Industry, listen: You want to secure a dignified old age for your liber-wealthy founders and venture capitalists and investors? Drop some billions into building a better system of elder care; pay aides and licensed vocational nurses decently; incentivize doctors to practice geriatric medicine. You want to do some-thing really high tech? Figure out how to clone the best of these.

Meanwhile, those dedicated to helping us through our own individual aging circumstances will continue to concentrate on The Particularity. That means person-centered caring, something all of us have been doing for a very long time, and to no great fanfare.

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Person-Centered Care: Are We Really Doing It?

Joan Devine, RN

Jim Collins makes the case that “good” is the enemy of “great” in his book Good to Great (New York: Random House Business, 2001). Similarly, in looking at the progress that has been made in bringing person-centered prac-tices to elder care and in changing the culture of aging, I would like to propose that “We’re doing it” is the enemy of actually “doing it.”

As skilled nursing providers prepare for phase 3 of the Centers for Medicare & Medicaid Services (CMS) Requirements of Participation (RoPs), most communi-ties are no doubt taking inventory of where they are in relation to compliance. Honoring resident preferences, check! Resident access to the outdoors, check! Person-centered care plans, check! Could go on, but you get the idea.

After our inventory is completed and we have checked off all the right boxes, we say, “We’re doing it!” So all is well, and we can move on to some-thing else. But I would issue the chal-lenge that organizations need to look deeper before checking these things off as done. We need to keep in mind that creating a person-centered culture is a journey, not a destination. The road has many winding paths that will require shifts and often a reset of the GPS as we go.

Perhaps things are being checked off as done because of how we define what they are. For example, when asking the staff what it means to be person-centered in their community, the feedback is often “Residents get to sleep as late as they want and decide when they want their bath or shower.” They will point to the beautiful outdoor spaces and talk about the fact that they are doing “I” care plans.

So yes, they are doing those things — but do those changes in practice reflect an organization that has embraced person-centered care at all levels and is actively instilling these beliefs into its culture? Or are they just a variation of the task-oriented approach to care that is so ingrained in the traditional model of care? Are the staff only doing it because that’s what management told them to do? Does staff even understand why they are doing it? Did the design behind these practices come from man-agement or from the residents and the direct care team?

Before we can be confident that we are doing it, we need to probe a little deeper. For example, before you check off that the residents determine when they sleep or bathe, find out what the staff has been doing to define when an individual resident likes to sleep or bathe. What about the residents living with dementia — does the staff under-stand how to identify their needs, or do issues of preference only apply to the residents who verbalize what they want? Do the community policies and practices support person-centered prac-tices, or are they sabotaging them? (For more discussion of this topic, see Caring for the Ages 2018;19[6]:18; http://bit.ly/2U1dMPjB.)

Take a look at the outdoor spaces and consider not only how they look but how they are being used. Are the doors locked, with access only when a care team member has time to take a resident out? Is access limited to only the days when the weather is perfect? Are there ways to support the accommodations needed for going outside when it’s warm, chilly, raining, or even snowing? Can the residents enjoy the outdoor spaces on their own — just as they would enjoy the quiet of their bedroom — if that is their preference?

Let’s also look at person-centered care plans. These are not a new idea — in fact, they have been the “thing to do” for at least the last 15 to 20 years. For skilled care providers, they are now a requirement of the new CMS RoPs. Most assisted living providers don’t do care plans, but they do service plans; it’s often assumed that because these are a tool of the social model that is the foun-dation of assisted living, of course they are person centered.

But what constitutes a person-centered care plan or service plan? Changing “the resident” to “Mary Jones” is a nice thing to do. In fact, it’s what many communi-ties have done, and it’s what most of the software vendors who claim to support person-centered care plans do as well. Yet it’s far from what is needed to develop an individualized, person-centered care plan.

If a care plan is truly person centered, then someone should be able to read it without seeing the resident’s name and recognize exactly whose plan it is — it should contain information unique to each individual, based on that person’s needs, preferences, individualized approach, and personality. (Note that I did not say “problems, goals, and inter-ventions.”) A person-centered care plan should not define people by their dis-abilities, but rather should help identify how people’s abilities can support them in ensuring not only quality of care but quality of life.

Also take a look at how the care plan was created. Was it put together in a software template? When the team met, was the focus merely on the disabilities and medical needs of the resident? Or was the conversation about the indi-viduals — who they are, and what they want? Were the right people there for the discussion — the resident, the interested family members, and the certified nurs-ing assistant?

Pioneer Network is grateful to CMS for the work that has been done to incorporate person-centeredness into the new survey process, but like any-thing, there is good and bad to regu-lating practice. Communities need to be cautious that person-centered prac-tices are not reduced to being merely a different way to do a task. When a deficient practice is identified in person-centered care, we must consider care-fully how this is addressed following the survey and in the plan of correction. Sustainable change in practice can rarely be done within the 30-day time frame built into the survey process. Ask your-self if the person-centered practice you are putting in place reflects a change in culture and beliefs. Is it merely a Band-Aid over ongoing practice so that when the surveys come back for their revisit, the community can say, “Mrs. Jones gets to sleep late.”

Person-centered practices should involve the quality assurance/process improvement team. They should review what was noted to be a deficient practice as well as what needs to change to support a person-centered approach. Then you should identify who needs to be a part of the team (including the residents and direct care staff) and work with them to develop the performance improvement plan that will help move the practice to one that is person-centered.

Remember, bringing person-cen-tered practices to your community is about more than just implementing the “what”; it’s about how you ingrain these practices into the culture of the organiza-tion. As medical directors, what can you do to help support a person-centered culture? When you hear someone say “we’re doing it,” challenge them — per-haps ask them about the “5 whys.” Share stories with the team about experiences you have had of knowing someone has made a difference in your ability to meet a resident’s needs.

You can help your team in ensuring that person-centered practices don’t become another task to check off. In the end, it will be a great thing when that nurse doesn’t have to call you in the mid-dle of the night because in their person-centered culture, one that supports each resident as an individual, the team has developed a care plan that truly reflects the resident’s needs and preferences and provides the keys to the answers to how to meet that person’s needs.

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Founded in 1997, Pioneer Network is a not-for-profit organization that has pioneered and leads the national movement of culture change to person-directed elder care. Today, it is a large, diverse group of passionate individu-als from the entire spectrum of aging services.