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Feature Article

Supporting autonomy in long-term care: Lessons from nursing assistants

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ABSTRACT

Maximizing nursing home (NH) resident autonomy is a person-centered care (PCC) best practice. The purpose of this study was to identify and describe specific autonomy-supportive techniques used by nursing assistants (NAs) in three NH neighborhoods at one Veterans Affairs medical center. Thirteen interviews and approximately 80 h of behavioral observation of NAs were conducted across the three NH neighborhoods. Data were analyzed using thematic analysis. Ten autonomy-supportive tactics were identified: assisting, monitoring, encouraging, bargaining, informing, providing instructions, persuading, asking, providing options, and redirecting. Although all tactics honored some degree of resident autonomy, some were more restrictive than others. Results from the study elucidate specific actions NAs can take to promote resident autonomy, even when cognitive or physical limitations are present or there is potential concern for safety, and thereby support PCC best practice.

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Introduction

Autonomy has been defined as self-determination and freedom to act on or make decisions based on individual choice or preference.[1] Individuals residing in nursing homes (NHs) report that they value autonomy and believe it to be a necessary component of a satisfactory life.[2,3] Seminal studies by Langer and Rodin[4] and Schulz[5] highlight the positive effects of choice and control on well-being. Other research has indicated that greater subjective autonomy is related to better quality of life,[6] decreased risk of depression[7], and reduced mortality among NH residents.[8] Advocating for personal autonomy is also at the heart of the NH person-centered care (PCC) movement.[9–11] This movement, also described as "culture change" and "cultural transformation," aims to de-institutionalize NHs by flattening the organizational hierarchy, modifying environmental designs to make them more home-like, and promoting care and practices that are designed and focused on residents' needs and preferences.[12] Since the Omnibus Budget Reconciliation Act of 1987, long-term care (LTC) has been shifting from a medical to a biopsychosocial model of care that focuses on the person rather than the illness or disease.[13]

An autonomy-supportive approach includes a positive communication style that is not dominating or forceful but, rather, promotes collaboration and independence.[14] It is characterized by offering encouragement and rationales, being responsive to questions, and being open to dialogue.[15] Scholars in the areas of education, parenting, coaching, health care, and psychotherapy have studied antecedents and benefits of autonomy support.[15] Benefits of an autonomy-supportive approach include greater engagement, psychological well-being, and intrinsic motivation.[16,17] A contrasting autonomy-*restrictive* approach is defined by focusing solely on the end goal rather than the process, especially in the context of performance-based outcomes.[18,19] In other words, when tasked to teach or promote a skill with the overall goal of improving learners' or dependents' performance, educators and caregivers using an autonomy-restrictive approach tend to engage in controlling or paternalistic behaviors such as uttering directives, providing solutions or answers to problems, and making "should" and "ought" statements.[20]

Few studies have described specific autonomy-supportive tactics. Two qualitative studies by Davies, Ellis and Laker[21] and Whitler[22] describe methods nursing staff used to support autonomy. In one study, nurses working in medical settings serving older adults (e.g., rehabilitation, emergency, acute medicine) were observed before and after implementation of an educational program designed to further nurses' knowledge of promoting older adults' autonomy.[21] Seven types of autonomy-supportive

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methods were described, though results were not delineated by setting. In the other study, Whitler[22] interviewed registered nurses (RNs) in eight NHs to explore the methods they used to support resident autonomy. Interview data reflected five approaches to assist residents in making decisions. A summary of the autonomy-supportive methods is presented in Table 1.

The existing autonomy-supportive approaches summarized in prior studies provide a strong starting point, but they are limited by two factors. First, they do not describe autonomy-supportive methods in LTC from the perspective of nursing assistants (NAs). While understanding how RNs and other professional nursing staff support resident autonomy is important, NAs provide the majority of direct daily care to NH residents. Consequently, they face multiple ethical dilemmas every day regarding their responsibility to keep the residents safe from harm and the residents' right to personal autonomy. Understanding how NAs support resident autonomy may offer new and valuable insights regarding how PCC can best be implemented in LTC. Second, these studies primarily describe strategies (i.e., the broad conceptual goals), but NAs need guidance in tactics or techniques (i.e., the specific actions to be implemented to achieve the strategies). For example, *recognizing individuality* and *promoting individualized care*, as presented in Table 1, are two autonomy-supportive strategies that provide general directions for care but do not offer precise tactics for how to execute these approaches, whereas Table 2 (results from the present study) presents specific techniques such as *assisting* and *monitoring*.[21,22]

One of the more obvious autonomy-supportive techniques that can be implemented in LTC is offering choice to residents (e.g., offering choices about food, time of day of shower or bath, bedtime, etc.). Consequently, it is one of the few techniques that has been described and studied in the literature on resident preference in LTC.[23–25] Simmons et al.[26] found that offering choice was not a common technique that nursing assistants readily used in two LTC facilities, but research suggests that interventions providing explicit direction on how to offer choice can increase the use of this PCC autonomy-supportive technique.[27] Thus, specific techniques are needed to further PCC.

As the PCC movement progresses, NAs will need to find ways to honor residents' autonomy while also providing care that, at times, residents might initially decline. Learning how NAs in PCC-oriented LTC facilities grapple with such matters can offer insight into effective techniques that allow NAs to do their job and respect residents' wishes. Using qualitative methodology, the present study identifies and describes specific autonomy-supportive techniques NAs used in a LTC setting that was in the process of shifting toward a PCC model of care.

Table 1
Autonomy-Supportive Methods Used by Nurses.

Strategies
Providing information and describing pros and cons of decisions to residents/ patients so they could make informed decisions
Negotiating care with the patient through choice, feedback, participation, and compromise
Encouraging physical independence
Recognizing individuality
Personalizing instructions based on the RN's values and experiences
Avoiding controlling language, such as commands or infantilizing language
Being alert to cues
Promoting individualized care
Persuading residents
Shaping instrumental circumstances by advocating for residents' autonomy and finding creative solutions to support residents' autonomy

Note. Derived from studies by [21] and [22].

Methods

Participants and setting

All NAs in three units, known as "neighborhoods," in one Community Living Center (CLC) at a Veterans Affairs Medical Center in the (region blinded for review) were eligible to participate in the study. An initiative to move toward a PCC model of care began in this CLC four years prior to the start of this study. Environmental design of the CLC at this facility had been remodeled to be consistent with the culture change redesign. What had once been one large open "day rooms" had been remodeled into common areas that were broken up into multiple small living area niches including small common rooms and patios with windowed doors so that an open expansive feel was balanced with intimate small areas where privacy was possible. Each setting had a kitchen, dining room, living room, and family room. Traditional nursing stations were replaced with a charting room. Four-person bedrooms were redesigned into private or two-person bedrooms with private bathrooms. Institutional-style décor (e.g., white walls, linoleum floors, white metal doors) was replaced with home-like designs (e.g., wood-like floors, comfortable recliners and rocking chairs).

Resident characteristics and focus of care varied across settings. One neighborhood, designed for dementia care, accommodated up to 20 residents and employed nine NAs total. Doors to the outside remained locked, and residents were not allowed off the unit unless accompanied by staff or family. Most residents spent the majority of their time in the main living areas and were frequently monitored by staff. Most residents were ambulatory but a few used wheelchairs and even fewer were limited to geriatric chairs (chairs that provide trunk support but restrict movement).

The second neighborhood had a capacity of 30 residents and employed 10 NAs total. Most residents had physically debilitating medical conditions and used wheelchairs or were limited to bed or other reclining devices, such as geriatric chairs. Doors to outside were unlocked. Residents were often in their bedrooms, though a few visited the living room and were observed watching television, watching others, and napping.

The third neighborhood accommodated up to 10 residents and employed nine NAs total. All residents were free to leave the CLC as they wished; visitors had to ring the doorbell and be invited inside, as would a typical visitor to a private home. Most residents stayed in their bedrooms during the day, though a few frequently watched television in the living room. Most residents were independent with ADLs, washed their own laundry, and helped set the dining table for mealtimes.

Study design and procedures

Two qualitative data collection methods were used to increase credibility and breadth of data collected: observations and semi-structured interviews. Demographic information was collected from NAs who participated in semi-structured interviews.

Observations. One researcher (MLJ) conducted observations of NAs and their interactions with residents in the three selected neighborhoods. Observations spanned all shifts (i.e., day, evening, and night shifts during the weekdays and weekends) at random time points, allowing for data collection during busy times (e.g., meals, activities), downtime (e.g., between meals during times of rest when residents were in the common areas) and between residents' bedtime and rise time. Observation duration ranged from 15 to 60 min and varied depending on the environment (i.e., observations were longer if there were interactions to observe, whereas observations were shorter when there was little to no

Table 2
Autonomy-Supportive Tactics and Techniques.

Tactic	Specific technique(s)	How resident autonomy is supported
Assisting	- Respectfully assisting by treating the resident as a collaborator in care	- Encouraging physical independence to the extent possible to help maintain function
	- Helping a resident fulfill a desire or wish	- Recognizing individuality in backgrounds and preferences
	- Stepping in to complete a resident's chore	- Providing individualized care
Monitoring	- "Keeping an eye" on a person who is performing an action so as to intervene quickly if an accident occurs or is about to occur	- Promoting physical independence to the extent possible
		- Being alert to cues of imminent danger and intervening only when risk is imminent
Encouraging	- Boosting a resident's confidence	- Shaping residents' self-perception to promote physical independence
	- Praising a resident for an accomplishment	- Promoting residents' participation in their health care
Bargaining	- Negotiating with residents	- Encouraging collaborative care through choice, feedback, and compromise
Informing	- Informing a resident about an available opportunity	- Avoiding controlling language, such as commands
	- Informing others about residents' preferences	- Providing information so residents can make informed decisions
		- Promoting individualized care
Providing instructions	- Providing instructions in the moment to increase independence	- Personalizing instructions based on residents' needs and strengths
	- Shaping long-term behaviors to increase independence	- Providing individualized care
		- Promoting physical independence to help maintain function
Persuading	- Persuading by presenting a rationale	- Describing pros and cons of options to help residents make informed decisions
	- Persuading by ensuring trust	
	- Persuading by giving an opinion	- Avoiding controlling language, such as commands
Asking	- Asking preferences	- Providing individualized care by eliciting preferences
	- Asking as a form of suggesting	- Recognizing individuality in background and preferences
	- Asking "why" to understand the root of residents' preferences	- Avoiding controlling language when making suggestions
Providing options	- Providing any available or feasible options	- Promoting individualized care
	- Providing restricted options as a way to influence residents' decisions	- Avoiding controlling language, such as commands
		- Offering choices
Redirecting	- Redirecting a resident's attention away from a harmful desire and onto a different activity of interest	- Avoiding controlling language, such as, "Stop," or, "You cannot do that"
		- Promoting individualized care by knowing and supporting residents' unique interests

activity in the environment). The researcher (MLJ) conducted observations in two manners: (a) standing or sitting in one place for the duration of the observation period, and (b) walking around the neighborhoods and strategically pausing for a period of minutes to observe activity throughout the neighborhood. The former approach was typically used when a formal activity was taking place, such as a meal time or during a recreational activity, and the latter approach was typically used when no formal activity was taking place. During each observation, the content, quality, and duration of interactions between staff and residents were noted. Detailed field notes were typed following each observation. The total amount of observation time was distributed unevenly across neighborhoods because the observational data collection began at different time points, though observations continued until data saturation occurred, which was determined by ongoing data analysis. In total, over 80 h of observations were conducted across the three neighborhoods.

Semi-structured interviews. One researcher (MLJ) conducted semi-structured interviews (see Appendix) with eight NAs (29% of all NAs across the three settings) to elicit information about their experiences with and opinions of supporting and restricting residents' autonomy. Recruitment for interviews occurred during the last eight months of the study. Snowball and purposive sampling were used to identify and recruit NAs who would be willing to participate and would offer a range of experiences and opinions. All participants were invited to participate in a second interview, which was intended to increase the depth, rather than breadth, of interview data collected. In the second interviews, NAs were asked to provide additional examples of autonomy support and other related information. Five NAs completed second interviews, yielding 13 interviews total. All interviews were conducted individually in a private area; some NAs chose to interview in a private area in the CLC neighborhoods, while others chose to interview in a private office or conference room off the unit. Interviews ranged from 20 to 45 min in duration, depending on the NAs' availabilities and length of answers to the questions. All interviews were audio recorded and transcribed verbatim.

Demographics. Data was collected using a brief demographic questionnaire and included items on race and ethnicity, age, gender, education level, marital status, number of years at current place of employment, and degree of satisfaction with current job (1 = extremely dissatisfied, 10 = extremely satisfied).

IRB approval

Approval for research was granted by the CLC study site's medical center and the affiliated university site's institutional review boards. For the observation component of the study, the IRB determined that observation consent was not required because observations were conducted only in public areas; however, to assure staff trust and comfort, all staff were provided verbal and written information about the observations before they began. Staff were given a general description of the purpose of the observations that indicated the observations were conducted to understand the culture of the neighborhoods and develop a better understanding of PCC practices. To reduce the likelihood of a Hawthorne effect, the general description avoided specific mention of autonomy-supportive practices. For the interview component of the study, participants completed written informed consent.

Operational definition

Autonomy-supportive tactic was operationally defined prior to identification of themes during data analysis. Characteristics of autonomy-supportive approaches described in the literature were applied to the operational definition in this study. Autonomy-supportive tactic was defined as an action that is (a) positive or neutral in communication tone, (b) used to influence residents in some way for the purpose of increasing positive, healthy behaviors or decreasing negative, unhealthy behaviors, and (c) ultimately results in honoring choices and preferences.

Data analysis

The unit of analysis for this study was the CLC; data were not analyzed by neighborhoods. We used thematic analysis to analyze the data, with the aim of explicitly identifying and coding autonomy-supportive techniques.[28] All field notes and interview transcripts were combined into a data file within an Excel database. The first author (MLJ), trained in qualitative data analysis, assigned thematic codes to field notes and interview transcripts. The coding was informed by previous review of the literature but not constrained by this. The second author (ALS), also trained and experienced in qualitative data analysis, coded five selected interview transcripts to enhance credibility (in qualitative research, credibility is analogous to the concept of validity in quantitative research).[29] Weekly meetings between the first and second authors were held to discuss all codes and themes. These coding meetings and data analyses occurred concurrently. Any discrepancies that arose between the two authors' codes were reconciled through discussion during the coding meetings. Analysis continued until data saturation occurred (i.e., no new themes emerged) and themes were refined. Next, the first and second authors deconstructed the autonomy-supportive tactics, identifying specific autonomy-supportive techniques within each theme. The first author (MLJ) wrote coding memos to aid in reflexivity and maintained an audit trail of the data analysis process[29]; these were reviewed and commented on by the second author (ALS).

Results

Of the eight NAs who participated in the semi-structured interviews, 75% were female, and the majority were African American (75% African American and 25% Caucasian American). Half of the sample was married, while 25% of the NAs were divorced and 25% were single. Half received some education in technical school or college and one person completed technical college or received an associate degree, and the others received a high school diploma or less. Participants had been at their current place of employment for a range of one to twelve years ($M = 7.13$), and their job satisfaction ranged from five (i.e., somewhat satisfied) to ten (i.e., extremely satisfied, $M = 6.63$).

Ten autonomy-supportive tactics emerged from the data. As shown in Table 2, these tactics were *assisting, monitoring, encouraging, bargaining, informing, providing directions, persuading, asking, providing options*, and *redirecting*. They were defined and deconstructed, resulting in 20 specific autonomy-supportive techniques (more than one technique was identified in most tactics). NAs often simultaneously employed more than one technique to influence residents' behaviors while also honoring their autonomy.

Assisting

The primary responsibility of NAs is to assist residents with ADLs. NAs commonly reported this as an important activity and were frequently observed in this context. Autonomy-supportive tactics for assisting were characterized by providing aid that the resident wanted or openly accepted without hesitation and assisting in a timely manner. Autonomy-supportive assisting was further divided into *respectful assisting, helping to fulfill a desire or wish,* and *stepping in.*

Respectful assisting. Respectful assisting was defined as providing help to a resident while verbally or nonverbally communicating that the resident is a collaborator in care tasks rather than a dependent individual who lacks self-care capacity. NAs used respectful assisting while helping with ADLs such as bathing or grooming. Respectful assisting was most often used when residents wanted to exercise independence in self-care but needed some support due to physical or cognitive limitations. One NA described, "We more or less assist them. And like I said before, I try to make them feel [that they are in the] lead, that they're in charge of what we're doing. But at the same time, I'm knowing their capabilities."

Helping fulfill a desire or wish. NAs described going above and beyond their understanding of their duties to fulfill residents' wishes. For example, one NA noted that she and other NAs occasionally cooked meals at home to bring to the residents when they had special requests (e.g., dessert cobbler). Another NA mentioned that she bought food, such as fried chicken, for residents when they did not like the dinner prepared in the CLC kitchen. Similar helping behaviors expanded beyond mealtimes. One NA described assisting a resident outside the facility so the resident could smoke a cigarette.

Stepping in. Because NAs strongly valued supporting functional independence, residents were encouraged and, at times (particularly in the more independence-focused neighborhood), expected to do chores (e.g., washing and drying their laundry; changing their bed linens). When residents did not want to engage in chores, NAs would occasionally "step in" to complete these tasks. This technique was used to support residents' preference and choice to not do chores, which is a choice, recognizing and supporting their right to choose to not with the philosophy that it would be more likely to eventually persuade a resident to be more involved by first joining with the resident and supporting their initial preference to not be involved.

> I just said, "OK. If you don't want to do it right now, I'll come back later. And if you still refuse, OK, I'll do it this time. But, the next time we'll have to talk about it a little longer." You know. "If you don't want to do it today, you want to think about doin' [*sic*] it tomorrow?" (NA 5)

Monitoring

Monitoring was defined as "keeping an eye out," as described in a direct quote from an NA. NAs diligently thought about the safety of residents; monitoring was a tactic used to prevent harm or quickly intervene if harm occurred. As an autonomy-supportive technique, NAs were observed monitoring residents engaging in potentially risky activities, such as independent walking by residents with falls risk factors or the eating of foods outside the prescribed diet for residents with dietary-related risk factors, with the intention of intervening if an accident occurred. One NA described:

> They want, uh, food that they can have a regular diet. Some of 'em [*sic*] really want it, and I want 'em [*sic*] to have it. But, they have a swallowing problem...And then sometimes I do take maybe a fried piece of chicken instead of the pureed, . . . and just cut it up really, really fine for them so they can get the taste of the crispiness and the fried, you know, at the same time satisfying their taste, but looking out for them. (NA 1)

Encouraging

Encouraging was used to motivate residents with the intention of positively shaping their behaviors. Positive communication tone was an essential component of effective encouraging. Specific autonomy-supportive encouraging techniques included *boosting confidence* and *praising.*

Boosting confidence. Infrequently, NAs encouraged residents to engage in self-care independently or with minimal assistance by boosting residents' confidence in their functional abilities. This tactic was executed by reminding residents what they were capable of or had recently accomplished. For example, one NA wanted a resident to dress himself, but the resident insisted that he was not capable. The NA encouraged the resident by saying, "Yeah, you can put your shirt on. I saw you do it the other day. Remember? You got your shirt and put it on."

Praising. NAs praised residents for engaging in care tasks, with the intention of encouraging independent self-care and helping behaviors in the future. Praising occurred by attending to a goal that the resident accomplished and offering emphatic approval or reward. NAs believed that nearby residents who witnessed the praise would also be motivated to do tasks independently in the future.

> So, when I come in sometimes, they'll [residents] say, "Look. Come here. I need you to see. . .. I went in there last night and you was not here, and I put my shoes right there" [imitating a resident]. I said, "Good for you!" You know, I really clapped. I said, "You really did a wonderful job." And I said, "Did you hear that?" – if there's another resident around. I was like, "Did you hear that?" (NA 1)

Bargaining

NAs used bargaining to get residents to do things, such as bathing or participating in an activity, in return for honoring a specific resident wish. This technique was autonomy-supportive because the resident ultimately had control over the negotiation, since he or she could participate in the activity or not. One NA described how she used bargaining to get a resident to calm down and go back to sleep in the middle of the night.

> He will try to get up out the bed to try to make it to his wheelchair to get up and go, 'cause [*sic*] he feels somebody [*sic*] outside waiting on him... So, and I told him, I said, "If I get you up out the bed and take you outside and let you see that nobody's out here, would you come back. . .?" – It's at night now. "Would you get back in the bed and have a good night?" (NA 3)

Informing

NAs are knowledgeable about the daily NH schedule and can provide helpful information to residents as they navigate everyday life, which was labeled *informing about an opportunity.* NAs are also in an ideal position to assess and advocate for residents' preferences, because they spend more time with residents than do other staff. This technique was categorized as *informing others about residents' preferences.*

Informing about an opportunity. Residents were sometimes not aware of occasions to exercise autonomy unless staff informed them. For example, several residents stayed in their bedrooms most days and only came out to eat meals. When a social event or recreational activity was available, NAs informed these residents about the activity. By providing this information, NAs gave residents the opportunity to accept or decline participation, further supporting autonomy. One NA explained that she regularly informs residents what foods will be served at breakfast, thus allowing them to make an informed decision about whether to get up or sleep late. "They'll usually want to know, 'Well, what are we havin' [*sic*]?' And you can tell 'em [*sic*] and, sometimes it depends what you're havin' [*sic*] as to if they'll get up and eat or not."

Informing others about residents' preferences. Although NAs did not have the power to override doctors' orders that conflicted with residents' preferences, they were equipped with valuable knowledge about the residents to advocate for them. Furthermore, they educated new staff about residents' preferences. For example, a new staff member was observed telling a resident to sit in his chair at the kitchen bar while eating his meal. An NA familiar with this resident informed the new staff member that the resident prefers to stand while he eats to interact with kitchen staff on the other side of the bar. Although NAs were not directly observed informing higher-level staff about residents' preferences, they reported that they tell treatment team members when residents refuse to eat pureed food, and sometimes residents' meal plans were changed accordingly: "We've had one or two since I've been here that just refused to eat that [pureed food]. And, of course, when we sent the RN around there, theirs [their meal] would actually be changed to accommodate them."

Providing instructions

NAs often provided directions to residents. Sometimes directions were given to prevent harm, but this usually resulted in restricted resident autonomy. For example, NAs would often instruct residents to sit down to reduce the risk of falls. In contrast, autonomy-supportive directions were intended to increase functional independence and included *providing instructions in the moment* and *shaping long-term behaviors to increase independence*.

Providing instructions in the moment to increase independence. Most observed and reported accounts of providing directions were intended to increase residents' independence in the moment. This technique was appropriately used during self-care or chores when residents forgot necessary steps, e.g., instructions about how to dress, fold clothes, and bathe. While describing how to assist with bathing, one NA stated, "I'm just like [speaking to the resident], 'Yeah, well, let's just get this part right here. Get you [*sic*] rag and put some soap on it. Make sure you hit under here, wash under here and wash there.'"

Shaping long-term behaviors to increase independence. Only one NA reported using an autonomy-supportive technique known as shaping, an effective method for behavior change (Pryor, 2002). Shaping is accomplished by presenting an activity one step at a time and only moving forward when the first action is mastered. An NA reported this example:

> A resident that wasn't making his bed. Uh, we decided that, uh, every morning when he gets up, we'll be in the room with him. First, we started helpin' [*sic*] him strip his bed, and we started helpin' [*sic*] him put his linen on his bed. Then we worked him up and said, "Ok. It's time for you to do it on your own." (NA 6)

Persuading

NAs often used autonomy-supportive persuading to get residents to engage in healthy behaviors or refrain from partaking in unhealthy behaviors. This tactic was used in a variety of situations including basic and instrumental ADLs and recreational activities. Persuading

was further divided into *persuading by presenting rationale, persuading by ensuring trust,* and *persuading by providing an opinion.*

Persuading by presenting a rationale. When residents did not want to participate in an activity, NAs would often present a rationale for why they should. One NA described a situation when a resident did not want to put on pajamas, instead insisting on wearing his day clothes and shoes to bed. After the NA provided a simple rationale for why the resident should change clothes (it would be more comfortable), the resident complied. The following is an excerpt that illustrates how an NA persuaded a resident to refrain from engaging in a potentially risky behavior.

> He [resident] had fallen the day before. So, the next day after supper, he had, you know, got through eating and pulled away from the table and . . . just proceeded to go over there to the wall, and wanted to do his exercises on his own. So, I went over there. I said, "You just fell yesterday, so you probably a little unsteady on your feet." And, you know, I just, asked him to sit down in the chair. (NA 2)

Persuading by ensuring trust. At times, providing a rationale was not sufficient to persuade residents. Instead of moving toward an autonomy-restrictive approach, such as forcing residents to comply, NAs sometimes used the rapport they had with residents to their advantage by using persuasion to ensure that residents could trust them. This often resulted in compliance.

> Some of the medicines' color vary [*sic*]. And if it's not the color that they're used to, we really have a problem. . . Now, we have one I can pretty much talk to and say, "That's the same medication. . . I say, "I promise you, you know. Now, you and I are ok, and we're friends, and I wouldn't fool you." (NA 1)

Persuading by giving an opinion. NAs provided their opinion as a way of persuading residents. For example, during an observation at lunchtime, a resident did not want to drink his water. An NA encouraged him to drink the water because it was healthy, and followed up by stating that she liked water. This tactic was most successful when the resident respected the NA providing the opinion.

> . . .. Last night . . . I mentioned to one of 'em [*sic*] about takin' [*sic*] a bath, and he said, "Naw [*sic*], I had one the night before last." And I said, "Well, I had one the night before last, and I had one last night, and I had one before I came to work." And, I said, "I think everybody needs a bath." Well, about 30 min later, he said, "Well, if you think I need to take a bath, I'll take one." (NA 7)

Asking

Asking was used by NAs to engage residents in communication about preferences. When NAs asked residents questions over time, they learned their preferences and were more efficient at offering PCC. Asking was divided into three techniques: *asking about preferences, asking as a form of suggesting,* and *asking "why" to understand the root of residents' preferences.*

Asking about preferences. NAs noted that residents' preferences were assessed on admission but were documented in a binder not accessible to NAs. NAs consequently directly asked residents about their preferences in order to provide PCC. At times, residents' preferences changed, especially when they were avoiding a particular care task. NAs sometimes reassessed a resident's preferences multiple times during a single shift.

> Well, if I, if I go in and ask 'em [*sic*] do they want to take a shower, and they tell me no. . ..so, I'll probably leave out and go back later and ask again, because you know that we have Veterans that, you know, that dementia or whatever... So, I will go back and ask about three or four times before I put down that they didn't want a bath today, or ask them what day would they want they shower or bath or whatever. (NA 3)

Asking as a form of suggesting. Sometimes, NAs used questions as a way to suggest things. This tactic was particularly useful when a specific activity was not required of residents (e.g., laundry), or when residents were generally agreeable. "They aren't going to voluntarily make the bed, but some of 'em [*sic*] we'll ask, 'Are you gone [*sic*] make your bed today?' And, you know, they'll go ahead and do it and try to spread it up and everything."

Asking "why" to understand the root of residents' preferences. When NAs were unable to convince a resident to engage in a certain behavior, they attempted to understand why the resident was resistant. Gaining a better perspective on residents' decisions allowed NAs to empathize and address residents' concerns/needs. One NA explained that he conducts a "root cause analysis" to better understand how residents' values influence their preferences. Another example involved taking medications.

"Let's just talk about this. What's goin' [*sic*] on? Why you don't want to take your medication? . . . What are you thinking right now? Why do you feel like it would hurt you? Why do you feel that we would hurt you? We're tryin' [*sic*] to help you. We're here for you. What do you need? What do you need to talk about? What would make this work? What can we do to have you less angry or less agitated?" (NA 1)

Providing options

NAs provided options as a way to honor choice and promote autonomy. Even when a more paternalistic approach was deemed necessary, NAs identified at least two options to offer residents, which balanced the struggle between paternalism and autonomy. The autonomy-supportive tactic of providing options was further divided into *providing available or feasible options* and *providing restricted options as a way to influence residents' decisions*.

Providing available or feasible options. NAs provided options in a variety of ways, such as offering different choices for snacks or movie showings. In almost any situation, options were available. However, sometimes options were limited due to inherent constraints of NH policies, resources, or staff availability. For example, residents had the option of waking early or sleeping late, but breakfast options depended on choice of rise time because there was not enough staff to cook for residents whenever requested. Early risers were afforded the opportunity to eat a hot breakfast. Those who chose to sleep late were often not offered a hot breakfast, but could choose to eat cereal or other items that did not require cooking.

Providing restricted options as a way to influence residents' decisions. Occasionally, NAs felt it necessary to exercise a degree of paternalism to get residents to engage in self-care, i.e., when residents consistently declined to follow NAs' requests. One NA stated, "And some of 'em [*sic*], we have to make the choice for them. I have to stress that because there are some just would rather do without cleaning themselves up, period." However, even when NAs made commands and restricted autonomy for a greater good, they ultimately supported residents' autonomy by providing any options that were feasible. An NA explained, "And some just will not [take a bath], and that's when you step in and say, 'OK, you have got to have a bath. Do you want to do it now, or do you want to do it later? But we gotta [*sic*] do it today.'"

Redirecting

NAs used redirecting, defined as diverting one's attention away from one thing and on to another, when residents who had cognitive impairment wanted to engage in an activity that was potentially harmful or not feasible. Redirecting is classified as autonomy-supportive because it was used in place of explicitly telling residents they could not partake in their desired activity.

> What I do is I try to redirect 'em [*sic*]. And when I see that I can't, I'll talk to them. I'll try to talk to them. And then I'll try to start some other activity, like, "Do you want to play a game? Let's watch a movie." (NA 1)

Discussion

This study used qualitative methods to identify concrete tactics NAs use to support everyday resident autonomy in a LTC setting. Observations and interviews revealed ten autonomy-supportive tactics consisting of 20 specific techniques (see Table 2 for a list of ways in which each tactic supported resident autonomy). All techniques incorporated some degree of autonomy support in that they were delivered with a neutral or positive communication tone, were used to influence residents' choices or behaviors to improve health or minimize harm, and ultimately resulted in honoring the residents' choices or preferences. *Bargaining, persuading, providing restrictive options*, and *redirecting* were the most prohibitive techniques and were used when residents were engaging or attempting to engage in a risky behavior or when residents declined engaging in a healthy behavior. Other techniques, such as *assisting, monitoring, encouraging*, and *providing instructions*, were oriented toward fully supporting residents. Other times, NAs advocated for freedom and autonomy by providing education and information (i.e., *informing residents of available opportunities* and *providing options*) and *asking about their preferences*.

Autonomy is complex, and some crucial distinctions in the degree or type of autonomy have been made that are vital to understanding how to support autonomy in LTC settings and individuals with disabilities.[1,30] Specifically, decisional autonomy, defined as the capacity to have preferences and make decisions, has been differentiated from executional autonomy, categorized as the ability to implement choices or carry out decisions.[1] This study identified autonomy-supportive techniques that highlight both decisional and executional autonomy. Examples of honoring choices and preferences that promote decisional autonomy include *informing a resident about an opportunity, informing others about residents' preferences, bargaining, asking preferences, providing options*, and *stepping in* to complete a task that the resident delegates to another person (e.g., asking NA to make resident's bed or wash linens). Due to functional or cognitive limitations, residents may have diminished executional autonomy. As illustrated in this study, *respectful assisting, helping to fulfill a desire or wish, monitoring, providing instructions in the moment*, and *shaping long-term behaviors to increase independence* are techniques NAs can use to promote executional autonomy.

Although self-determination theory was not part of the original underpinnings of this study, the techniques described in this study were found to be consistent with autonomy-supportive approaches mentioned in the literature on self-determination theory. At the heart of self-determination theory is motivation, and among the factors that influence a person's motivation is autonomy support.[31] Given the promising research on self-determination theory in such applications as motivating adolescents to refrain from smoking[32] and students' engagement in the classroom[16], it is reasonable to posit that an autonomy-supportive approach is an ideal method for engaging NH residents in daily care. This may be especially applicable when a resident initially declines or resists care. Training materials for dementia care and interventions based on self-determination theory for residential and LTC settings have already been developed and studied.[33,34] Because the identified methods in these training materials are relevant to the autonomy-supportive tactics identified in this study, specific techniques described in this study may be added to existing materials to offer more concrete directions on providing PCC-oriented autonomy-supportive care.

Upon analyzing the data, we found that our sample of NAs used a variety of techniques congruent with recommended dementia care approaches. Person-centered dementia care approaches include staff behaviors such as announcing activities, avoiding arguing, providing step-by-step instructions, setting realistic goals, encouraging independence when appropriate, speaking in a calm manner, using distraction and diversion when necessary, and asking about residents' preferences, needs, and wishes.[35,36] Specific techniques observed in the present study that are consistent with dementia care approaches included providing instructions and shaping behaviors to increase independence, redirecting residents rather than arguing with them, and learning about the residents' past to understand current preferences and behaviors. Moreover, NAs often used more than one technique during an interaction to influence behaviors – another recommended strategy for working with residents with dementia. These findings indicate that strategies outlined in dementia care training and related literature may prove useful when working with individuals without dementia as well.

Limitations

An inherent limitation of qualitative research is the researcher's influence on how the data are collected and interpreted. A number of techniques were employed to minimize researcher bias. Interviews were semi-structured and open-ended to avoid guiding participants' responses. To increase reflexivity, the first two authors coded the data and met frequently to discuss the data and codes, and memos were written throughout the research process to aid in conceptualization and identify potential biases.

Two other limitations of this study are the small sample size and location of the study. Despite an eight-month recruitment period, only eight NAs participated in interviews. Efforts were made to offset this limitation by increasing the number of observations conducted. To improve credibility and trustworthiness of the results, persistent observation and prolonged engagement in the study settings were employed until data saturation occurred. Given that the study was conducted at one VA medical center in the Southeast, it is possible NAs in other LTC settings may practice different autonomy-supportive techniques. Future research should evaluate if the autonomy-supportive techniques observed in this setting are found in other settings.

Finally, this study focused on cataloguing autonomy-supportive techniques and did not attempt to identify or describe all interactions, including autonomy-restrictive techniques. Interview and observational data were not analyzed separately. Therefore, we were unable to compare results to determine if self-report in the interviews was disparate from observed behavior. Moreover, data was analyzed across neighborhoods, so we were not able to compare differences between settings.

Conclusions

Study findings augment existing knowledge with a rich inventory of field-based techniques used by NAs to support autonomy in LTC settings. NAs are frequently tasked with promoting resident choice and autonomy

when there are competing issues related to resident safety or medical needs.[37] Concrete autonomy-supportive techniques can help NAs balance resident autonomy and safety while providing PCC. Past literature describes methods or approaches very broadly, leaving room for individual interpretation of *how* to implement each strategy. For example, *promoting individualized care* is a general approach described by Davies, Ellis, and Laker[21] (Table 1) and recommended in dementia care. To implement this approach, NAs can use specific techniques described in the present study, such as *asking preferences, asking "why" to understand the root of residents' preferences, helping fulfill a desire or wish*, and *informing others about residents' preferences*. Similarly, the general tactic *persuading residents*, as shown in Table 1, can be achieved by *presenting a rationale, ensuring trust*, or *giving an opinion*, which are techniques described in this study.

Research supporting the benefits and importance of autonomy for NH residents[8] has influenced the shift toward a PCC approach.[10,38] Additionally, residents, their family members, and staff agree that resident autonomy is an essential component of quality of life in the NH setting.[3,39,40] Because NAs provide the bulk of assistance with everyday care tasks, it is important to understand how they can support resident autonomy, especially when residents initially decline to participate in care. Study findings converge with the literature on person-centered dementia care and self-determination theory. Future research should further explore the match between these areas of research and the application of dementia care approaches and interventions based on self-determination theory in any LTC setting (i.e., settings serving individuals with and without dementia).

Appendix

Goal 1: To explore CNAs' perceptions of resident autonomy and NAs' beneficent responsibility to residents

Interview Script:

1. First, I want to talk to you about your role as a NA. What do you see as your main responsibilities as a caregiver?
2. How do you think about resident independence and choice?
3. How do resident independence and resident choice fit in with your caregiver responsibilities, or affect your caregiver responsibilities?
4. Do your supervisors ever discuss resident independence and choice with you, or have you received any training that has touched upon these topics?
5. Tell me about an experience when a resident wanted to do something you thought was unhealthy or unsafe and you felt it was your job to keep them safe or prevent harm?
   a. What happened?
   b. How did this affect how you performed your job?
   c. Thinking back on that experience, how did you feel at the time?

6. Cultural transformation has been happening in the CLCs for a while now. How, specifically, has your work with residents changed as a result of cultural transformation?

a. Tell me about an experience when a resident wanted to do something, and you felt he now should be able to follow through with his choice because of cultural transformation?

7. I can imagine that sometimes a resident might want to do something that you or other employees feel is potentially harmful. Now, because of cultural transformation, do you ever feel unsure about whether or not to allow the resident to follow through with his choice?
   a. What do you think about in this kind of situation?
   b. How does it make you feel?
   c. How does it affect how you perform your job?

Goal 2: To describe which activities of daily living and other activities NAs deem important and not important for the maintenance of resident autonomy

Interview Script:

I want to learn about your opinion of resident independence. Specifically, I'm interested in your thoughts and values about their independence in specific activities.

1. When you think about how residents spend their day, what kinds of activities do you think of? That is, what are the categories of activities that residents must take part in, need to take part in, and/or have the option to take part in?
   a. ADLs
   b. Leisure/Recreation
   c. Rehabilitation/Restorative
   d. Other?
   e. Or do you think of the categories differently?

2. Thinking about resident control or independence, are there categories of activities, or specific activities for which resident control or independence are important or should be prioritized?

3. Are there categories of activities, or specific activities for which resident control or independence is less important or should not be prioritized?(If this varies by resident) How/why is it different for different residents?
4. Can you tell me a little bit more about why you think these activities (show list of NA's responses) are important for resident independence and these activities (show list of NA's responses) are not important for resident independence?
5. Please give me some examples of situations in which you think resident choice or independence should be limited?

Goal 3: To explore techniques NAs use to promote or maintain resident autonomy

Interview Script:

I'm interested in learning about the specific ways in which NAs work with residents to encourage resident independence.

1. Please give me examples of ways in which you give residents choices.
   a. How do you think this helped the resident?
   b. What are the most successful ways you've given residents choices?
   c. How are they helpful to your job?
   d. What are the least successful ways you've given residents choices?
   e. (If this *b* and *c* above vary by resident) How/why is it different for different residents?
   f. Thinking back, is there something you might do to improve how you offer choices?

2. Please give me examples of ways in which you encourage residents to do more independently or with less assistance from you?
   a. How do you think this helped the resident?
   b. What are the most successful ways you've encouraged resident independence or reduced residents' need for assistance?
   c. How are they helpful to your job?
   d. What are the least successful ways you've encouraged resident independence or reduced residents' need for assistance?
   e. (If this *b* and *c* above vary by resident) How/why is it different for different residents?
   f. Thinking back, is there something you might do to improve how you encourage resident independence or reduce residents' need for assistance?

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