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Original Study

Delivering Person-Centered Care: Important Preferences for Recipients of Long-term Services and Supports



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A B S T R A C T

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Objectives: Although assessing individual consumer preferences are an important first step in providing person-centered care, the purpose of this study was to identify the top 10 shared preferences that are important to a majority of consumers receiving long-term services and supports.

Design: A cross-sectional survey design was used.

Setting and participants: Preference assessment interviews were conducted with 255 nursing home (NH) residents and 528 older adults receiving home and community-based services (HCBS).

Measurements: The Preferences for Everyday Living Inventory (PELI) was used to collect consumer preference information. Two versions of the PELI were used—the PELI-NH for NH residents and the PELI-HC for clients receiving HCBS and analysis focused on 41 shared items between the 2 versions. All respondents answered PELI questions independently and rated the importance of psychosocial preference items on a scale from not at all to a lot/very important.

Results: Ten preferences were shared as being important or very important by NH residents and older adults receiving HCBS. Most notably, more than 90% of respondents in each group rated “having regular contact with family” as an important priority. Having privacy, choices about what to eat, when to bathe, and activity options also were important preferences for a majority (77%–93%) in both settings.

Conclusion: Providers seeking to incorporate preference-based care can utilize study results as a foundation to incorporating important preferences into the care delivery process at the organizational level across care settings. For example, assessing all consumers on this core set of 10 shared preferences can assist with relationship building, transitions in care, and quality improvement. However, preferences with aggregate low-rated levels of importance in this study should not be discredited or eliminated. It is important for providers to understand the unique preference inventory of each older adult, which can then be targeted toward meeting goals for preference fulfillment. This can aid in bringing preferences into practice to improve the quality of care and quality of life to best meet the psychosocial needs of each person.

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The culture change movement in long-term care began in the early 1980s as a widespread effort led by consumer advocacy groups, policy makers, and health care providers to improve the quality of care and quality of life for individuals residing in nursing homes. The overarching goal of the culture change movement is to transform care delivery from a “medical model” to a more comprehensive, holistic model of care that recognizes all aspects of the person beyond his or her disease or disability. Following the Omnibus Budget Reconciliation Act of 1987, nursing home providers were required by law to provide “services sufficient to attain and maintain his or her highest practicable physical, mental, and psychosocial well-being” to their residents.¹ As a result, providers began incorporating more individualized approaches to care delivery and the concept of person-centered care emerged. Identifying and documenting residents’ preferences is an important first step toward providing individualized, person-centered care. However, early efforts at meeting care preferences were often based on limited, standardized questionnaires due to a gap in literature surrounding psychosocial preferences.² Carpenter and colleagues conducted a conceptual mapping of psychosocial preferences, which provided an in-depth analysis of the organization and hierarchical structure of older adults’ preferences.² This map created a foundation for the development of a standardized assessment of psychosocial preferences in multiple care settings known as the Preferences for Everyday Living Inventory (PELI).

The first version of the PELI was created using a home health sample of individuals receiving home care services—referred to as the PELI-HC.³ The question of family proxy knowledge and congruency with older adult preferences was also examined for the PELI-HC.⁴ The second iteration of the PELI was its modification for use in a nursing home population (PELI-NH) based on results from cognitive interviewing techniques.⁵ Cognitive interviews resulted in the 72-item PELI-NH, which assesses nursing home (NH) resident preferences grouped into the 5 originally derived concept mapping domains.² Since its development, the PELI-NH has been studied extensively looking at its validity,³ consistency of self-reported preferences among nursing home residents over 1 week,⁶ reasons that nursing home residents give when changing their ratings about the importance of specific preferences,⁷ family proxy’s knowledge of and congruency with resident preferences,⁸ qualitative analyses of contextual factors influencing specific resident preferences,^{9–11} and staff perspectives on their ability to fulfill specific resident preferences.¹² In addition, the PELI-NH has been used in evidence-based approaches that integrate preferences into care delivery,¹³ as well as the development of quality improvement tools to help providers measure their success in integrating resident preferences into care delivery.^{14,15} Several items from the PELI instrument informed the development of the Centers for Medicare and Medicaid Services’ Minimum Data Set (MDS) 3.0 Section F “Preferences for Customary and Routine Activities”—a required assessment of all residents in certified nursing facilities. In addition, results from a controlled trial and a translational study found significant, but small, increases in morning care choices and mealtime feeding quality.^{16,17} However, several studies have identified barriers to translating NH residents’ basic preferences into practice. For example, an observational study of morning care found that 70% of the time staff offered no choices to residents.¹⁸

Although a large body of research examines the use of the PELI and the psychosocial preferences of older adults, little research explores which preferences are identified as important to the majority of older adults receiving long-term services and supports (LTSS). Although it is crucial that providers focus on the unique preferences of each resident, looking at aggregate data of important preferences across settings of care can serve as a starting point for providers beginning the process of enhancing their organization’s capacity to deliver person-centered care, regardless of the specific setting of care. The important preferences identified by a majority of respondents in each care

setting can serve as a guide for goals geared toward delivering person-centered care at the organizational level, whereas responses of individual older adults can serve as a vehicle to further customize care plans for each person based on his or her individual preferences, values, and needs. The purpose of this study was to identify shared preferences that are important to a majority (75%) of nursing home residents and older adults receiving home- and community-based services.

Methods

Procedures

This study used secondary data analysis of PELI responses collected from 2 separate samples—NH and HCBS. The HCBS sample respondents (n=528) were selected using a stratified random sampling method from the Visiting Nurse Service of New York’s (VNS-NY’s) client database to ensure that at least a third of the respondents were new to receiving HCBS. Respondents were deemed cognitively capable to participate by passing the Orientation-Memory-Concentration Test (OMCT).¹⁹ The OMCT was administered by telephone by the research assistants.³ Based on cutoffs reported in the OMCT validation study, weighted scores of 0–6 were presumed to indicate no cognitive impairment. Interviewers were instructed to use clinical judgment in deciding whether respondents could complete the interview for those who scored 7 to 9. Scores of 10 or higher signified cognitive impairment, and respondents scoring in this range were excluded from the study. After passing the cognitive screening, participants were interviewed in their homes by trained research staff. The mean OMCT score for our sample was 3.56 (SD 2.7, range 0–8). The PELI-HC measures 55 items of psychosocial preferences through a 5-point Likert-scale format where respondents rate preferences using the following scale: 0 = not at all; 1 = no preference; 2 = a little; 3 = somewhat; and 4 = a lot.

The NH respondent sample (n=255) was collected through a convenience sample of 28 nursing facilities in the greater Philadelphia, Pennsylvania, region. Social workers identified older adults in selected NHs that were eligible to participate in the study. To be eligible, participants needed to be English speaking, have a Mini-Mental State Exam (MMSE) score greater than 13, have long-stay status, and residing in the facility more than 1 week at the time of the study. Research assistants administered the MMSE after participant or family consent as part of the eligibility screening. A total of 581 residents were referred by organizations to participate in the study, and 207 declined participation in the study. Of the 123 individuals deemed incapable of self-consent, family consent was obtained from 70. There were 321 participants enrolled at baseline, and 255 completed both the baseline and 3-month follow-up interviews. This indicates a consent rate of 43.8% and an estimated 5.5% of the total resident population that the sample represented. Research assistants conducted face-to-face interviews using the 72-item PELI-NH specifically for this study, asking respondents to rate preferences on a 4-point rating scale: 1 = very important; 2 = somewhat important; 3 = a little important; and 4 = not at all important. The response option of important but can’t do/no choice used in the MDS 3.0 was not offered as an answer category for this research study. Institutional internal review board approval was obtained for both studies from a federally assured review board.

Data Analysis

This study analyzed PELI responses of both samples to determine a hierarchy of preference importance within each sample. Sample groups were analyzed separately rather than in the aggregate to provide comparisons between these unique care settings. Because of

Table 1
Demographic Characteristics of Nursing Home and Home- and Community-Based Services Participants

Variable	Nursing Home (n = 255)	HCBS (n = 528)	P
Age, years, mean (SD)	80.97 (11.21)	76.88 (8.21)	.000
Female	67.8	75.6	.022
Hispanic	0.0	10	.000
Black	22.8	26.8	.251
Not married	82.5	72.9	.003
High school degree	54.2	35.6	.000

SD, standard deviation.

Values are percentages unless otherwise noted.

the unique characteristics of the different settings, not all items are identical across the 2 versions of the PELI (PELI-HC and PELI-NH). Therefore, 41 items were selected for comparison in this study because they were asked of both samples. Frequency tables of each PELI item were analyzed in SPSS v.22 to determine the percentage of respondents within the sample that identified the preference as being important. Items were deemed important if the respondent identified the preference as being 1 = very or 2 = somewhat important in the NH sample or 3 = somewhat or 4 = a lot important in the HCBS sample. Collapsed important percentages were created by summing the valid percentages for respective responses for each PELI item. Percentage importance ratings were then ranked to create a full preference hierarchy for each care setting. The top 10 shared preferences are reported in this article. There were no missing data in the HCBS sample and very little missing data (between 0.8% and 2.4%) in the NH sample.

Results

Sample Characteristics

HCBS participants were on average 77 years of age (standard deviation 8.2); 76% were female and 60%, Caucasian. The mean educational attainment of participants was 11 years (range 0–20) and 10% were Hispanic. Fifty percent were widowed and 43% had received greater than 120 days of home health care services. The mean age of the NH subjects was 81; 68% were female, 78% were Caucasian, 44% were widowed, and 75% had a high school diploma. The average MMSE score was 25 (standard deviation 3.9, range 13–30), and residents had lived in the nursing home for an average of 924 days (standard deviation 900.6). Demographic comparisons indicate that as

expected, there were several statistically significant differences between the samples (see Table 1). The NH sample was on average older than the HCBS sample. In addition, the HCBS sample had a greater percentage of Hispanic and female participants. The NH sample had a higher percentage of not married and high school degree completion than the HCBS. There were no statistically significant differences by race (see Table 1).

Shared Important Preferences

Among the 41 shared preference in the 2 PELI versions, there were 10 preferences that 75% or more of both samples reported as important. The top 10 shared important preferences reported by both samples included having regular contact with family and friends, watching TV, choosing what to eat, going outside, privacy, music, giving gifts, traveling, and choices around bathing times (see Table 2).

HCBS Sample

When only examining the PELI-HC results, the 55-item preference importance hierarchy ranged from 92.1% importance to 11.6% importance. The top 10 important preference items for older adults receiving HCBS included keeping in contact with family, spending time outside, having certain family or friends involved in your life, privacy, music, keeping things in a certain place, giving gifts, being active at certain times of day, choosing what to eat, and traveling.

NH Sample

When only examining the PELI-NH results, the 72-item preference importance hierarchy ranged from 96.5% importance to 18.2% importance. The top 10 most important PELI-NH items for NH residents included having staff show you respect, taking care of personal belongings, having staff show they care about you, having regular contact with family, doing what helps you feel better when upset, choosing who are to be involved in discussions about care, keeping room at certain temperature, choosing how to care for your mouth, choosing medical care professional, and choosing how often to bathe.

Discussion

Results from this study demonstrate important care preferences among older adults receiving long-term services and supports in

Table 2
Top 10 Shared Preference Items Rated as Important by 75% or More of Older Adults Receiving Care in Nursing Homes (NHs) and via Home- and Community-Based Services (HCBS)

Ranking	NH (n = 255)	% (n) Missing n	Ranking	HCBS (n = 528)	% (n) Missing n
1	Have regular contact with family	93.3 (238) 6	1	Have regular contact with family	92.1 (486) 0
2	Choose what to eat	90.6 (231) 5	2	Spending time outside	89.4 (472) 0
3	Listen to music you like	89.0 (227) 4	3	Having certain family members/friends involved in life	88.8 (469) 0
	Have regular contact with friends*	89.0 (227) 3	—	—	—
4	Watch/listen to TV	85.9 (219) 5	4	Privacy	88.4 (467) 0
5	Have privacy	85.1 (217) 4	5	Music	86.0 (454) 0
6	Go outside for fresh air when the weather is good	82.4 (210) 4	6	Giving gifts to other people	85.4 (451) 0
7	Give gifts	80.4 (205) 6	7	Choose what to eat	84.8 (448) 0
8	Choose what time of the day to bathe	79.2 (202) 2	8	Traveling	82.6 (436) 0
9	Do things away from here	76.5 (195) 4	9	Watching TV	80.5 (425) 0
10	—	—	10	Taking bath/shower at a specific time	79.6 (420) 0

*Have regular contact with friends received the same ranking as listen to music you like.

NH or HCBS settings. Providers seeking to incorporate preference-based, person-centered care can use study results as a foundation to incorporating important preferences into the care delivery process at the organizational level in both care settings. This can aid in bringing preferences into practice to improve the quality of care and quality of life to best meet the psychosocial needs of older adults receiving long-term services and supports. We recognize that several items from the PELI were rated as “important” to older adults receiving LTSS; however, focusing on the top 10 preferences serves as a starting point for quality improvement purposes for providers who seek to meet the preferences of the majority of their consumers. Even though this study highlights the top 10 preferences, individual preference assessments are still essential for person-centered quality improvement purposes within long-term care organizations and recognizing the needs of the individual consumer.

Preferences in Common

Results indicate that having regular contact with family and friends is an important preference among respondents in the NH and those receiving HCBS. This was the only preference rated above 90% in both sample's top 10 lists. Many NH providers routinely provide opportunities for family engagement in birthday parties, picnics, cookouts. In addition, NH providers can encourage family involvement in care planning meetings and family councils. Home care providers have unique challenges in supporting opportunities for clients to connect with family and friends. Multiple methods may need to be employed beyond in-person and telephone contacts. For example, an aide could type an email or help set up a Face Time video call. Maintaining important family and friend relationships should be goals for providers to meet in both long-term care settings.

In the NH, choice in personal hygiene and self-care preferences were important to 90% or more of respondents. Examples include choosing how to care for your mouth, choosing how often to bathe, and choosing how to care for your hair. For HCBS respondents, self-care preference importance items were more centered on time and scheduling, such as taking a bath or shower at a specific time and following a routine right before bed and right after awakening. Results support prior studies that have found staff training in person-centered techniques that provide for choice and autonomy surrounding self-care and personal hygiene have beneficial outcomes.^{20–22} Meeting personal hygiene and grooming preferences can be a first step for providers to fulfill several important preferences of older adults. Further, listening to and supporting a person's preferences promotes autonomy and dignity.^{16–18}

Respect for personal belongings was identified as a shared important preference. For NH residents, this was the second most important preference. For HCBS respondents, taking care of things around the house, keeping things in a certain way, or decorating a certain way all relate to having autonomy and control regarding one's living space or personal belongings. We acknowledge the difficulty of meeting this preference in an NH setting when clothing is laundered together or when a cognitively impaired resident may take something out of another resident's room. However, we recommend that providers review options to meet this preference that may include opportunities for residents to lock personal belongings up to secure them (eg, safes, door locks). In addition, mesh bags to keep clothing together for individual residents can be used and/or cloth name labels can be sewn into clothing. For expensive items, such as glasses and hearing aids, or dentures, there are tracking devices that can be affixed to the item and used to find it if misplaced. In the home, providers may urge staff to show respect by asking before using personal belongings, or showing respect to the home by removing one's shoes or putting on disposable non-skid shoe covers before entering.

Privacy was identified as an important preference to 85% or more of both sample groups. Despite barriers to privacy in the NH such as shared bedrooms and common areas or need for assistance during personal care (eg, toileting, showering), reinforcing the need to maintain privacy is important to meet this preference. For those receiving care in their home, privacy barriers can also be problematic. Goals to meeting this preference should be based on each person's unique preferences and their individual privacy concerns. For example, although some residents may require assistance transferring to and from the bathroom, privacy during toileting unless assistance is needed may be an important privacy preference. For individuals in their home, privacy preferences may be related to specific areas of the home, or asking for privacy when making personal phone calls or having visitors.

Preferences related to intellectual and creative activities or engagement overlapped between the samples. Examples include listening to music, reading, keeping up with the news, and learning about topics of interest. In the NH, keeping up with the news was important to 91.0% of the sample and learning about topics of interest was important to 89.8% of respondents. Multiple ways to access information through newspapers, television, radio, and Internet are opportunities for providers to meet this preference and encourage feelings of competence among residents. Means of fulfilling preferences can also be modified to meet the abilities of moderately or severely impaired individuals using a strengths-based approach commonly used by certified therapeutic recreation specialists. HCBS providers may encourage staff to match this preference by bringing in the newspaper for individuals; helping them use the computer, radio, or music player to access new information and music; or simply discussing current events with individuals if they are interested. Fostering opportunities for growth, learning, self-enrichment, and creativity may help promote feelings of competence and overall well-being for older adults in both care settings.

Limitations

Despite a rigorous approach to sampling among participants and settings, all respondents had the cognitive capability to answer questions about their preferences. Therefore, preferences of individuals with moderate or severe cognitive impairment or those who were unable to communicate are not represented in this study. We found that providers were more inclined to refer residents who were able to consent for themselves. The extra step of having to reach out to the family for consent prior to referring the individual to the study team was a barrier to including more individuals with moderate cognitive limitations.

Comparisons between PELI-HC and PELI-NH are not exact as a result of changes in the question stems based on cognitive interviewing findings (eg, “Do you like...?” vs “How important is it to you to...?”), and response categories (eg, 1 = very and 2 = somewhat important in the NH and 4 = a lot and 3 = somewhat in HCBS). Although these issues may not make exact comparisons among items between settings appropriate, the ranking methods we used assessed each item and its corresponding stem and responses against other items of the same type. We believe this strategy compensates for the difference between the 2 tools. In addition, the 2 samples were drawn from large metropolitan areas on the East Coast of the United States and may not reflect the preferences of LTSS recipients living in other areas of the country. Because of the unique characteristics of the different settings, not all PELI items could be compared. Finally, we did not assess the level of physical dependency or subjective well-being of the 2 samples, which may impact the importance ratings of preferences. The level of physical dependency is an important point that we were unable to address with our current data. We have found in work currently under review that functional ability did not affect the rating

of preference importance. However, the subjective well-being (SWB) of a resident does impact ratings of preference importance. Residents with lower SWB rated preferences as more important than those with greater SWB. We think that the expression of greater importance may reflect greater felt need of preferences for those with lower SWB.

Conclusion

Providers seeking to incorporate preference-based care can utilize study results as a foundation to incorporating important preferences into the care delivery process at the organizational level across care settings. This foundation can serve as a starting place for organizations seeking to start small and, over time, expand their person-centered care initiatives. In addition, using a core set of items within an organization with multiple service delivery lines can provide a metric for quality improvement among individuals who transition across settings of care. This concept is in line with what the Improving Medicare Post-Acute Care Transformation (IMPACT) Act of 2014 is striving to achieve.

Although people receiving care in NH and HCBS have a shared set of important preferences for everyday living, preferences with low-rated levels of importance in this study should not be discredited or eliminated. Even though the majority of older adults in different settings have expressed important preferences, it is vital to remember that everyone has their own unique preferences that must be addressed and personalized in care plans. Assessing an individual's preferences is a method for building/fostering meaningful relationships between individuals and their caregivers in a variety of settings. When an individual's preferences are incorporated into practice, it can improve the quality of care and quality of life to best meet the psychosocial needs of older adults receiving care.

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References

- Koren K. Person-centered care for nursing home residents: The culture-change movement. *Health Affairs* 2010;29:1–6.
- Carpenter BD, Van Haitsma K, Ruckdeschel K, Lawton MP. The psychosocial preferences of older adults: An examination of content and structure. *Gerontologist* 2000;40:335–348.
- Van Haitsma K, Curyto K, Spector A, et al. The Preferences for Everyday Living Inventory: Scale development and description of psychosocial preferences responses in community-dwelling elders. *Gerontologist* 2013;53:582–595.
- Carpenter BD, Lee M, Ruckdeschel K, et al. What would your mother want? Adult children as informants about parent's psychosocial preferences. *Fam Relat* 2006;55:552–563.
- Curyto K, VanHaitsma K, Towsley G. Cognitive interviewing: Revising the Preferences for Everyday Living Inventory (PELI) for use in the nursing home. *Res Gerontol Nurs* 2016;9:24–34.
- Van Haitsma K, Abbott KM, Heid AR, et al. The consistency of self-reported preferences for everyday living: Implications for person-centered care delivery. *J Gerontol Nurs* 2014;40:34–46.
- Heid AR, Eshraghi K, Duntzee CI, et al. "It depends": Reasons why nursing home residents change their minds about care preferences. *Gerontologist* 2016;56:243–255.
- Heid AR, Bangertner L, Abbott KM, Van Haitsma K. Do family proxies get it right? Concordance in reports of nursing home residents' everyday preferences. *J Appl Gerontol* 2015;1–25.
- Bangertner L, Van Haitsma KS, Heid A, Abbott K. "Make me feel at ease and at home": Differential care preferences of nursing home residents. *Gerontologist* 2015;56:702–713.
- Bangertner L, Heid A, Abbott K, Van Haitsma K. Honoring the everyday preferences of nursing home residents: Perceived choice and satisfaction with care. *Gerontologist* 2016;00:1–8.
- Bangertner L, Abbott K, Heid A, et al. Health care preferences among nursing home residents: Perceived barriers and situational dependencies to person-centered care. *J Gerontol Nurs* 2015;42:11–16.
- Abbott K, Heid A, Van Haitsma KS. "We can't provide season tickets to the opera": Staff perceptions of providing preference based person centered care. *Clin Gerontol* 2016;39:190–209.
- Van Haitsma KS, Curyto K, Abbott KM, et al. A randomized controlled trial for an individualized positive psychosocial intervention for the affective and behavioral symptoms of dementia in nursing home residents. *J Gerontol B Psychol Sci Soc Sci* 2015;70:35–45.
- Van Haitsma K, Crespy S, Humes S, et al. New toolkit to measure quality of person-centered care: Development and pilot evaluation with nursing home communities. *J Am Med Dir Assoc* 2014;15:671–680.
- Van Haitsma K, Abbott K, Heid A, et al. Person-centered care in the nursing home: Honoring resident preferences for recreational activities. *Ann Long-Term Care* 2016;24:25–33.
- Schnelle JF, Rahman A, Durkin DW, et al. A controlled trial of an intervention to increase resident choice in long-term care. *J Am Med Dir Assoc* 2013;14:345–351.
- Simmons SF, Durkin DW, Shotwell MS, et al. A staff training and management intervention in VA long-term care: Impact on feeding assistance care quality. *Transl Behav Med* 2013;3:189–199.
- Simmons SF, Rahman A, Beuscher L, et al. Resident-directed long-term care: Staff provision of choice during morning care. *Gerontologist* 2011;51(6):867–875.
- Katzman R, Brown T, Fuld P, et al. Validation of a short Orientation-Memory-Concentration Test of cognitive impairment. *Am J Psychiatry* 1983;140:734–739.
- Sloane PD, Zimmerman S, Chen X, et al. Effect of person-centered mouth care intervention on care processes and outcomes in three nursing homes. *J Am Geriatr Soc* 2013;61:1158–1163.
- Sloane PD, Hoeffler B, Mitchell CM, et al. Effect of person-centered showering and towel bath on bathing-associated aggression, agitation, and discomfort in nursing home resident with dementia: A randomized, controlled trial. *J Am Geriatr Soc* 2004;52:1795–1804.
- Hoeffler B, Talerico KA, Rasin J, et al. Assisting cognitively impaired nursing home residents with bathing: Effects of two bathing interventions on care-giving. *Gerontologist* 2006;46:524–532.