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Original Article

Health personnel's experience with resident-centered care in nursing homes in Korea: A qualitative study

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ABSTRACT

Objectives: Changing the culture in nursing homes in South Korea comes with challenges, and the key issues of resident-centered care have been described. This study aims to describe health personnel's experience in providing resident-centered care in nursing homes.

Methods: Qualitative data were collected through individual and focus group interviews consisting of registered nurses ($n = 4$), certified nurse assistants ($n = 2$), and long-term caregivers ($n = 12$) working at nursing homes in South Korea. The participants ($n = 18$) completed the interviews from May to June 2018, and all interviews were recorded, transcribed, and analyzed by employing the content analysis method.

Results: Five main categories are conceptualized: (1) residents' participation in decision making, (2) the sharing of the history and story of residents, (3) the recognition of facility- or task-based attitudes, (4) the guarantee of private time and space for residents, and (5) the need for standardized guidelines.

Conclusions: Results corroborate that health personnel regard resident-centered care as a desirable nursing paradigm. However, facility- or task-centered care is the most effective in hectic situations. A standardized protocol on the application of resident-centered care based on the facility-tailored specification is unavailable. Therefore, health personnel's perception and practice of resident-centered care can differ. Efficient nursing intervention programs should be developed after clarifying facility culture.

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1. Introduction

In 2018, the proportion of the aged in South Korea was 14.3%, and this trend is still increasing [1]. The aging rate and support costs for the elderly are expected to become the second highest to that of Japan by 2040 [1]. In addition, the aging index was 110.5 in 2018, and the elderly population is expected to surpass that of the youth. In 12 years, one out of five people is predicted to be aging [1,2]. Consequently, the number of welfare facilities for senior citizens in South Korea has significantly increased. According to a survey in 2018, 75,708 newly registered facilities were available; among them, 3,136 were welfare facilities for the elderly, which is an 83.2% increase compared with that in 2012 [3]. The demand for facilities can gradually increase as the elderly population increases. However, this value can be placed on the qualitative factors of facility management, such as services, rather than the scale or number of facilities [4].

Previous reports [4,5] have corroborated that the greatest obstacle for the elderly or their families—who are reluctant about facility admittance—is the facility culture (e.g., perceived as hospitals or hospices). Therefore, building trust and promoting the maintenance of daily life functions after facility admittance are necessary. Since the late 1990s, resident-centered care, in which preferential value is placed on the choices of the elderly residing in an elderly-care facility and the philosophy and belief in creating a home-like atmosphere, has emerged [6,7]. Various terms are used to define this shift toward providing home-like nursing homes that are receptive to residents' preferences, such as person- or resident-centered care [6]. In addition, the terms refer to a collection of principles for nursing homes, including a relationship-based model of care, resident direction of his/her lifestyle, stability in staff who support residents, design of the physical space, and other foundations that contribute and define the quality of life on a personalized basis in nursing homes [6,7].

However, a supplier-centered, rather than a user-centered, market environment is created given the liberalization of establishing nursing homes in South Korea. A problem with inferior

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service quality also arises due to excessive competitions among facilities caused by the random establishment of facilities [8]. Since the 1990s, resident-centered care has been practiced widely around the world and has been set as a basic direction for Long-Term Care services in the USA and European countries [9]. Moreover, similar trends of increased demand for resident-centered care are also described for Asian-Pacific nations, such as Japan [10] and China [11]. Expecting similar trends in other countries with similar residential aged care systems is reasonable. However, empirical research and in-depth discussions on the service quality of nursing homes or the quality of life of the elderly are significantly lacking in South Korea. Although institutional care for the elderly has increased in the country, research on the elderly residing in nursing facilities is still lacking because the topic is relatively less widespread in South Korea than in the West. Further, domestic studies are limited to either evaluating resident satisfaction with facilities [12]; service quality [13]; or their physical, mental, and social health [14] or to examining burnout, job satisfaction, changing jobs, or the stress of facility employees [15–17]. Therefore, finding direct discussions on the culture change of nursing homes is rare in the domestic literature.

In the present study, we clarify culture change and resident-centered care in nursing homes to provide basic data for devising practical educational programs for nursing personnel and employ focus groups to identify the demands of nurses and long-term caregivers. These demands can be used to develop nursing intervention programs that provide resident-centered care [18]. Accordingly, we conduct a qualitative content analysis to elucidate resident-centered care from the perspectives of nurses and long-term caregivers.

2. Methods

This qualitative research utilized a content analysis of the data, which were collected through one-on-one and focus group interviews to understand the resident-centered care experience of nursing personnel working at nursing homes. The reason for integrating individual and focus group interviews was to enhance data richness and to respect participants' preferences [19]. In addition, individual in-depth interviews were performed in place of focus group interviews if the participants expressed being uncomfortable talking openly in a group. Focus group interviews were selected as they have several advantages over other qualitative data collection methods, such as individual interviews [20]. First, each participant can deliberate on a range of similar or different experiences expressed by other participants because they are exposed to diverse perspectives [20]. Second, group research methods allow a flexible expression of feelings, which may ultimately expose the key aspects of the phenomenon of interest by reducing the guidance and control of the researcher [19,20].

The Consolidated Criteria for Reporting Qualitative Research (COREQ) checklist was used to guide reporting [21]. [Appendix A](#) presents a completed COREQ checklist for this study.

2.1. Participants and setting

Purposive sampling was used to select 18 participants who worked at one of the four nursing homes for the elderly in Seoul and its metropolitan area, and the inclusion criteria comprised participants who are either currently working or have worked for one year or longer at nursing homes. On the basis of focus group interview standards [20], the target number of participants in each focus group was five to ten. Each group consisted of six to eight participants who understood the purpose of the study and consented to participate.

2.2. Ethical considerations

This study was conducted after receiving approval from the Institutional Review Board at Gyeongsang National University Research Board of Ethics (Approval No. GIRB-A18-Y-0032) in 2018. The author received consent from the participants, who certified that they understood the research objective and agreed to voluntarily participate. Further, the one-on-one interviews were conducted after explaining the intent and method of this study to the heads and nurses of the eligible nursing homes located in Seoul and its metropolitan area. The author clarified in the instruction documents that participation in the focus group interviews was completely voluntary, and these individuals also provided consent. In addition, the participants signed consent forms after being informed of the research objective, and this was performed after discussing the data collection (recording interviews) process, plans for using and storing the data after analysis, risks related to participation in this research, and compensation. Ultimately, the author informed the respondents that the results would only be used for this research, that all data would be processed anonymously, and that they could refuse to answer questions or stop the interviews entirely whenever they wished.

2.3. Data collection

The participant interviews were conducted by the investigators from May to June 2018. One of the research questions was the following: What experience do you have in connection with 'resident-centered care' while caring for the elderly at a nursing facility? The questions were composed considering previously noted interview methods [19,20] to determine the level of experience nursing providers had with providing resident-centered care. In addition, the questions were either added or deleted as the interviews and data analysis progressed. The specific research questions were as follows: (1) What is the experience of caregivers at nursing homes with resident-centered care? (2) How is resident-centered care different from facility-based nursing or task-based nursing? (3) What is most needed for resident-centered care? (4) What are the nursing services or activities the nursing personnel perform for resident-centered care at nursing homes? (5) What are the things you think should be included in nursing practice to efficiently apply resident-centered care? (6) What is easy or difficult in providing resident-centered care at nursing homes?

The one-on-one interviews were conducted four times with four nurses, and it took approximately one and a half to 2 h. A separate focus group interview was conducted with a group composed of one nurse assistant and five long-term caregivers and a group composed of one nurse assistant and seven long-term caregivers, and each interview lasted 2 h. In addition, the interviews were conducted in a quiet place such as in a meeting room. All the interviews were audio recorded on a digital recorder and were conducted by the same investigators, and the entire audio recordings were transcribed by a research assistant. Moreover, the collected data were composed of the transcriptions of the focus group interviews, field notes written by the investigators during the interviews, and debriefing notes written directly after the focus group and individual interviews. The incomplete or inaccurate parts were verified through phone or e-mail after the first interview.

2.4. Data analysis

We verified and modified the recorded interviews to prevent omissions and missed entries during transcription. In addition, we analyzed the transcribed data using the qualitative content analysis

method, which is an inductive analysis that considers the meaning of the data with the research questions as a fundamental axis without detailed specific theoretical and philosophical backgrounds as grounded theory or phenomenology. The qualitative content analysis method is an appropriate technique when existing theory or literature on a phenomenon is lacking, and the purpose of analysis is to obtain knowledge and understanding of such a phenomenon [22].

For open coding, we treated one line of the transcript as one unit of analysis. We also extracted words, sentences, and paragraphs that corresponded to our purposes. After open coding, in which analysis units that have similar contents and dimensions are categorized, we structured category items into subtopics in the secondary analysis. Thereafter, we added or modified the categories from additional interview data using the constant comparison method and then terminated data collection when no new category was found. Ultimately, we characterized the central theme by refining the categories collected up to that point.

To secure rigor, which is an evaluation criterion for qualitative research, we followed Guba and Lincoln's [23] four issues: truth value (believability), applicability (fitness), consistency (auditability), and neutrality (objectivity). To secure believability, we collected vivid data as told by participants by parenthesizing the existing prejudices and fixed ideas against nursing personnel who provide resident-centered care. Moreover, we evaluated fitness by determining whether the findings were suitable in other situations and whether they were meaningful and applicable when people read such findings considering their own experience. Accordingly, we employed theoretical sampling, where participants with varied backgrounds (e.g., diverse occupations, education level, and length of employment at nursing homes) were included to prevent participant bias. Reliability can be established when the study can be replicated by other researchers. Therefore, we began coding by separately marking words or phrases that included key thoughts/concepts, which revealed participants' experience. We also focused on and repeatedly read interview data in its entirety. In addition, we classified and named categories through further abstraction by combining codes related to each other. Centering on these categories, we examined the reliability of the categories by returning to the raw data and grossly reading and analyzing them. Further, we increased the reliability and validity of the results by continuously discussing the analyzed concepts, category names, and abstraction levels among the investigators. The last evaluation criteria—neutrality—signifies research that is free of bias, which is obtained when truth value, applicability, and consistency are established. Overall, we obtained rigor in this study.

3. Results

Table 1 presents the participants' characteristics. The participants were all women aged 35–55 years, and their experience working at nursing homes for the elderly ranged from nine months to one year.

The results affirmed the distinct categories of participants' experience in providing resident-centered care for the elderly residing in elderly care facilities, including the participation of the elderly in decision making, sharing of the history and story of the elderly, the recognition of facility- or task-based attitudes, the guarantee of private time and space for residents, and the need for standardized guidelines.

3.1. Participation of the elderly in decision making

The participants believed that for resident-centered care, residents' opinions should be considered before making decisions

regarding care directions, detailed schedules, or program content implemented at the facility. They also stated that participation in establishing operation regulations is critical. For example, *"Listening to what residents are thinking is necessary as a first step regardless of how small the opinions are"* (Participant 7). Another perception explained that a *"Nursing facility is a living space for residents where their food, clothing, and shelter are fulfilled. They may have to stay in the facility until they die."* However, one participant recognized the nursing facility as *"Inevitably a workplace"* (Participant 1). Another participant disclosed, *"We have to let residents know what is going on in this space"* (Participant 2), thereby supporting the previous sentiments.

3.2. Sharing the history and story of the elderly

The resident-centered care perceived by nursing personnel *"Enables them to accept the elderly as a being who can still produce something, rather than as a deteriorated being whose function has declined"* (Participant 3). In the center of production possibility, *"Stories are created by weaving their own lives and history"* (Participant 1). However, the thoughts of residents are unknown until they are discussed. The participants noted that the methods of communication, even with the elderly with a decreased cognitive function, must be revealed to determine the thoughts of the elderly. Efforts to create unique relationships with the elderly are necessary.

"Each elderly has a personal history because each person lives long. Calling them by their last title of their social life may be a way. Treating them as great survivors who have been living through their lives, rather than treating them as patients, may also help. Frankly, they think that it is the end when they are admitted to the facility. We all know that they stay here and cared for not by the family but by others and then transferred to a geriatric hospital when the illness becomes serious and end their lives there. Although we know it, seeing them as they are with the thought that we have a new life to live today is possible" (Participant 12).

3.3. Recognition of facility- or task-based attitudes

The participants stated that nursing personnel make light contact with the elderly and smile and take the attitude of paying attention even to murmuring sounds as a small strategy for resident-centered care. *"I have set work to do when I come to work. I must make time to eat while performing my duties of assisting with meals, sending them to programs, washing them, and taking them for a walk. With all that, my work becomes facility- and task-based when I am treating the elderly. I perceive them only as work, rather than people communicating with me."* (Participant 13). *"I see them as work to do, and I talk to the elderly who cannot perform self-care as if I am talking to children without realizing it because caring for them is similar to caring for large children"* (Participant 15).

"I have a method. I make eye contact when I am assisting them with meals or when taking them to the restroom. Sometimes, they are weak, and their eyes are not focused. Other times, they look at me straight when they gain strength and smile without realizing it. Such a moment of joy or pleasure gives me the strength to work every day." (Participant 15).

3.4. Guarantee of private time and space for residents

Elderly residents have a limited space around their beds as they use multi-occupancy rooms. Therefore, securing private time and space for each resident is difficult considering that they must move according to the daily schedule and programs devised by the facility. Accordingly, nursing personnel stated that resident-centered

Table 1
Socio-demographic characters of participants (n = 18).

N	Interview type	Age (years)	Occupation	Education background	Work experience at nursing home
1	Individual	35	Registered nurse	University graduate	4 years 2 months
2	Individual	37	Registered nurse	University graduate	3 years 7 months
3	Individual	40	Registered nurse	University graduate	1 year
4	Individual	42	Registered nurse	University graduate	4 years 9 months
5	Focus group	52	Certified Nurse Assistant	High school graduate	4 years 2 months
6	Focus group	46	Certified Nurse Assistant	High school graduate	3 years 7 months
7	Focus group	47	Long-term caregiver	University graduate	3 years
8	Focus group	55	Long-term caregiver	Middle school graduate	3 years 11 months
9	Focus group	52	Long-term caregiver	High school graduate	4 years
10	Focus group	55	Long-term caregiver	Middle school graduate	3 years 2 months
11	Focus group	53	Long-term caregiver	High school graduate	3 years 10 months
12	Focus group	50	Long-term caregiver	High school graduate	3 years 7 months
13	Focus group	55	Long-term caregiver	University graduate	4 years 8 months
14	Focus group	53	Long-term caregiver	High school graduate	4 years 3 months
15	Focus group	45	Long-term caregiver	High school graduate	2 years 2 months
16	Focus group	48	Long-term caregiver	High school graduate	3 years 5 months
17	Focus group	50	Long-term caregiver	High school graduate	4 years 7 months
18	Focus group	55	Long-term caregiver	High school graduate	3 years 10 months

care is “Providing the elderly with private space and time” (Participants 2 and 11). “No private life exists. Nevertheless, the time and space shared with the family when they visit seem to be the only private life” (Participant 11). Therefore, “Efforts should be made so that elderly citizens can see various family members, can be treated as adults, and can spend their time when they want to stay in a space they like” (Participant 3).

“We use that method, too. We also display their family and childhood pictures, as well as place personal decorations by their beds. We consider their preferences such as private clothes over patient gowns or uniforms. However, if a picture frame falls and breaks, then safety issues can arise, and these pictures and decorations are eventually removed because they get in the way of cleaning or disinfecting. I have no choice but to make a small effort by keeping on challenging tire-some or inconvenient matters.” (Participant 2).

3.5. Need for standardized guidelines

Conducting formal education for nurses and caregivers at nursing homes may be feasible through programs with the concept of resident-centered care formally in place. In addition, educational programs with the value and philosophy of resident-centered care in place can deviate according to the nursing facility. The demands for standardized guidelines may be due to the recognition of the participants that resident-centered care is ultimately only possible when it suits the atmosphere of the facility.

“I have never thought about resident-centered care. It probably means that I should see the person first when I work. Quite frankly, such an enlightenment is almost non-existent in daily routine. Telling me that I should have such a mind-set is ambiguous because it is a matter of mind. If I am given specific guidelines as to how my attitude and behavior should be when I care for the elderly, then I may perform my duty realistically. Our staff can practice them together, and we may modify them so that they are practicable.” (Participant 4).

4. Discussion

The results in this study contended that nursing personnel were unfamiliar with the terminology resident-centered care. Nevertheless, they agreed that recognizing that they have been performing facility- and task-based nursing when they heard the terminology is an opportunity. The participants could not discourse on the first research question: “What experience did you have in connection with resident-centered care while you were caring for

the elderly at the nursing facility?” They needed the process of all members agreeing on the meaning of the terminology within the focus group, which supported the contention of Fusch and Ness [24]. As the interview progressed, the participants clearly understood the concept of resident-centered care after they heard a question that used facility-based care and task-based care. At that point, they began to share various cases. In addition, changes, which can be considered the level of recognition and growth of caregivers who oversee direct care by the elderly compared with nurses [25], occurred during the focus group interviews. In the case of nurses who participated in individual interviews, they perceived that the concept is not consistent with the nursing philosophy of care. In the case of nurse assistants and long-term caregivers, we also frequently heard phrases such as, “I know it, but I cannot help it.” A discrepancy was observed in that they agreed with nursing beliefs and knowledge of resident-centered care, but they had no choice but to perform facility- or task-based nursing. This discrepancy has been previously described [26], and it may be applicable to the nursing paradigm of resident-centered care. Accordingly, for resident-centered care to be realized in nursing homes, the culture must be changed first.

Moreover, the participants stated that elderly adults’ participation in decision making is critical for resident-centered care and asserted that actively reflecting residents’ personal preferences is necessary. This has been repeatedly verified in resident-centered care intervention studies, including a nursing facility—Eden Alternative™—in the United States [27]. In such studies, residents’ personal preferences were actively reflected in planning menus or activity programs; providing the elderly with personal belongings (e.g., clothes), private time, and space; and allowing them to keep pets and various plants.

Many participants claimed that resident-based care begins with sharing the history and stories of the elderly. Storytelling allows individuals to share past experiences and express their culture and can also be used as a counseling technique that helps one recreate the meaning related to a topic. Given that past nursing interventions for improving the cognitive function of the elderly in nursing homes have been mostly limited to reminiscence [27] or medication [28], storytelling that involves the creative utilization of the remaining cognitive function of the elderly may also improve severed relationships [29].

Storytelling is applied not only to residents but also to nursing personnel who provide care. In addition, storytelling positively affects the formation and quality of relationships, which are the

core of resident-centered care [30]. Although long-term caregivers, who are the main nursing workforce at long-term care facilities, oversee the key components of elderly nursing, their turnover rate is also high due to emotional labor and job stress. Both factors negatively affect residents and their families' satisfaction [26]. The occupation "caregiver" is new in South Korea. Furthermore, utilizing stress-reducing interventions for caregivers in South Korea is urgent, and storytelling is a useful, psychosocial approach for increasing the emotional intelligence of caregivers to reduce job stress and strengthen competence.

The participants further stated that resident-centered care can start from recognizing facility- or task-based care activities. The philosophical and practical antitheses of resident-centered care are facility-based care. Facility- or task-based care reveals itself in the caring attitude of nursing personnel and by using the person-directed care measurement tool [31]. The tool is one of the representative scales that measures the level of resident-centered care. In addition, it comprises 14 items across five factors, and factors such as personhood, knowing the person, and nurturing relationships focus on the attitude of the workforce of the target facility. Meanwhile, Barbosa, Marques, Sousa, Nolan, and Figueiredo [32] revealed a significant increase in residents and nursing personnel's satisfaction by maintaining an emotional tone and being cautious not to use normal elderly language called "elderspeak," which is a common intergenerational speech register similar to baby talk, during resident-centered care interventions.

The relationship between residents and nursing personnel in nursing homes must be investigated to detect attitude changes. Thus, participatory action research (PAR), in which observations and analyses include participants' involvement, is appropriate and necessary. PAR develops and applies programs, which are then analyzed and modified through continuous observation. Therefore, PAR is an optimal research and intervention method that can detect and lead the cultural change of nursing homes [33]. Furthermore, the participants perceive residents confined to their wheelchairs as the most obstructing factor to assuring autonomy in resident-centered care, and restraining bands, which are used to safely fasten residents to wheelchairs, are considered a symbolic phenomenon of facility- and task-based care [34].

Reflecting the trend of preparing and applying detailed and systematic intervention strategies for resident-centered care, Li and Porock [35] reviewed 24 studies that applied the resident-centered care interventions of long-term facilities conducted in three countries from 1990 to 2013. Among many intervention strategies, staff training for a resident-centered paradigm was the most frequently conducted. Moreover, respecting the non-verbally expressed demands of residents was emphasized. These results are consistent with the demands of the participants in the present study for standardized guidelines. The resident-centered care is also thoroughly reflected. The organizational culture and system as well as information on employee profiles, staffing cycle, and the stability of human resource management must be learned to develop and apply guidelines customized for nursing facilities [36]. Therefore, insights into whether resident-centered care can be accepted and applied should be obtained first. As such, cultural change in nursing homes must be incorporated first to accomplish optimal resident-centered care. Methods to promote cultural change at the facility level and among nursing personnel should be investigated, and change can foster and strengthen residents' capabilities. In addition, the concept of nursing home culture change is a resident-directed model of care that also includes the family environment, but not the facility. To create an elderly-centered environment, empowerment, the support of primary care workforce, and the creation of a family-like environment are essential. Furthermore, changes in nursing practice and leadership

commitment are required [37]. Nursing interventions in facilities are mostly focused on individual elderly. Therefore, nursing intervention programs that identify and include factors affecting the health of elderly residents, such as facility-specific customs or nursing methods, are rare to find. Ecological interventions that utilize facility culture are necessary because they can focus on improving residents' quality of life [38].

In the case of facility culture, the organization of daily life is centered on the operation of the facility. Given that the meal time is adjusted to shift, structural arrangements according to the hospital model, admission to the facility is perceived as the concept of hospital admissions. Accordingly, the identification of an environment's characteristics can reflect the facility culture. Elucidating the influence on residents' physical and psychosocial health is also necessary to develop and apply nursing interventions that include residents' preferences, daily schedules, and relationships. Further, researchers should develop specialized programs for residents and their families based on observations and training experiences given the environmental and workforce culture obstacles.

This qualitative study provides basic data for the culture change necessary to provide resident-centered care at nursing homes and implement practical educational programs for nursing personnel. In the context in which the long-term care insurance system for elderly is becoming established, such as in South Korea, these research findings can contribute to the development of institutional systems and programs for resident-centered care from the beginning phase of a settlement of nursing home culture.

5. Conclusion

In sum, although nursing personnel perceive resident-centered care as the most basic nursing philosophy and method, they also believe that facility- and task-based nursing are the most effective way of performing their work in various unavoidable nursing situations. Efficient nursing intervention programs should be developed after clarifying facility culture. However, resident-centered care is difficult to implement practically due to the declining cognitive functioning and safety concerns of elderly residents. If resident-centered care intervention programs are developed on the basis of the perceptions of nursing providers for facility-dwelling elderly whose communication is deteriorated and their effects are supported, then a vast social value for an aged society can be obtained. Unnecessary medical expenses can be reduced through resident-centered care; thus, benefits to long-term care insurance can also be expected. Furthermore, if residents' health status, quality of life, and satisfaction with nursing services can be improved by developing effective nursing intervention programs, then their practical applicability can be apparent, and they can become standardized in South Korea. Therefore, the health management of elderly adults can be promoted nationwide.

Of note, the generalization of our findings is limited because the participants were nursing personnel who were either working or have worked at nursing homes in specific areas of Korea. Accordingly, we propose the following suggestions. First, guidelines for resident-centered care that can be used in nursing homes must be developed, and the items evaluating caregivers' changes in knowledge and attitude must be included. Second, the obligatory inclusion of education related to resident-centered care in the curriculum for relevant caregivers should be promoted. Ultimately, qualitative research that conducts an in-depth analysis of residents and their families' experience with resident-centered care in nursing homes is necessary to support the current findings.

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Conflicts of interest

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Appendix A. Supplementary data

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