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Person-centered Care for Institutionalized Older Adults in the Context of the COVID-19 Pandemic in Brazil

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ABSTRACT

Objective: This study aims to discuss the caregiving practices developed by Long-term Care Facilities (LTCFs) during the COVID-19 pandemic and analyze the daily care practices in long-term institutions for older adults in Brazil, all in light of the PCC framework.

Methods: This is a mixed methods study in which data were collected through interviews with managers from 10 LTCFs. The qualitative discussion was carried out through the PCC framework divided into 5 categories: leisure, accommodation, food, hygiene and comfort, and clinical care. The quantitative data collected were analyzed in a descriptive way, being discussed in the light of the literature.

Results: Analyzed LTCFs are unaware of our present difficulties in the implementation of PCC, with a greater presence of the traditional biomedical model being recognized. Given the vulnerabilities that the LTCFs present, PCC is an important alternative for LTCFs to promote the quality of life and autonomy of residents. Deconstructing the vision of LTCFs as a last resort of care and investing in the quality of care is an urgent and essential imperative for dignified and comprehensive care.

Conclusions: This study highlights the need for a change in culture and understanding of the LTCFs not only as a place to provide healthcare, but also as a residents' home that fosters their autonomy, and feeling of belonging. Thus, it is essential to ensure that healthcare teams in LTCFs know about PCC and that further studies investigate the impact on the costs of PCC for institutionalized older adults.

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1. Introduction

Despite the inversion of the age pyramid being a global reality, there are different levels of long-term care provision. In lower-income countries, long-term care is still very incipient in most cases. According to Poltroniere, Souza & Ribeiro ^[1], countries such as Chile, Argentina, Uruguay and Costa Rica have different types of services consistent with long-term care, but in Brazil, the provision of such care is precarious compared to what is provided for in national legislation since the 1990s. There is no state support for the family in the process of caring for older adults, whether it be in their own home or in day centers. Through ordinances published in March and June 2021, the National Care Policy is under construction, essential for the care of older adults. Even so, long-term care facilities (LTCFs) for older adults are considered the last service modality to be activated, as they are geared toward older adults without family, social, or economic support ^[2].

It is noteworthy that in the Brazilian context, the concept of LTCFs, the number of institutions, access to philanthropic or public facilities, and the monitoring and evaluation of the quality of care provided is still obscure. As a result, there is currently serious criticism of the care provided in LTCFs in which they are often cited as negligent, permeated by violence in different aspects, and marked by mistreatment ^[1]. It is important to emphasize that this stigmatized view of LTCFs is not only present in Brazil, but also in countries such as Argentina and the United Kingdom who report a lack of government support, prejudice against older adults, and even violation of human rights in the face of institutionalization ^[3,4].

In this sense, it is worth highlighting the emergence of an initiative, known as person-centered care (PCC). That can be measured and operationalized throughout the world ^[5]. According to Kusmaul & Tucker ^[6], PCC starts from a change in culture, making the transition from care centered on the team or procedure to care centered on the patient or person. Because of this, PCC deviates from routine decisions that depend on the team's preferences, such as the selection of healthcare professionals and bathing schedules, by taking into account the participation, choices, and desires of those who receive care: the older adults.

Thus, the PCC framework requires special attention in LTCFs since they are an extremely vulnerable long-term care tool in terms of economic and social support, with PCC being one of the strategies to mitigate this reality of violence, lack of assistance, and marginalization of older adults ^[7]. Given the visibility of LTCFs in the

Brazilian context during the COVID-19 pandemic as well as the pressing need for improvements in the quality of care provided to residents, this study was relevant. Additionally, examining care centered on institutionalized older adults is vital to the understanding of quality of care, costs, the impact of the pandemic, and the needed investment in the qualification of teams, thus enabling the implementation of this study.

The study's theme is justified by the low dissemination of PCC references, especially in Brazil, since the referring bibliography is very scarce in this country. Consequently, this paper seeks to contribute to the reduction of the gap present in the bibliography of this topic, as well as reinforce the need to implement PCC in health services, particularly among nursing homes. Finally, this study aims to discuss the caregiving practices developed by LTCFs during the COVID-19 pandemic and analyze the daily care practices in long-term institutions for older adults living in Brazil, all in light of the PCC framework.

2. Methods

This is a mixed methods study which data were collected from 10 LTCFs, 5 private and 5 philanthropic, located in the state of Minas Gerais of the southeastern region of Brazil. The participants were managers and healthcare workers. These institutions were part of 6 municipalities in the main region of the state, where around 10 of the 1,116 LTCFs existing in Minas Gerais are concentrated ^[8].

The project was submitted and approved by the Brazilian Institutional Review Board and all institutions participating signed the Informed Consent Form.

As the study occurred in a pandemic context, we employed Information and Communication Technologies, which, according to Menezes & Santos ^[9], relate to electronic and technological devices. Thus, data collection was conducted through electronic forms and video interviews and presented through videoconferences to the participants.

The data collection instruments (online questionnaire and interviews) were elaborated by the research team and based on studies detailing the most frequent activities in LTCFs. These activities became the main qualitative categories/themes for PCC actions, identified as: nutrition, accommodation/structure, hygiene and comfort, clinical care, and leisure ^[10]. Thus, first, each typed interview report was read and re-read to identify the most relevant and confounding aspects regarding the initial hypotheses of the study. Then, data were classified into empirical categories that had the ability to apprehend determinations and specifics expressed in the empirical

reality. To conclude, interpretations and articulations between the obtained data and the theoretical references were defined to answer the research questions based on their objectives. Thus, for each category of the PCC, two biweekly meetings were held through the Google Meet platform, and a form was made available through Google Forms with questions related to PCC in order to assess LTCFs' perceptions about this approach. At the end of this research stage, two more meetings in a semi-structured interview format were held for each institution to return their results and discuss issues that needed further elaboration. The qualitative data from the interviews were transcribed and coded. The quantitative data collected were analyzed in a descriptive way, being discussed in the light of the literature.

3. Results and Discussion

The results were organized in 5 categories, following the PCC framework proposed by Roithmann, Ruschel & Paula^[10]: nutrition, accommodation/structure, hygiene and comfort, clinical care, and leisure.

Leisure

Leisure is an important practice in LTCFs, as most of the residents are retired and the amount of free and idle time they have is noticeably greater as well as being an important component of quality of life. Providing older adults with the option of choosing among various leisure activities and whether they desire to participate in them is crucial for the maintenance of not only residents' physical health, but also their mental and emotional health^[11]. With this in mind, leisure is considered to be one of the vital components of PCC for institutionalized older adults.

When asked if residents participated in the definition and choice of activities to be carried out in the LTCF, 75% of the institutions selected the answer option "partially, there is discussion of some activities with the residents", 12.5% responded that the residents rarely participate, and 12.5% answered that "yes, the choice of activities are always carried out by the professional team together with the residents". Through these responses, it is apparent that most LTCFs consider the participation of older adults in this category important. The PCC approach suggests that understanding residents' preferences for certain types of leisure activities is necessary for the implementation of PCC in LTCFs^[12]. Because of this, including older adults in team discussions of leisure activities is crucial to identifying what older adults prefer. Bangerter et al.^[12] also suggested that LTCFs should incorporate policies that enable residents' choices and increase resident autonomy.

These policies should allow for more options of leisure activities to be provided for residents, and listening to their input supports their autonomy by allowing them to choose or deny certain activities according to their interests, needs, and experiences.

Participating in leisure activities can serve to benefit older adults living in LTCFs regarding perceived quality of life and mental health. Edvardsson et al.^[13] found that residents who participated in everyday activities (such as making coffee, setting or clearing the table, watering plants, and participating in outdoor walks) had significantly higher quality of life and higher cognitive scores than residents who did not participate in everyday activities. Person-centered interventions were also associated with lower rates of boredom and feelings of helplessness^[1]. Moreover, Sköldunger et al.^[14] revealed that working in a PCC manner supports and enhances residents' autonomy with regard to mobility, self-care, and daily activities, all of which contributed to a higher quality of life for the residents. In this sense, identifying residents' preferences and encouraging resident participation in leisure activities are significant steps to individualized PCC delivery that will improve the quality of life and psychological status for older adults living in LTCFs.

Inquiring whether the activities suggested by the residents are implemented in the LTCF, 50% of the facilities answered that they are always implemented, 25% indicated that they are partially implemented, 12.5% answered "eventually", and 12.5% responded "whenever possible". Notably, none of the LTCFs marked "never" as an answer. As leisure represents personal choices to achieve well-being, it is imperative that the suggestions of older adults are listened to and, if possible, attended to.

Finally, older adults should be able to choose when they want to participate in an activity or when they would like to opt out of the activity. While residents should be encouraged to participate in leisure activities, they should also be given the choice of opting out of leisure activities. It is necessary to understand that behavior can be influenced by certain circumstances, such as the abrupt emergence of rigid routines, the reduction of privacy, and the adherence to a traditional biomedical care model, making older adults uncomfortable to perform certain activities at times.

It is noteworthy that the COVID-19 pandemic impacted the availability of leisure practices in LTCFs, whether it be due to the need for isolation or the absenteeism of healthcare professionals, among others. In other words, the pandemic seemed to have a negative impact on the availability and implementation of creative activities for the residents' leisure.

Accommodation / Structure

The structure and management in LTCFs play a significant role in the establishment of schedules and rules, and the available opportunities for older adults to have an active role in their own care plans is vital when incorporating a PCC approach in LTCFs. It is necessary that LTCFs not only provide quality medical care, but also ensure the construction of a comfortable environment that allows residents to feel at home^[12].

The COVID-19 pandemic also greatly impacted the Accommodation/Structure of LTCFs in Brazil, since virtual technologies became an everyday reality in the LTCFs. The suspension of visits due to the residents' need for isolation required residents to physically distance themselves from their already weak socio-familiar network.

Most LTCFs (60%) indicated the presence of individual rooms or subdivided spaces for each resident. Residents tend to feel that the institution and its policies restrict their freedom when there is a lack of privacy^[15]. To avoid challenging their personal dignities, the existence of individual spaces within LTCF rooms for each resident should be an important factor to guarantee the privacy and identity of the resident in their new home. These preferred places work as intimate spaces where residents feel they belong, so the construction of a new identity is encouraged, reducing feelings such as contempt, loneliness, and abandonment^[16].

Participants were also asked about the strictness of schedules and routines, specifically whether or not residents are free to define their own hours of sleep, leisure, physical, and socialization activities. The answers showed that some LTCFs were more flexible regarding residents choosing their own schedules, in which 5 LTCFs determined that residents were free to set their own hours. Other LTCFs were more rigid in having residents adhere to established schedules or certain activities, where 3 LTCFs indicated that residents were not allowed to set their own hours and 1 facility specified that only individual activities (rather than group activities) were available to change. One LTCF answered "sometimes yes, residents have the freedom to choose whether or not they want to participate in activities that are scheduled at an established time." According to Costa & Mercadante^[17], the identity and individuality of residents are distorted as they move and adapt to a new environment based on rules, norms, routines and strict schedules guided by the LTCF. Furthermore, residents having the ability to make decisions about their own needs is essential for their quality of life. If they are conditioned to follow an

inflexible pattern, they cannot exercise their autonomy.

Another foundation of PCC is the respect for the culture and life history of each individual, so the extent that these aspects are respected in the LTCFs was investigated. 8 of the LTCFs responded that they totally respect the culture and life story of each older adult, while 2 said they partially do. This demonstrates the significant understanding of each person as a unique being, who differs from others and must be respected. Moreover, when questioned whether older adults are encouraged to bring personal objects and belongings at the time of admission, 9 out of the 10 LTCFs said yes. In this context, Freitas and Noronha^[16] determined that depriving older adults of carrying a piece of their history with them can lead to the loss of privacy and individuality, impacting self-care and thus justifying the importance of respecting the history of life and culture.

Finally, the opportunity for residents to participate in masses, cults, or other religious rituals was questioned. All 10 LTCFs provided residents with the opportunity to participate in masses, cults, readings, and other religious rituals. Costa & Mercadante^[17] found that promoting leisure activities is extremely important to arouse the interest and autonomy of older adults in a way that makes them feel alive and useful. With this in mind, encouraging the practice of religious activities unites the respect for individual customs, spirituality, and culture, as well as promotes active aging.

Nutrition

Exploring the engagement of institutionalized older adults with their meals allows for a deeper understanding of how PCC is being implemented in the LTCF. Due to the lack of flexibility with meal times and activities, residents' participation and decision-making within this category is limited. This may translate to a lack of autonomy, which can further act as a detriment to the wellbeing of older adults in LTCFs^[15].

All 10 participating LTCFs were reported to have fixed meal times, but only half of them considered the possibility of changing these times according to residents' preferences, demonstrating limited flexibility and autonomy in at least half of the LTCFs for this category. However, all respondents stated that they allow the residents to feed themselves. Still within the theme of autonomy in LTCFs, when asked about the amount that residents can eat, 6 (60%) responded that residents are free to serve the desired amount, 4 (40%) said that residents are not free to serve the desired amount, 9 (90%) said that residents can refuse the meal, and 1 (10%) answered that residents cannot refuse the meal.

According to the Brazilian policies for LTCF, it is expected that at least six meals are provided to residents per day. However, there were no direct instructions that identified the will of the residents, such as the autonomy to choose the amount of food in each meal and whether or not they are able to refuse the food^[18]. Concerning the permission to refuse the meals, autonomy is an important aspect to be fostered in facilities, but the healthy nutrition of older adults is highlighted in order to stimulate the residents to eat well based on nutritionists' instructions^[19]. Therefore, to better understand why and in which cases the residents are unable to refuse the meal in that one LTCF, a closer view is needed.

In addition, two possible obstacles to the provision of person-centered food services were identified: 1) the shortage of employees, and 2) the rules and guidelines provided by Brazilian legislation which prevent residents from entering the kitchens of the LTCFs. In this context, it is noteworthy that, according to current regulations, institutions must have human resources that guarantee the execution of care activities for residents. However, this is a prevalent problem for LTCFs, since the number of employees is often below what is recommended by law. As a result, certain services, such as food, are limited in institutions since a multidisciplinary team is needed to properly perform the services^[20].

As for the second mentioned complicating factor, some limitations are found due to the guidelines that govern these institutions: despite the promotion of autonomy and dignity of older adults being strongly emphasized by the PCC framework, residents are blocked from entering the LTCFs' kitchens as a means to prevent accidents. In other words, the activity of cooking often becomes impossible for institutionalized older adults. In order to solve this problem, Barcelos, Horta, & Ferreira et al.^[21] reported the strategy adopted, in which an alternative kitchen was built that respected the requirements of sanitary surveillance and, at the same time, provided safe access for residents to the kitchen. The search for strategies like this reinforces several aspects brought by the person-centered framework, such as autonomy, the creation of a cozy environment, dignity, and the encouragement of active aging^[22].

To better understand institutionalized older adults' engagement in their own care, the LTCFs were asked whether the residents participate in the preparation of the institution's menu. It was discovered that 4 LTCFs did not participate in this activity, while 6 said that residents participate in the preparation of the institution's menu. Regarding the frequency of elaborating the menu, only one LTCF reported always including some order from residents, while the others reported different frequencies

of including residents' orders on the menu: 3 did it monthly, 3 did it daily, 2 weekly, and 1 biweekly. Since eating is a daily activity for living, it is up to the LTCF to enable participation in meal activities as a way of promoting autonomy.

It is noteworthy that, according to the study conducted by White-Chu et al.^[23], older adults who practice autonomy within the institution, whether through helping themselves at lunchtime or participating in decisions within the LTCF, showed greater self-esteem, desired weight gain, and reduced need to implement supplementary diets. Autonomy, as one of the core aspects of PCC, should be encouraged in the day-to-day life of LTCFs in order to promote better outcomes and quality of life for residents.

As mentioned before, the feeding routine is essential in PCC for institutionalized older adults. It is possible to conclude that nutrition is an area that has important potential for improvement in the LTCFs participating in this study. It is also important, however, to highlight that the COVID-19 pandemic has impacted food costs making it even more challenging to the facilities in providing nutritious meals to the residents.

Hygiene and Comfort

In addition to being considered a cultural and hygiene practice, studies show that baths stimulate peripheral nerve endings and blood circulation, triggering positive feelings of comfort and relaxation. In this sense, the actions and procedures framed within the hygiene guide are also related to providing comfort to institutionalized older adults, thus correlating with PCC in fostering feelings of belonging, autonomy, and respect among older adults^[16].

When the LTCFs were initially asked about the existence of fixed routines for bathing times, all LTCFs responded with having predetermined bathing hours. On the other hand, some of these facilities also positively indicated that there is flexibility of these times based on residents' choices, especially the independent ones. The presence of inflexible hours appears as an obstacle to achieving PCC, especially with regard to losses of residents' autonomy. It is extremely important to ensure the maintenance of older adults' autonomy even after institutionalization, since the limiting physical, physiological, biological and social processes traditionally tend to reduce their access to decision-making^[24]. By guaranteeing residents' preferences related to hygiene and comfort, including bathing times, the promotion of active and participatory aging can be achieved.

Following this line of reasoning, LTCFs were asked

about the freedom of older adults in deciding on various aspects of hygiene and comfort. Among the available options, the most marked (9 LTCFs) opportunities were being allowed to set the bath water temperature and female residents being allowed to get their nails painted. In contrast, permission to choose the bath time, decide on the number of baths per day, select the professional responsible for assistance in hygiene and comfort activities, and opt for skin hydration in their needed and preferred form were each reported to be the least marked (4 LTCFs) opportunities according to resident perceptions. Other options marked included choices regarding the duration of baths and their modality, the frequency of oral hygiene moments, the clothes to be used, bedtimes and the number of naps and rest during the day, haircuts, and shaving. It is worth noting that daily activities, such as those previously mentioned, have a significant influence on identity and the promotion of well-being for older adults. Thus, everyday tasks should be encouraged since, in addition to acting as a stimulus for therapy and motivation, they also help prevent social isolation^[22].

One of the most notable findings was the lack of LTCFs providing residents with the possibility of choosing their own professional to assist in hygiene and comfort activities. In a study by Machado-Lima et al.^[25], it was pointed out that shame with the body is more evident among older adults and nudity, in the presence of other people, including family members, is indicated as something uncomfortable and embarrassing. Bathing, whatever its modality, generates discomfort for both the resident and the professional, which ends up triggering silence and increasing the discomfort of the situation. As pointed out by Machado-Lima et al.^[25], this situation opens an important debate on the need for communication by the caregiver or other professional responsible for hygiene care at bath time. Regarding this dimension of PCC, the possibility for the residents to choose the caregiver contributes positively to the reduction of discomfort through the promotion of intimacy, communication, and respect for residents' limits and wishes.

Finally, 66.7% of the LTCFs responded that older adults do not have the freedom to perform oral and facial hygiene actions (such as shaving) in the way that they prefer and are always assisted to avoid accidents, while the rest (33.3%) supported the opportunity. Most activities carried out in LTCFs following strict schedules and performed by the professionals themselves usually contribute negatively to the loss of identity and autonomy by transforming residents into passive subjects, made to live in an unfamiliar environment where their life stories

are not respected^[26]. While helping residents is important, especially in activities that put them in danger, autonomy and freedom are essential for the promotion of PCC.

In conclusion, it is worth emphasizing the substantial impact that the COVID-19 pandemic has had in the costs of supplies for residents' hygiene, as well as for individual protective equipment, which have been increased by the current context, hampering the costs and their availability.

Clinical Care

According to Roithmann, Ruschel & Paula^[10], clinical care is a category that encompasses the multidisciplinary team, where a set of professionals from different areas converge their activities in order to promote more adequate and holistic patient care. Stewart et al.^[7] reinforce that the multidisciplinary team must promote a good relationship between the members, and that there must be mutual knowledge between the members in order to raise the capacity for conflict resolution, foster respect and empathy, and recognize the strengths and weaknesses of the team. Furthermore, White-Chu et al.^[23] discuss the importance of a proactive team, where the aspects mentioned above encourage a realignment of members who promote more attentive care, in addition to generating more professional satisfaction and employee efficiency. However, it is emphasized that, for these points to be achieved, there must be frequent team meetings that require consensus among all members in order to keep in touch with the problems that may arise within the LTCF and seek increasingly efficient and creative solutions^[7,23].

Within this theme, it is identified that only half of the participating LTCFs (5) have a fixed regularity of alignment meetings, and of those that do, only one (10%) holds alignment meetings every six months, 3 (30%) monthly and one (10%) every two weeks. In this case, each of these LTCFs should be questioned about the sufficiency of the regularity that each one presents, in addition to encouraging the implementation of a fixed frequency of meetings for institutions that do not have regular meetings since, as previously highlighted, this predetermined frequency is vital to a team.

According to Savundranayagam, Sibalija & Scotchemer^[27] the framework of PCC reinforces the importance of the affinity between the team and the resident, for it is possible to establish a plan of care for older adults while maintaining their personality, especially for those with dementia, and contributing to their quality of life, with the selection of healthcare professionals in LTCFs being extremely important considering the preferences of the residents and the proximity between the resident and the professional.

Further results that deserve attention were identified, since only 2 (20%) LTCFs considered the relationship between the care provider and the resident as a decision factor in the selection of professionals and 2 (20%) the resident's preference, while 2 (20%) reported considering the convenience of professionals, 4 (40%) the degree of dependence of the older adult, 6 (60%) the availability of professionals, 8 (80%) the skills and competences of professionals, and 7 (70%) reported having influence from other activities and practices that take place in the LTCF. Another important fact is that one (10%) of the LTCFs reported that they did not hold meetings for the alignment and discussion of clinical care provided to residents. Therefore, it is identified that the LTCFs show some inconsistency between the management implemented in the selection of healthcare professionals and PCC, since few LTCFs reported considering the resident-team relationship for decision-making.

Within the theme of resident autonomy, White-Chu et al. [23] emphasize the importance of resident participation in defining their care, while Stewart et al. [7] address the relevance of creating a joint care plan, where both the multidisciplinary team and the person receiving care are active agents in the construction of this plan. However, the results found that in 40% of the LTCFs, the residents cannot participate in team meetings, while 60% of these are attended by the older adults "sometimes". Additionally, when institutions were asked whether residents have an opinion regarding the team and collective care offered to them, 2 (20%) LTCFs said "no", revealing an important aspect that raises the need to understand why the residents of these two LTCFs do not opine about this point.

According to Stewart et al. [7] it is necessary to focus on the relationships between the professional team members and older adults by conducting meetings that share the experiences, life stories, and perceptions of each resident in order to effectively implement PCC for them. However, as highlighted by the same authors, there may be conflicts depending on the themes addressed in these meetings, especially when the issues cover working time, remuneration, or issues that do not directly concern all team members.

Finally, the LTCFs were asked about the predominant issues discussed in the professional team meetings. One (10%) reported addressing the length of clinical care in meetings, 10 (100%) reported including the needs of residents in the agenda, 10 (100%) reported strategies to improve the quality of service provided, 2 (20%) the remuneration of employees, 4 (40%) the lack of professionals in the team, 3 (30%) the work overload, 9 (90%) the degree of dependence of the residents and

their particularities and, 6 (60%) the construction of care plans. A high prevalence was identified for certain issues discussed consistent with PCC: residents' needs, strategies to improve the care provided, and construction of care plans. Thus, the team's attention to residents' quality of life during meetings is prominent, since the points mentioned assume a concern with the individualities of the residents, all of which is crucial for the PCC framework [27].

4. Limitations

The main limitation of this study includes the word size and difficulties encountered on data collection due to the current COVID-19 pandemic. The online data collection and virtual interviews/meetings limited the recruitment and interaction between participants and researchers and took longer than expected.

5. Conclusions

The lack of studies on PCC for institutionalized older adults, mainly in Latin America, presents gaps in literature for this care approach in LTCFs. As a reflection of this bibliographic insufficiency, the lack of knowledge of the PCC framework links to the low adherence of PCC among LTCFs. Furthermore, the traditional biomedical model of care is centered on routines interfering negatively in the quality of life of older adults as well as preventing their autonomy.

The analysis of PCC for institutionalized older adults in the participating Brazilian LTCFs reaffirmed the lack of knowledge of this approach and identified the difficulties encountered in its implementation, since care is still based on professional convenience and accommodation to routines, characterized by a difficulty in detaching from usual practices. However, it should also be noted that the participating institutions recognized the importance and principles of this approach. For the implementation of PCC in LTCFs, it is necessary to create a professional team that recognizes residents as the main protagonists of their care and, in a holistic and proactive approach. Managers should be knowledgeable about the PCC framework and should enable residents to develop an active role in the process of care and aging itself.

Finally, this study highlights the need for a change in culture and understanding of the LTCFs not only as a place to provide healthcare, but also as a residents' home that fosters their autonomy, and feeling of belonging. In addition to analyzing the current state of some Brazilian institutions, this article serves as the basis for further studies in the implementation of the PCC model

in other LTCFs. Moreover, the culture change should require LTCFs to analyze the costs related to PCC for institutionalized older adults, as this approach is still not fully accepted by LTCFs due to beliefs of it being costly. Thus, it is essential to ensure that healthcare teams in LTCFs know about PCC and that further studies investigate the impact on the costs of PCC for institutionalized older adults.

Conflict of interest

The Author(s) declare(s) that there is no conflict of interest.

Author Contributions

Marina Celly Martins Ribeiro de Souza, Natalia de Cassia Horta, Marco Aurélio Santos Pereira, Júlia das Graças Rodrigues de Almeida, Jasmine Yee, Leonardo Ayres Cordeiro, Tainá Rodrigues Gomide Souza Pinto were involved in the data collection, results evaluation and article writing of the study. Constance Kartoz was involved with the data analysis and final revision of the manuscript.

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