# The Relationships Between Nursing Staff Knowledge of Personhood and Resident Cognitive Status

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## THE RELATIONSHIPS BETWEEN NURSING STAFF KNOWLEDGE OF PERSONHOOD AND RESIDENT COGNITIVE STATUS

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### Abstract

*The purpose of this pilot study was to explore the relationships between nursing staff knowledge of extended care resident personhood and resident cognitive status. Eighty nursing staff from two similar extended care facilities in Arkansas completed a self-administered questionnaire to assess their knowledge of 21 residents, including information related to residents' past jobs/careers; likes/dislikes/ interests; family members; other non-specific knowledge; and total knowledge. The Brief Interview for Mental Status (BIMS) was used to evaluate resident cognitive impairment. Results of a Pearson correlation demonstrate a positive correlation between (1) staff knowledge of residents' families, and (2) total knowledge of residents with resident cognitive status. Findings suggest that nursing staff utilize creative interventions and exert intentional efforts to obtain resident information to preserve personhood and provide PCDC.*

### Introduction

Respect for personhood is essential to the progressive movement of Person-Centered Dementia Care (PCDC) (Dewing, 2008). Personhood is a state of being a person encompasses and includes characteristics, such as values, spirituality, history, and personal strengths that have been amassed through life experiences and years of living (Coker, 1998). Nursing home resident memory loss and communication deficits significantly challenge caregivers who strive to provide and maintain PCDC (Buron, 2008, 2010). In addition, extended care facility institutionalization can threaten all aspects of personhood (2008), including cognitive status, when their identity, which is developed through years of living with close, nurturing social contacts, is suddenly dependent upon staff members who may or may not make efforts to know and relate to residents living with dementia (RLWD).

### Review of Literature

Respect for personhood is the basis for personal, patient-centered care (Dewing, 2008). We extend this conceptualization to suggest that a focus on personhood is necessary for quality PCDC in extended care facilities. According to Kitwood (1997), personhood is defined as the "standing or status that is bestowed upon one human being by others in the context of relationship and social being"; personhood "implies recognition, respect, and trust" (p. 8) between a caregiver and resident.  We further hypothesize that in the extended care facility setting, staff knowledge of a resident may contribute to preserving the resident's personhood.

Residents living with progressive dementia can often no longer provide historical personal information for their caregivers. As a result, the burden is placed on the nursing staff to provide PCDC and to see and relate to the client as an individual person without adequate life history information (Buron, 2010).  According to Long (2009), "if caregivers do not actively pursue and assure a holistic approach" for the client with dementia, the client can be robbed of

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their personhood (p. 21). Goyder (2009) suggests that a progressive loss of personhood also creates a power differential between healthcare staff and clients living with dementia. Thus, in order to provide quality dementia care, it is incumbent upon healthcare staff to develop strategies to preserve personhood status (Buron, 2008; Goyder 2009; Long, 2009). Accordingly, quality person-centered care depends on staff knowing, respecting, and preserving the "life" of the resident, not just his or her basic human needs (Buron, 2008).

In addition to improved direct resident care, increased staff knowledge of clients can improve the overall milieu of care. For example, some researchers suggest that increased attention to preserving resident personhood has the potential to improve the living/working environment through a decrease in disruptive resident behaviors, and in the rate of staff turnover (Buron, 2008; 2010; Long, 2009). In addition, when personhood is not valued, residents may experience depersonalization, depression, and/or social isolation (Cecchin, 2001; Coker, 1998).

Since knowledge of a client may have an effect on the nursing staffs' ability to maintain a client's personhood, it is reasonable to suggest that knowledge of a client could also positively impact Person-Centered Dementia Care (PCDC). Unfortunately, dementia progression and caregiver knowledge about residents living with dementia (RLWD) are unknown. A better understanding of these connections may lead to the implementation of specific person-centered strategies and the identification of ideal caregiver qualities to best preserve future resident personhood for individuals with a progressive dementia disease. The purpose of this pilot study is to explore relationships between nursing staff knowledge of the resident and resident cognitive status.

## Methodology

**Resident Sample.** This research study involved two similar extended care facilities in the state of Arkansas.  To determine the eligibility of residents for inclusion in the study, The Brief Interview for Mental Status (BIMS), a section on the Minimum Data Set 3.0, was used to screen extended care residents and to detect levels of cognitive impairment.  The results of this screening are readily available through patient chart review. The tool is used to numerically categorize cognitive status on a scale from 0-7 (severe impairment), 8-12 (moderate impairment), and 13-15 (cognitively intact) (Keane Care, Inc., 2010).  The principal investigator (PI) requested that a nursing facility administrator select four residents from at least one of each category to participate in this study. The PI desired to have an even distribution of residents from the three categories to bring about more reliable results.  Residents were required to verbalize their willingness to participate in order to be included in the study.

To ensure privacy and protection for the resident, facility administrators first contacted potential resident legal guardians to explain the study; they then referred them to the PI for questions regarding potential participation in the study. Legal guardians were also required to provide consent on behalf of the resident for his/her participation in the study. Consent forms were sent via United States mail for guardians of residents who lived out of town. Residents without a legal guardian, and who were able to provide their own informed consent, were first approached by the administrator, or designee, and then the PI to inquire if he/she was interested in participating in the study. The PI requested an initial consent from the guardian before asking for the resident's consent to be included in the research study. ,

The MacArthur Competence Assessment Tool for Clinical Research (MacCAT-CR) was used as part of the consent process to evaluate decisional capacity among residents, comprehension of information, and the ability to express a clear choice (Appelbaum & Grisso, 2001). This assessment allowed residents even in the severe impairment cognitive status to voice

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their desire to either participate in or to not participate in the study.  All residents included in the study voiced a desire to participate in the study. Any resident who did not wish to participate was not included in the study. Resident recruitment continued until four residents from each cognitive status category and from each of the two facilities agreed to participate in the study.  Residents with other mental illness diagnoses, including but not limited to schizophrenia, delusions, and auditory hallucinations, were excluded from the study.

Twenty-four residents were recruited from two extended care facilities to participate in this study.  However one resident died before the questionnaire was administered to nursing staff; in addition, while the legal guardian for two residents provided initial verbal consent for the resident to participate in the study, they did not submit the final consent form before the questionnaire administration deadline.  Thus, 21 residents from two extended care facilities participated in the study; all residents represent various cognitive statuses based on BIMS (eight severely impaired, four moderately impaired, nine cognitively intact) (Keane Care, Inc., 2010). Twenty female residents and one male resident, all of whom were sixty years of age and older, participated in the study.

**Staff Sample.** Following the selection of residents for the pilot study, potential nursing staff participants consisting of registered nurses (RNs), licensed practical nurses (LPNs) and certified nursing assistants (CNAs) who had cared for at least one of the resident participants were identified. All nursing staff participants had engaged with at least one resident participant a minimum of three times per week for the past two months or more. Nursing staff were notified that participation or refusal to participate in the pilot study would have no negative or positive impact on their job status and that identifying information would not be shared with nursing facility administrators. Eighty nursing staff participants (RN, LPN, and CNA) from the two extended care facilities completed 100 questionnaires to assess their knowledge of residents in their care.

**Data Collection Methods**. Data collection occurred at one point in time either as part of a staff meeting or during scheduled pay days at the facilities. Staff participants were supplied with the questionnaire in a group setting; researchers requested that they complete it and not share information about residents with other staff participants completing the questionnaire.  The PI maintained a quiet environment for participants to complete the questionnaire.  If participants had any questions concerning the questionnaire, they silently raised their hand and the PI addressed their concerns without disturbing any of the other participants.

Participant identities were kept confidential throughout the study and all questionnaires and consent forms were stored in a locked file at the university which only the PI and faculty project mentor could access to ensure privacy and confidentiality.  There was little to no risk for participants in this study.  Each resident and nursing staff participant was compensated with a $10 gift card for their time. Legal guardians managed gift cards for residents living with dementia.

**Measures.**  Buron's (2010) *Know Me Now* form (see the Appendix) was used to assess knowledge of residents in three specific areas: resident's family, past jobs/careers, and past and current dislikes/likes/ interests, along with a section for any other non-specific pieces of knowledge.  Total knowledge included data from all four specific areas.  Nursing staff completed one form for each resident participant who was consistently under their care (a minimum of three times per week for the last two months or more). Nursing staff could complete multiple forms if they fulfilled the care requirements for more than one resident in the study.

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In terms of scoring the instrument, one point was allocated for each piece of correct information within each type of knowledge, with a maximum score of ten points for any one type of knowledge. Responses were verified either by the client or the client guardian. No reliability or validity data are available for this instrument.

## Results

Results were analyzed by computing a Pearson correlation coefficient. This analysis revealed a significant positive correlation between the cognitive level of the residents and the staff's knowledge about the family, $r=.40$, $p< .001$ and the total knowledge about the resident $r=.24$, $p=.02$. When the other types of knowledge were examined in relation to resident cognitive level, staff's (a) knowledge about resident likes, dislikes and interests, (b) knowledge about resident past job or career, and (c) other knowledge about the resident were not significant. The correlation analysis of the types of knowledge of the staff to the resident's cognitive level is found in Table 1.

Table 1.  Correlation Analysis between Cognitive Level of Resident and Staff Knowledge

|  |  | Knowledge of Family | Knowledge of Likes/Dislikes/ Interests | Knowledge of Past Job/ Career | Other Knowledge | Total Knowledge |
|---|---|---|---|---|---|---|
| Cognitive Level | Pearson Correlation | .40* | .05 | .10 | .17 | .24* |
|  | Sig.  (2-tailed) | < .001 | .63 | .33 | .09 | .02 |
|  | N | 100 | 100 | 100 | 100 | 100 |

**\*** Correlation is significant at the 0.05 level (2-tailed).

Figure 1 denotes a scatter plot that describes the cognitive level of the staff's total knowledge about the resident; the scatter plot demonstrates a positive correlation.
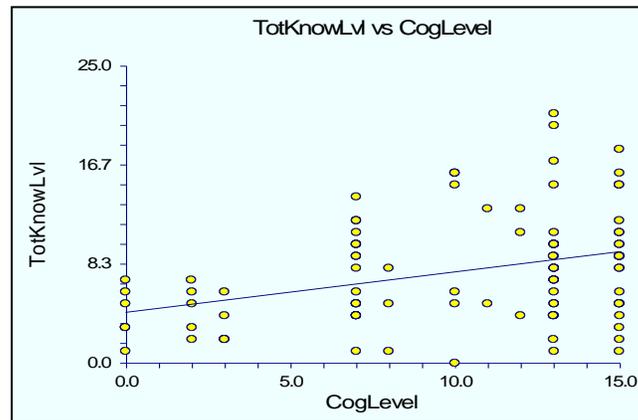


*Figure 1*. Total Knowledge versus Resident Cognitive Level

Data were analyzed using a one-way Analysis of Variance (ANOVA) procedure, between groups design, to examine differences between level of staff training (RN/ LPN and CNA) and staff total knowledge about the residents. This analysis failed to reveal a significant effect for staff levels, F (2.89) = 2.64, $p= .08$. The three groups' mean scores on total knowledge are displayed in Figure 2. Although the RN mean scores on total knowledge were higher than the mean scores for either LPNs or CNAs, the difference in scores was not statistically significant.
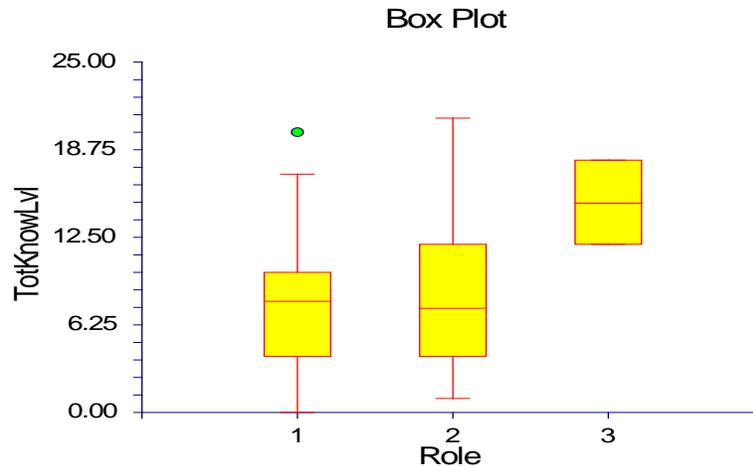
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*Figure 2.*  Mean Total Resident Knowledge for CNA (1), LPN (2), and RN (3)

### Limitations

*Limitations*. This pilot study was intended to explore the possible relationships between nursing staff knowledge of residents (i.e. personhood) and resident cognitive status. It is important to note several limitations to the study, including the small sample size of study participants (e.g. residents and nursing staff). An increase in the number of residents in each cognitive category and an increase in the number of nursing staff participating in the study is warranted to further evaluate the study aims.

A second limitation is that nursing staff members were unwilling to complete more than one questionnaire despite being in contact with and meeting the requirements to complete questionnaires for multiple residents in the study. This could be due to a possible limitation of time, fatigue, or potential embarrassment at not being able to recall more facts about certain residents.  Thus, the data received may reflect best case scenarios in terms of patient-centered care.

A third limitation is related to the use of BIMS scores to establish resident level of cognition. Since different individuals at each facility administered the BIMS to their residents, it may have resulted in inconsistent test results. In other words, variation in administration techniques may result in different cognitive status categories between recruitment and administration of the questionnaire.

Fourth, the limited access to residents' legal guardians made the consent process and verification of facts a challenging and lengthy process that caused delays in the study's anticipated timeline. Finally, since questionnaires were administered during a nursing staff meeting and pay check pick up time, nursing staff members were given the questionnaire in a group setting.  This may have led to sharing of answers or collaborative efforts to recall facts about residents despite the administrator's instructions for completing the questionnaire singularly and without conversation with other participants.  While the PI administered the questionnaire to help avoid this problem, a more controlled environment may be beneficial in future studies.

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### Discussion and Implications

In this study, we hypothesize that personhood is essential for person-centered care. In other words, nursing staff must deliver care that goes beyond merely meeting physical needs to encompassing personhood into the care process. Thus, in order to provide holistic care to a specific resident, nursing staff must have knowledge about the resident's personhood. Dementia threatens a resident's personhood and when a resident living with dementia (RLWD) can no longer preserve their own personhood, it is the responsibility of the nursing staff to provide person-centered care. Nursing staff may preserve personhood with a RLWD by obtaining knowledge about the resident including their likes, dislikes, and interests, their previous role in their family, and past jobs and/or careers. This knowledge of the resident as a person is the conduit of person-centered dementia care (PCDC), thereby enabling nursing staff to preserve personhood and properly implement PCDC by tailoring care specifically to each resident.

Findings from this study suggest a statistically significant positive correlation between nursing staff knowledge of residents and resident cognitive status. In other words, nursing staff appear to have more knowledge of residents who have higher cognitive functioning. As the resident's cognitive status deteriorates, staff seem to have less familiarity with the important knowledge that makes up their personhood.

There was no statistically significant correlation between the and types of knowledge nursing staff had regarding resident family, jobs, likes, dislikes, interests, and specific and non-specific pieces of information and resident cognitive status. However, this study demonstrated that nursing staff knowledge of a resident's family is significantly associated with a resident's cognitive status. In other words, the higher the level of resident dementia, the less knowledge the staff has about the individual.

These findings generate concern as healthcare providers at all levels are expected to advocate for and provide patient-centered care. In order for these expectations to become a reality, nursing staff must gain knowledge of resident's personhood. Since dementia causes memory loss and communication deficits that often result in a resident's inability to provide information about themselves to nursing staff, creative interventions and intentional efforts must be developed by nursing staff to obtain this necessary information to preserve personhood and provide PCDC.

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**Appendix**
**Know Me Now Form**

Resident #: _____

Nursing Staff #: _____

| Please list everything you know about _____'s family. | Please list everything you know about _____'s likes, dislikes, and interests. |
|---|---|
| 1.<br>2.<br>3.<br>4.<br>5.<br>6.<br>7.<br>8.<br>9.<br>10. | 1.<br>2.<br>3.<br>4.<br>5.<br>6.<br>7.<br>8.<br>9.<br>10. |
| Please list everything you know about _____'s past job/career. | What are some things that you know about _____ that are not included on this form? |
| 1.<br>2.<br>3.<br>4.<br>5.<br>6.<br>7.<br>8.<br>9.<br>10. | 1.<br>2.<br>3.<br>4.<br>5.<br>6.<br>7.<br>8.<br>9.<br>10. |

About you:

1. Occupational role in Nursing Home:

2. Education Level/degree:

3. Estimated hours spent daily with resident:

4. Length of employment at Nursing Home:

5. Total number of past employments at Nursing Home Facilities: