-147. https://doi.org/10.1089/pop.2017.0063

Nakrem. (2015). Understanding organizational and cultural premises for quality of care in nursing homes: an ethnographic study. *BMC Health Services Research, 15*(1), 508. https://doi.org/10.1186/s12913-015-1171-y

Noblit, G. W., & Hare, R. D. (1988). *Meta-ethnography: Synthesizing qualitative studies* (Vol. 11). Sage.

Nolan, M. (2001). Successful ageing: keeping the 'person' in person-centred care. *British Journal of Nursing, 10*(7), 450-454. https://doi.org/10.12968/bjon.2001.10.7.5330

Oppert, M. L., O'Keeffe, V. J., & Duong, D. (2018). Knowledge, facilitators and barriers to the practice of person-centred care in aged care workers: a qualitative study. *Geriatric Nursing, 39*(6), 683-688. https://doi.org/10.1016/j.gerinurse.2018.05.004

Pinto, S., Fumincelli, L., Mazzo, A., Caldeira, S., & Martins, J. C. (2017). Comfort, well-being and quality of life: Discussion of the differences and similarities among the concepts. *Porto Biomedical Journal, 2*(1), 6-12. https://doi.org/10.1016/j.pbj.2016.11.003

Poey, J. L., Hermer, L., Cornelison, L., Kaup, M. L., Drake, P., Stone, R. I., & Doll, G. (2017). Does person-centered care improve residents' satisfaction with nursing home quality? *Journal of the American Medical Directors Association, 18*(11), 974-979. https://doi.org/10.1016/j.jamda.2017.06.007

Post, M. (2014). Definitions of quality of life: what has happened and how to move on. *Topics in Spinal Cord Injury Rehabilitation, 20*(3), 167-180. https://doi.org/10.1310/sci2003-167

Purc-Stephenson, R. J., & Thrasher, C. (2010). Nurses' experiences with telephone triage and advice: a meta-ethnography. *Journal of Advanced Nursing, 66*(3), 482-494. https://doi.org/10.1111/j.1365-2648.2010.05275.x

Rahman, A. N., & Schnelle, J. F. (2008). The nursing home culture-change movement: Recent past, present, and future directions for research. *The Gerontologist, 48*(2), 142-148. https://doi.org/10.1093/geront/48.2.142

Ring, N. A., Ritchie, K., Mandava, L., & Jepson, R. (2011). A guide to synthesising qualitative research for researchers undertaking health technology assessments and systematic reviews. NHS Quality Improvement Scotland (NHS QIS). http://www.nhshealthquality.org/nhsqis/8837.html

Roberts, A. R., & Ishler, K. J. (2017). Family involvement in the nursing home and perceived resident quality of life. *The Gerontologist, 58*(6), 1033-1043. https://doi.org/10.1093/geront/gnx108

Robison, J., Shugrue, N., Porter, M., Fortinsky, R. H., & Curry, L. A. (2012). Transition from home care to nursing home: Unmet needs in a home-and community-based program for older adults. *Journal of Aging & Social Policy, 24*(3), 251-270. https://doi.org/10.1080/08959420.2012.676315

Terada, S., Oshima, E., Yokota, O., Ikeda, C., Nagao, S., Takeda, N., Sasaki, K., & Uchitomi, Y. (2013). Person-centered care and quality of life of patients with dementia in long-term care facilities. *Psychiatry Research, 205*(1-2), 103-108. https://doi.org/10.1016/j.psychres.2012.08.028

Tong, A., Flemming, K., McInnes, E., Oliver, S., & Craig, J. (2012). Enhancing transparency in reporting the synthesis of qualitative research: ENTREQ. *BMC Medical Research Methodology, 12*(1), 181. https://doi.org/10.1186/1471-2288-12-181

Tsakitzidis, G., Anthierens, S., Timmermans, O., Truijen, S., Meulemans, H., & Van Royen, P. (2017). Do not confuse multidisciplinary task management in nursing homes with interprofessional care! *Primary Health Care Research & Development, 18*(6), 591-602. https://doi.org/10.1017/S146342361700024X

Usman, A., Lewis, S., Hinsliff-Smith, K., Long, A., Housley, G., Jordan, J., Gage, H., Dening, T., Gladman, J., & Gordon, A. L. (2019). Measuring health-related quality of life of care home residents: comparison of self-report with staff proxy responses. *Age and Ageing, 48*(3), 407-413. https://doi.org/10.1093/ageing/afy191

White-Chu, E. F., Graves, W. J., Godfrey, S. M., Bonner, A., & Sloane, P. (2009). Beyond the medical model: The culture change revolution in long-term care. *Journal of the American Medical Directors Association, 10*(6), 370-378. https://doi.org/10.1016/j.jamda.2009.04.004

Wilhelmson, K., Andersson, C., Waern, M., & Allebeck, P. (2005). Elderly people's perspectives on quality of life. *Ageing and Society, 25*(4), 585-600. https://doi.org/10.1017/S0144686X05003454

Williams, J., Hadjistavropoulos, T., Ghandehari, O. O., Yao, X., & Lix, L. (2015). An evaluation of a person-centred care programme for long-term care facilities. *Ageing & Society, 35*(3), 457-488. https://doi.org/10.1017/S0144686X13000743

World Health Organization, W. (2015). *World report on ageing and health* (9241565047). Retrieved from https://www.who.int/ageing/events/world-report-2015-launch/en/

World Health Organization, W. (2019). WHOQOL: Measuring Quality of Life. https://www.who.int/healthinfo/survey/whoqol-qualityoflife/en/index4.html

Zimmerman, S., Shier, V., & Saliba, D. (2014). Transforming Nursing Home Culture: Evidence for Practice and Policy. *The Gerontologist, 54*(Suppl_1), S1-S5. https://doi.org/10.1093/geront/gnt161

Table 1. *Study Characteristics*

| Study | Country | Methodology | Method | Sample | Aim |
|---|---|---|---|---|---|
| Edvardsson et al, 2010 | Australia | Qualitative | Interviews (individual/focus groups/telephone) | Persons living with dementia (n=11), Staff (n=37), Family (n=19) | To describe the content of PCC as described by persons living with dementia, family members and staff in LTRC |
| Barnes et al, 2013 | UK | Qualitative | Observations | Residents (n=68) in 4 LTRC homes | Describing individual residents' mealtime experience to understand best practice. |
| Adra et al, 2015 | Lebanon | Qualitative | Semi-structured interviews | Residents (n=20), Staff (n=11), Family (n=8) | To describe and explore QoL |
| Nakrem, 2015 | Norway | Qualitative | Ethnographic observation and interviews | Observations: LTRC (n=4), Resident Interviews (n=16) (selected from the 4 LTRC homes) | To describe LTRC culture from staff perspective including how residents describe QoC |
| Williams et al, 2015 | Canada | Mixed-methods | Interviews (focus group/individual) | Staff (n=19) | To evaluate staff experiences of an implemented PCC program and resident outcomes |
| Donnelly et al, 2016 | Canada | Qualitative | Interviews and observations | Residents (n=21) | Resident perceptions of care in LTRC offering PCC |
| Hartmann et al, 2018 | USA | Mixed-methods | Observations and interviews | Staff interviews (n=66), Resident and Staff Observations (n=1,490) | To describe how elements of PCC can improve resident engagement |
| Baxter et al, 2019 | Australia | Qualitative | Narrative interviews | Residents (n=21) | To illuminate meanings of thriving as narrated by persons living in nursing homes |
| Helgesen et al., 2020 | Norway | Qualitative | Focus group interviews | Staff (n=21) | To elicit health care staff experiences of implementing one-to-one contact between residents and care staff in nursing homes |
| Hennelly et al., 2021 | Ireland | Qualitative | Semi-structured interviews | Persons living with dementia (n=8), Family (n=8), Staff (n=15) | To generate an understanding of current approaches to 'personhood' |

*Note.* PPC = Person-Centred Care, LTRC = Long-term Residential Care, QoL = Quality of Life, QoC = Quality of Care

Table 2. *Definitions of Person-Centred Care and Variants*

| Author | Term Used | Definition Based on Author Understanding/Research |
|---|---|---|
| Edvardsson et al., 2010 | Person-centred care | Promoting a continuation of self and normality |
| Barnes et al., 2013 | Resident-centred care | Fitting activities to the individual needs of the resident, providing support while fostering independence |
| Adra et al., 2015 | Relationship-centred care | Negotiations, which consider the needs of everyone involved, as well as the context of the wider community. Resident, staff, and family contributions are viewed with equal importance |
| Nakrem, 2015 | Person-centred/relationship-centred care | Adopting individual resident perspective and recognising resident/family values. Developing a shared understanding of the needs and values of residents, staff, and family members |
| Williams et al., 2015 | Person-centred care | Residents should be understood by individual needs, preferences, abilities, and life experiences |
| Donnelly & MacEntee, 2016 | Person-centred care | Placing the resident and their individual needs and preferences at the centre of care |
| Hartmann et al., 2018 | Collaborative care | Providing an integrated care system |
| Baxter et al., 2019 | Person-centred care | Involving residents in decision making and encouraging resident independence |
| Helgesen et al., 2020 | Person-centred care | An ideal – a means of preserving a vulnerable person's dignity and well-being |
| Hennelly et al., 2021 | Person-centred care | Care elements of personhood: interests; preferences; life course experiences; social interaction; family; and place should all be included in person-centred care models |

Table 3. *2nd order construct inclusion by study.*

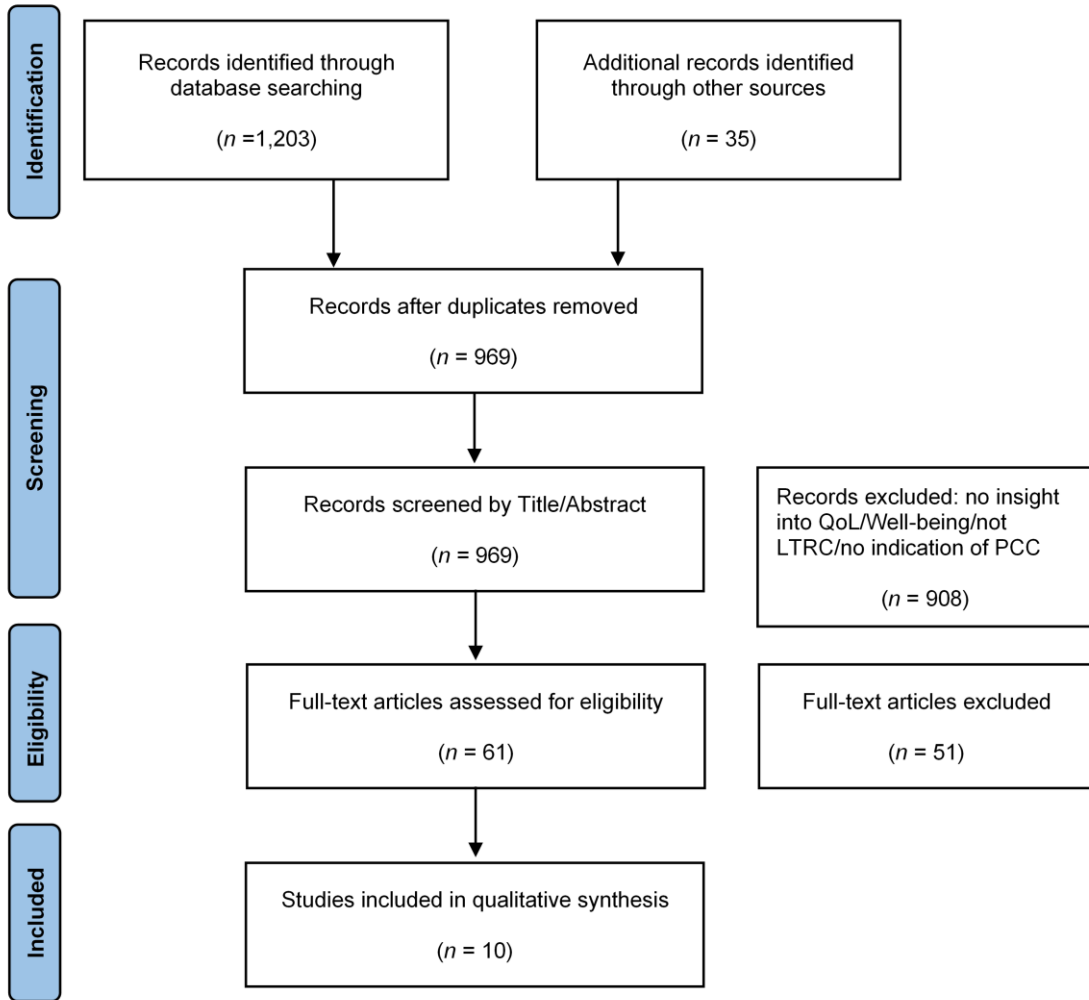| Study | Themes | | | | |
| --- | --- | --- | --- | --- | --- |
| | **Maintaining Independence, Dignity and Autonomy** | **Knowing the Whole Person** | **Creating a 'Homelike' Environment** | **Establishing a Caring Culture** | **Integrating Families and Nurturing Internal and External Relationships** |
| Edvardsson et al., 2010 | Residents should be acknowledged and respected as competent /valuable people | Knowing each individual resident history important to staff | Important to enrich environment with personal items and suitable aesthetics | Residents should be prioritised over tasks | Family involvement important to all actors, but in different ways |
| Barnes et al., 2013 | Different settings can promote resident independence. Choice improves resident experience | Understanding needs/limitations important to personalised care | N/A | Staff had good knowledge of resident care requirements | Level of interaction is dependent on setting. Residents requiring more support have most interaction |
| Adra et al., 2015 | Listening to residents and providing 'meaningful activities' improves dignity | N/A | Personalised space integral to PCC and resident QoL | N/A | Family/friends still play valuable roles. Continuity from new relationships between residents |
| Nakrem, 2015 | N/A | Maintaining personal routines important | Personalised space provides continuity | PCC = 'continuous learning process' | N/A |
| Williams et al., 2015 | Need to balance promoting independence /creating risk | QoL improved by knowing resident history | N/A | Different facilities focussed on different elements of PCC | N/A |
| Donnelly & MacEntee, 2016 | Asking for help should be encouraged. Individual limitations/needs must be understood. Choice provides autonomy | Base care on individual needs /preferences | N/A | Residents viewed task-based care negatively | N/A |
| Hartmann et al., 2018 | N/A | Knowing individual resident needs important to staff. Impacted by staff turnover | Personalised space promotes meaningful conversations | N/A | N/A |
| Baxter et al., 2019 | Choice and continuity support independence and helps residents 'thrive' | Care based on needs/choices improve resident well-being/QoL | Good atmosphere as important as homelike living space | Care/support in LTRC = 'knowing someone's there' | Resident-staff relationships provide further social support |
| Helgesen et al., 2020 | N/A | Knowing residents = positive for staff/residents. Some residents prefer short interactions/decline 1:1 contact | Environment can facilitate/prevent 1:1 contact | 1:1 time outside of necessary care should be standard practice. More 1:1 time = calmer unit | 1:1 time with residents provides additional social support |
| Hennelly et al., 2021 | Resident choice important for personhood. Supporting independence helps persons living with dementia live well | N/A | N/A | Power imbalances/ permissions block autonomy | Family = either positive or negative depending on nature of relationship |

Table 4: *Definitions of 1ˢᵗ, 2ⁿᵈ, and 3ʳᵈ order constructs*

| Term | Definition |
| --- | --- |
| 1ˢᵗ Order Construct | Participant views and beliefs as outlined in primary studies |
| 2ⁿᵈ Order Construct | Author interpretation of participant views and beliefs within primary studies |
| 3ʳᵈ Order Construct | Re-interpretation of explanations offered based on 1ˢᵗ and 2ⁿᵈ order constructs, providing overarching themes/metaphors |

Note. From Purc-Stephenson & Thrasher, 2010.

Figure 1