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Experiences of implementing person-centered care for individuals living with dementia among nursing staff within collaborative practices: A meta-synthesis

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ABSTRACT

Background: Person-centered care is considered standard care in long-term care for individuals living with dementia. However, qualitative reviews that synthesize the staff experiences of the implementation of person-centered care are lacking.
Objective: This review aims to synthesize the experiences of nursing staff members after the implementation of person-centered care for individuals living with dementia.
Design: A meta-synthesis was conducted.
Data sources: Overall, five electronic databases (i.e., PubMed, Cumulative Index to Nursing and Allied Health Literature, EMBASE, PsycINFO, and Cochrane Library) were searched for the following terms: "dementia," "person-centered care," and "qualitative." The search was limited to articles published in English from January 1998 to December 2021, considering the period when person-centered care was applied in dementia care.
Review methods: Qualitative content analysis was conducted using a person-centered nursing framework. Metadata analysis, meta-method, and meta-theory analysis were used to synthesize the results of the included studies. The methodological quality of included studies was assessed using the Critical Appraisal Skills Programme (CASP) tool.
Results: Altogether, 19 studies were included in this review. Through meta-synthesis, 12 themes, including professionally competent, perspective shift, shared decision-making among staff, appropriate supportive system, understanding and respecting individuals living with dementia, interaction with persons living with dementia and their family members, collaboration among staff members, concern about the well-being of an individual living with dementia, meaningful relationship between staff members and individuals living with dementia, quality care, reflections for maintenance, and barriers to overcome, emerged.
Conclusions: A person-centered nursing framework could be implemented in person-centered care for individuals living with dementia. However, the framework should be modified based on the characteristics of individuals living with dementia. Additionally, reflection strategies for maintenance and barriers are added to facilitate successful person-centered care implementation.
Registration: The study was registered with PROSPERO (International prospective register of systematic reviews) in May 2022 (registration number: CRD42022316097).

What is already known

- The endeavors concerning person-centered care application in dementia care have increased significantly as they have proved to be effective in enhancing the well-being of residents living with dementia in long-term care.
- There are limitations in how person-centered dementia care is translated into day-to-day practice; there is scope for improvement.
- There is a lack of synthesis of qualitative studies, which explore the after-experience of person-centered dementia care from the staff's perspective.

What this paper adds

- This review scrutinizes a diverse body of qualitative studies, mainly focusing on the implementation experience of staff members who offered person-centered care to residents with dementia.
- Person-centered processes included fundamental factors, such as understanding/respecting individuals living with dementia, and

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interacting with them in person and their family members; the outcomes included concerns about the well-being of individuals living with dementia, meaningful relationships, and quality care.
- In person-centered dementia care, the presence of a supportive care environment (e.g., having facilitators or leadership) and prerequisites (e.g., a perspective shift from task-centered to person-centered at individual and organizational levels) is essential to overcome barriers.

1. Background

Person-centered care is characterized as patient involvement in care and patient care individualization (Robinson et al., 2008), whereas long-term care emphasizes person-centeredness as a standard of practice (Brownie and Nancarrow, 2013). The concept of person-centered care was applied in dementia research in 1998 (Kitwood, 1998) and is now regarded as a "gold standard" practice for individuals living with dementia. According to the Alzheimer's Association Dementia Care Practice Recommendations, enhancing authentic caring relationships between staff and individuals living with dementia as well as maintaining a supportive and collaborative community among care staff are necessary to provide person-centered care in dementia care practice (Fazio, Pace, Maslow, et al., 2018). Specifically, the role of nursing staff is pivotal to successfully implementing person-centered care in long-term care settings as nursing staff serve both as direct care providers and care managers.

Numerous quantitative studies on the implementation of person-centered care for persons living with dementia have been published. Several review studies have synthesized quantitative studies using quantitative research methods (Chenoweth et al., 2019; Li and Porock, 2014), and meta-analyses were performed to assess the effectiveness of person-centered interventions on various outcomes related to residents (Kim and Park, 2017; Lee et al., 2022) and staff members (Barbosa et al., 2015; Brownie and Nancarrow, 2013). However, there is a lack of qualitative reviews that synthesize the literature on staff experiences regarding the implementation of person-centered care for individuals living with dementia.

Qualitative studies have increasingly reviewed various long-term care staff experiences of person-centered care implementation for individuals living with dementia. However, only a few qualitative systematic reviews regarding the experiences of nursing staff in person-centered care of overall long-term care residents have been conducted (Güney et al., 2021; Kim and Chang, 2022). Moreover, no qualitative synthesis has examined nursing staff experience in the implementation of person-centered care for long-term care residents with dementia. Our research question was raised because there may be a way to facilitate person-centered care, which is recognized as ideal but not applied practically. Hence, this study aims to describe the nursing staff's experience after the implementation of person-centered care for individuals living with dementia in long-term care by synthesizing findings from previous qualitative research. This study aims to provide new insights for person-centered interventions to be successfully embedded within dementia care culture in long-term care settings.

2. Methods

2.1. Synthesis methodology

This review is based on a meta-study, which provided a valuable framework to conduct interpretive synthesis and scrutinize the qualitative research based on a constructivist orientation (Paterson et al., 2001). Meta-synthesis is not a simple summary of primary studies but is rather an "interpretive integration" of qualitative findings from shared perspectives within the experiences of staff offering person-centered care. We used this methodology because it helps us to better understand how people perceive and implement person-centered care in dementia care practice (Thorne et al., 2004). According to the methodology presented by Paterson et al. (2001), the analysis process of the review comprised meta-data-analysis, meta-method, and meta-theory, which culminates in meta-synthesis to generate new insight about experiences of person-centered care implementation. The review protocol was registered in the International Prospective Register of Systematic Reviews (no: CRD42022316097); moreover, the reporting of the review followed the Enhancing Transparency in Reporting the Synthesis of Qualitative Research statement (Tong et al., 2012).

2.2. Search methods

The search strategy was pre-planned, and the search term was formulated using a framework of participants, the phenomena of interest, and context (i.e., PICo mnemonic) (The Joanna Briggs Institute, 2014). In this review, the participants were formal caregivers (when the majority of caregivers in the study were nursing staff) of dementia; the phenomena of interest were formal caregivers' experiences after the implementation of person-centered care for individuals living with dementia, and the context was long-term care facilities.

Based on this framework, three key concept words (i.e., dementia, person-centered care, and qualitative studies) containing the qualitative part of mixed-methods studies were included (refer to Table S1). As various formal caregivers can be included in one study, no restrictions on the term "formal caregivers" were set. Moreover, we evaluated whether the intervention corresponded to person-centered care based on the existing reference, including two components (i.e., individualized care and involvement facilitation), owing to the existence of a variety of non-pharmacological interventions in dementia care (Robinson et al., 2008). Before the beginning of the search, a university librarian reviewed the search terms and appropriate databases. The terms were constructed in consideration of the various words used (i.e., free text terms/controlled vocabulary terms, singular/plural forms, and British/American English).

The database search was performed using combinations of three keywords: dementia [e.g., "Dementia" OR "Alzheimer Disease" OR "Huntington Disease" OR "Lewy Body Disease"] AND person-centered care [e.g., "Patient-Centered Care" OR "Music Therapy" OR "Aromatherapy" OR "Phototherapy"] AND qualitative studies [e.g., "Qualitative Research" OR "Focus Groups" OR "Hermeneutics"] across five electronic databases (i.e., PubMed, Cumulative Index to Nursing and Allied Health Literature, EMBASE, PsycINFO, and Cochrane Library). The five databases, which were considered to contain the published articles for nursing and nursing care, were selected as search engines after discussing with a university librarian. The full search trail is demonstrated in Supplementary Table 2 (refer to Table S2). The search was limited to articles published in English from January 1998 to December 2021, considering the period when person-centered care was applied in dementia care (Fazio, Pace, Flinner, et al., 2018; Kitwood, 1998).

2.3. Eligibility and study selection

The studies were selected or excluded according to the inclusion/exclusion criteria (refer to Table 1). The primary studies were imported to the EndNote X9 software (Thomson Reuters, Philadelphia, PA, USA), and duplicates were eliminated. The primary studies were further exported to the Excel software where two authors screened the title and abstract independently. Through weekly meetings and frequent communication, all disagreements between the authors were resolved. Thereafter, the full texts were reviewed and any discordance between the two authors was discussed with the third author until an agreement was reached.

2.4. Data extraction and analysis

To conduct meta-data, meta-method, and meta-theory analysis, one author extracted data including basic information, study aim, study methods (design, type of intervention, specific setting, data collection and analysis, participants), and the theoretical framework (Paterson

Table 1
Inclusion and exclusion criteria.

	Inclusion criteria	Exclusion criteria
Participants	• Formal caregivers when nursing staff (e.g., nurses, nurse aides) represents the majority of the study population	• Individuals living with dementia or informal caregiver (e.g., family)
Phenomena of interest	• All types of person-centered care able to be defined by Robinson et al.'s (2008) criteria • Implementation for persons living with dementia	• Care or intervention, which cannot be defined in terms of Robinson et al.'s (2008) criteria • Implementation for informal or formal caregivers • Studies explored perspective on person-centered care without implementation
Context	• Long-term care settings (e.g., nursing home, long-term care facilities, residential home, care home, assisted living, residential aged care)	• Acute/subacute care settings and community settings
Design and publication type	• All types of qualitative studies, including the qualitative part of a mixed-methods study	• Non-peer-reviewed publication (e.g., editorial, abstracts, commentary, and thesis)

et al., 2001). For meta-synthesis, qualitative findings from each study were also extracted, and the correctness of extracted data was reviewed by other authors.

For data analysis, we used ATLAS.ti.Web (Version v3.18.0-2022-05-10), where data was accessible at any time, and opinions and comments could be freely exchanged among three authors to increase communication and the reliability of inter-coders. The data analysis followed a qualitative content analysis (Elo and Kyngäs, 2008), inter alia, deductive, and inductive analysis. This method is among the directed content analyses, which can be adopted when there is an existing theory or framework, to seek the phenomenon (Assarroudi et al., 2018). The directed content analysis is a structured method because the existing framework can be used to establish the initial codes and the relationship between codes, and vice versa. The findings from the analysis can further refine and enrich the existing framework (Hsieh and Shannon, 2005). In our review, there was an existing theoretical model of person-centered nursing care. However, the model is for the general population (McCormack and McCance, 2006), whose application to dementia care needs more discussion.

The specific process of data analysis was as follows. First, the three authors read and reread one-fifth of the studies. At this stage, meaningful texts were extracted. After discussion among the three authors, an unconstrained categorization matrix was developed according to the person-centered nursing care framework (McCormack and McCance, 2006). Second, the remaining articles were coded by the first author based on the four constructs of the framework (i.e., prerequisites, care environment, process, and outcome). The other two authors further double-checked whether the coding was appropriate as they read it again. At this stage, data were collected according to the content, and further coded. After all the studies were coded based on the unconstrained categorization matrix, the authors discussed whether coding from the framework adequately reflects the essence of the phenomenon in dementia care. Through intensive discussion, the authors concluded that frame modification is inevitable in dementia care. Hence, different categories were created within the bounds of the person-centered nursing care framework (McCormack and McCance, 2006). Fourth, we applied modified coding by rereading all data, after which we performed inductive data analysis using grouping data, categorizing data, and making abstractions within the bounds. All the authors actively participated in the entire analysis process and synthesis.

2.5. Quality appraisal

The methodological quality of included studies was investigated via the Critical Appraisal Skills Programme – Qualitative Research Checklist (Critical Appraisal Skills Programme, 2018), which comprises nine items that evaluate whether studies are suitable for qualitative research (e.g., aim and methodological appropriateness) and whether the methods and results (e.g., design, recruitment strategy, data collection, the relationship between researcher and participant, ethical issues, data analysis, and a clear description of findings) were adequately considered in terms of qualitative studies. All the final selected studies from the full-text review were appraised by two independent authors. Moreover, discussions during a team meeting were held to resolve any disagreements. In this step, there was no further exclusion owing to low quality.

2.6. Researcher reflexivity and trustworthiness

All authors were nursing scholars who had experience in dementia care and research. Trustworthiness was secured in the following ways (Lincoln and Guba, 1985). The authors meticulously followed the guideline of the meta-study methodology (Paterson et al., 2001). To ensure the validity of the findings, all authors actively participated in the screening, study selection, and data synthesis process. Throughout the entire research period, weekly research meetings were held to share ideas and opinions, make a decision about the research direction, and discuss data analysis findings. We discussed our preconceptions and assumption about dementia care through a critical reflection, to minimize the influence of prejudice on the findings. Lastly, the results of this review were reviewed by another nursing scholar, who is an expert and experienced in related phenomena and a non-dementia researcher, who is an expert in qualitative studies. The contents of the review were reflected in the manuscript.

3. Results

The searches resulted in 2488 articles, among which 226 underwent full-text screening. Among the 226 articles, 207 were excluded (see Fig. 1). Lastly, 19 articles were included in this review; and the overall quality of these articles is reported in Table S3. Nine studies (47.7%) did not describe the reflection on the relationship between researchers and participants or a description of such influence. Further, seven of the studies (36.8%) did not justify the study design.

3.1. Results of meta-theory and meta-method

Table 2 shows the characteristics of the included studies. All included studies were published between 2004 and 2021, with a majority (n = 14) published after 2014. Regarding countries where the 19 studies were conducted, more than half of the studies (n = 12) were conducted in Europe. Among various long-term care settings, most were nursing homes (n = 13). Other long-term care facilities included residential aged care, community living centers, etc. Types of person-centered care included dementia care mapping (n = 4), multisensory environments (n = 3), and others (e.g., caregiver singing and music and life story work). Among the 19 included studies, six studies reported theoretical frameworks, such as the V (valuing people), I (individualized approach), P (perspective of the person with dementia), S (social environment) framework (n = 2), RE-AIM (reach, effectiveness, adoption, implementation, maintenance), diffusion of innovation theory, implementation of change in health care, and consolidated framework for implementation research.

The sample size reported in 17 studies ranged from 6 to 200 participants. The total number of participants was 836 care staff; nursing staff

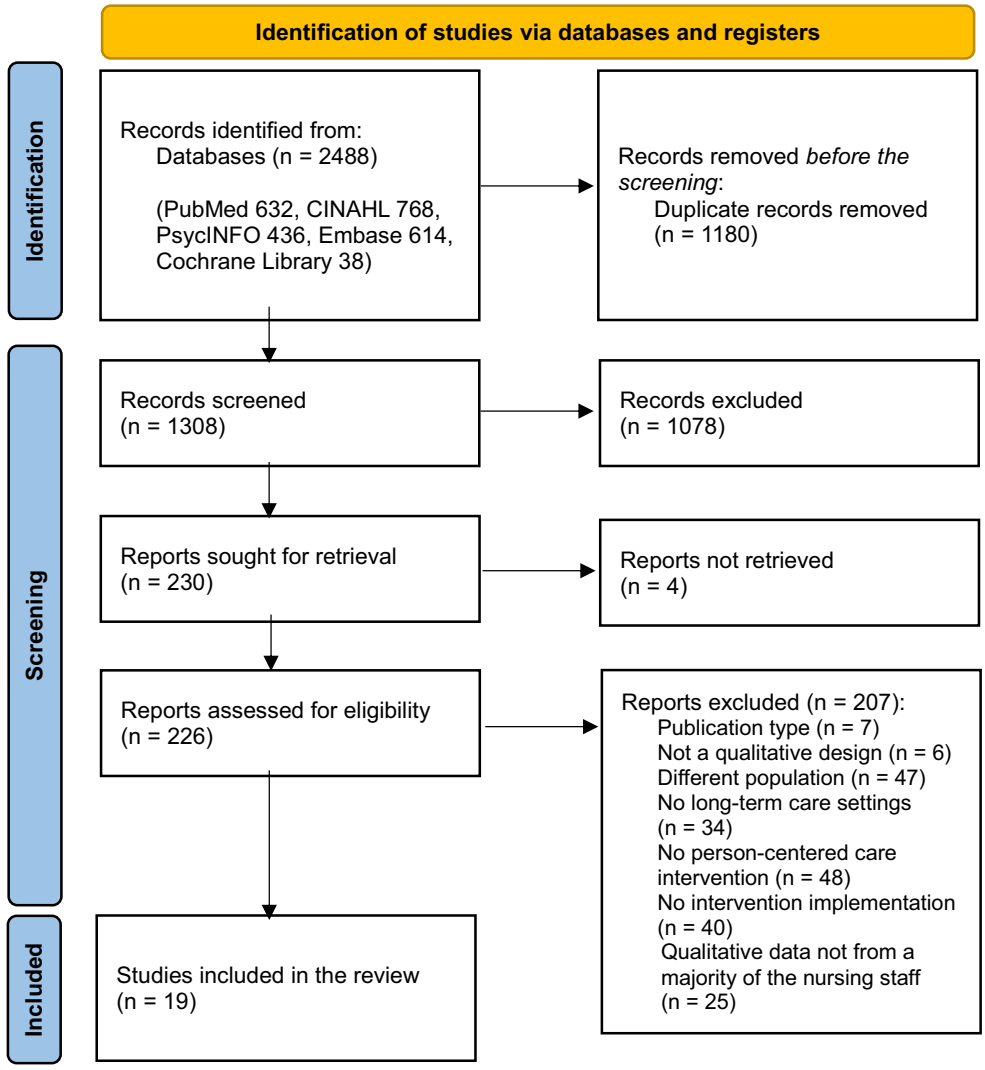

Fig. 1. The PRISMA 2020 flow diagram.

accounted for 76.9% of the total. One study only comprised nursing assistants, whereas participants of 18 studies had various occupations and positions (e.g., nurses, care workers, and therapists) that ranged from staff members to managers and directors. Regarding qualitative methodology, generic qualitative research (n = 9) with no clear allegiance to a traditional qualitative design was the most common; six studies adopted a mixed-methodology, two were participatory action research, and two adopted a case study design. Regarding data collection, seven studies used focus groups, six conducted interviews, and six collected data from various materials. All the included studies clearly stated the main findings either as a descriptive narrative (n = 9) or in the form of abstraction (e.g., theme) (n = 10) (refer to Table 3).

3.2. Key findings (meta-synthesis)

Our meta-synthesis revealed 10 themes regarding experiences of person-centered care implementation in long-term care under the person-centered nursing framework (McCormack and McCance, 2006) and two additional themes about maintenance and barriers. Quotations of each theme are presented in Table S4.

3.2.1. Prerequisites

Prerequisites encompass both institutional preparation for readiness to change, and individual preparation for personal competency. Notably, perspective changes were required at the organizational- and individual-level to apply a new, innovative person-centered orientation to existing routine care.

3.2.1.1. Professionally competent. Most studies suggested that staff members were well prepared to accept person-centered philosophy in their dementia care. They felt confident, empowered, knowledgeable, ready to change, and equipped. Staff described that the application of person-centered care provides more opportunities to learn and reflect on themselves or their care from a new perspective (Kontos et al., 2010; Melhuish et al., 2017). They realized that care at a slow pace keeps residents in a better mood (Kontos et al., 2010) and attempted to apply new strategies in daily care (Mansah et al., 2014). They could gain more knowledge about the therapeutic approach on how to interact with residents with dementia (Lorusso et al., 2020; Melhuish et al., 2017; Vikström et al., 2015) and how to work with residents with dementia (Kemeny et al., 2004) through training (Boersma et al., 2017; Williams et al., 2015) and education (Chenoweth et al., 2015). They also improved their communication skills and felt professionally competent (Melhuish et al., 2017).

3.2.1.2. Perspective shift. In many studies, the perspective shift from a task- to person-centered orientation was a key element in prerequisites, signifying a change from a traditional model (e.g., the pharmacological model) to a person-oriented model. Here, the perspective shift not only permeates the culture, mission, and philosophy of the institution

Table 2
Summary of the included studies (N = 19).

Author (year)	Country Setting	Type of person-centered care/theoretical framework	Participants	Study design Data collection Data analysis	Aims
Boersma et al. (2017)	Netherlands Nursing home	Veder contact method/RE-AIM	15 RNs, nine NAs, six coordinators, 15 managers, 12 others	Multiple case design FGI, interviews Thematic analysis	To conduct a process analysis of the Veder contact method, implementation includes an investigation of the facilitated and hindered factors
Chenoweth et al. (2015)	Australia Residential aged care facilities	PerCEN/VIPS	29 managers, 70 RNs and care staff	Non-reported Surveys, interviews, notes, and care plan records Content analysis	To gain insight on whether PCC and PCE had made any difference to the care quality, and to understand the enabling and inhibiting factors
Cooney and O'Shea (2019)	Ireland Long-stay care setting	Life story work/none	11 RN, 12 healthcare assistants	Descriptive design Interviews Constant comparative analysis	To explore the effect of life story work on healthcare professionals' understanding of an individual with dementia and care delivery
Cox et al. (2004)	Australia Nursing home	MSEs/none	Five RNs, one care attendant	Qualitative design Interviews Coding of data in accord with Neuman	To gain the opinions of caregivers regarding residents' MSEs experiences
Kemeny et al. (2004)	USA Nursing home	Not specified/none	Administrators, RNs, CNAs	Focus group FGI Not reported	To examine staff's behavioral changes after PCC training and its sustainability
Kindblom et al. (2021)	Sweden Nursing home	National guidelines for PCC/none	170 NAs, 20 RN, 10 others	PAR Poster and field notes Content analysis	To explore the staff learning process when adopting PCC into clinical practice
Kontos et al. (2010)	Canada Nursing home	Drama-based intervention/none	16 PSWs, two RNs, two RPNs, four allied health practitioners	Explorative design FGI and interviews Thematic analysis	To explore participants' perception of the drama-based education to teach PCC and facilitate changes in practice through intervention
Lorusso et al. (2020)	USA, Puerto Rico Community living center	MSEs/Roger's diffusion of innovation theory	12 RNs, four NAs, 16 others	Qualitative design Interviews Rapid qualitative inquiry	To explore staff perceptions of the barriers to implementing MSEs and the effectiveness of MSEs for veterans with dementia
Mansah et al. (2014)	Australia Residential aged care facilities	DCM/none	10 AINs	Explorative design FGI Content analysis	To investigate the experiences of assistants in nursing regarding dementia care mapping to improve dementia care quality
Melhuish et al. (2017)	UK Nursing home	Music and dance movement therapy/none	Two RNs, five healthcare assistants	Explorative design Interviews Interpretative phenomenological analysis	To explore the perceptions of staff members who participated in music therapy and dance movement therapy groups
Quasdorf et al. (2017)	Germany Nursing home	DCM/implementation fidelity, CFIR	Head nurses, staff nurses	Non-reported Interviews, resident records, and process document Content analysis	To explore whether DCM implementation was achieved as planned, including assess of facilitated and hindered factors
Quasdorf and Bartholomeyczik (2019)	Germany Nursing home	DCM/none	Four head nurses, four staff nurses, four project coordinators	Multiple case design Interviews Content analysis	To explore how leadership influenced DCM implementation
Rokstad et al. (2015)	Norway Nursing home	DCM/none	20 RN, 27 auxiliary nurses, 7 care workers	Descriptive design FGI Content analysis	To investigate the role of leadership in DCM implementation
Røsvik et al. (2011)	Norway Nursing home	VIPS practice model/VIPS	11 RNs, 12 auxiliary nurses	Evaluative design FGI Content analysis	To evaluate the VIPS practice model aimed at facilitating the application of PCC for persons with dementia
Swall et al. (2020)	Sweden Nursing home	Caregiver singing and music/none	26 assistant nurses, four NAs	Qualitative design World Café discussions Content analysis	To explore caregivers' perspectives on using caregiver singing/music and its influence on interaction with residents with dementia
van Weert et al. (2004)	Netherland Nursing home	Snoezelen/implementation of change in health care	Interview: head nurses, project leaders Meeting: caregivers, representatives	Qualitative design Interviews, meetings Using categories derived from the research model	To explore caregivers' experiences and the factors that facilitated or hindered the implementation of Snoezelen
Vikström et al. (2015)	Sweden Nursing home	National guidelines for PCC/none	170 NAs, 25 staff (RN, others)	PAR Seminar and poster Content analysis	To explore staff experiences of the national guideline implementation to care for people with dementia
Villar et al. (2018)	Spain Long-term residential setting	Individualized care-planning meetings/none	10 auxiliary nurses, four RNs, seven others	Qualitative design Interviews Thematic analysis	To qualitatively evaluate how individualized care-planning meetings impact staff perspectives
Williams et al. (2015)	Canada Long-term care facility	P.I.E.C.E.S./none	19 nurses (RN, RPN, LPN), 22 care aids, two managers	Descriptive design FGI, interviews Thematic analysis	To explore staff members' experiences with the PCC program and program maintenance

Note. AIN, assistants in nursing; CFIR, consolidated framework for implementation research; CNAs, certified nurse assistants; DCM, dementia care mapping; FGI, focused group interviews; LPN, licensed practical nurses; MSEs, multisensory environments; NAs, nursing assistants; PAR, participatory action research; PCC, person-centered care; PCE, person-centered environments; PerCEN, person-centered dementia care and environment; P.I.E.C.E.S., Program emphasizes the physical, intellectual, emotional, capabilities, environmental and social aspects of the resident; PSW, personal support worker; RE-AIM, reach, effectiveness, adoption, implementation, maintenance; RN, registered nurse; RPN, registered practical nurses; VIPS, value base, Individualized approach, understanding the perspective, social psychology.

Table 3
Main qualitative findings of included studies (N = 19).

Author (year)	Main qualitative findings
Boersma et al. (2017)	• The Veder contact method is easy to apply with no extra cost, and it increased interaction between caregivers and residents with dementia. Several facilitators and barriers to adoption and implementation were identified.
Chenoweth et al. (2015)	• The person-centered care model increased interaction with residents, flexibility in care work, staff's awareness of residents' needs, and residents' well-being. It reduced residents' negative feelings and symptoms. Many barriers and enablers of PCC model implementation were identified.
Cooney and O'Shea (2019)	• Four themes: 1) enhanced staff understanding of the person with dementia, 2) communication and relationship building, 3) person--centered dementia care, and 4) changes to the person's care plan
Cox et al. (2004)	• Multisensory environments increased the residents' pleasure or well-being. The garden made the residents more engaged and increased activity, whereas the Snoezelen made them feel calm and at peace.
Kemeny et al. (2004)	• CNAs continued using PCC skills in their work than nurses. The nurses viewed a positive change in the relationship between nurses and CNAs through CNAs' change in behavior, whereas CNAs thought that although their communication with nurses increased since training, nurses' behaviors had not changed.
Kindblom et al. (2021)	• Overarching theme: from simplicity to complexity and consensus • Sub-themes: learning process – from doing, through reflection, to change • Five categories: 1) staff approach to activity, 2) residential environment, 3) use of information, 4) staff priority, and 5) staff routine
Kontos et al. (2010)	• Two themes: 1) meaning beyond dementia and 2) the influence of the approach to care
Lorusso et al. (2020)	• Two themes regarding MSE effectiveness: 1) positive effects of multisensory environments and 2) unintended negative effects of multisensory environments • Seven themes regarding overcoming barriers: 1) dedicate a room for MSE therapy, 2) provide sufficient space, 3) provide effective training, 4) communicate lessons learned, 5) engage staff, 6) develop a clear maintenance plan, and 7) empower multisensory environments champion
Mansah et al. (2014)	• Three themes: 1) reflecting on care, 2) creating a caring connection, and 3) empathetic communication
Melhuish et al. (2017)	• Three themes: 1) discovering residents' skills and feelings, 2) learning from therapists' skills to change care practice, and 3) connection between staff and residents
Quasdorf et al. (2017)	• Incorporating the results of dementia care mapping into practice was difficult. Various organizational prerequisites, including networks and resident-friendly culture, and other facilitating factors, such as a positive attitude toward dementia care mapping, were needed. Key persons such as well-qualified facilitators were necessary.
Quasdorf and Bartholomeyczik (2019)	• Nursing homes that failed dementia care mapping implementation lacked leadership, while successful nursing home leaders were actively promoting the person-centered care philosophy and enthusiastically engaged in dementia care mapping implementation.
Rokstad et al. (2015)	• Three different types of leadership were illustrated as “highly professional,” “market-orientated,” or “traditional.” These leaderships affected the success of PCC implementation. Leaders should be role models and incorporate PCC in their vision and implementation process.
Røsvik et al. (2011)	• Five themes: 1) legitimacy in the staff, 2) facilitation of the staff's use of knowledge about person-centered care, 3) support of the resource persons' facilitating role, 4) the leading RN's authority in support of the legitimacy of the model, and 5) form of organization
Swall et al. (2020)	• Overarching theme: caregiver singing and music build bridges toward person-centeredness • Two generic categories: 1) caregiver singing and music are tools to promote interaction with individuals with dementia and 2) caregiver singing and music bring out a glimpse of the person • Four sub-categories: 1) promote mutual communication, 2) facilitate the caregiving encounter, 3) give rise to emotional expressions, and 4) awake dormant abilities
van Weert et al. (2004)	• Snoezelen improved quality of care and quality of life through changes from task-oriented to resident-oriented care. Caregivers experienced changes at the caregiver, resident, and organizational levels and found facilitating and hindering factors at both caregivers' level and organizational level.
Vikström et al. (2015)	• Six themes: 1) viewing one's work from a different perspective, 2) experiencing everyday outcomes from interventions, 3) feeling better prepared as a professional, 4) balancing enthusiasm with a high workload, 5) negotiating discrepancy between national guidelines and existing local policies/directives, and 6) integrating interventions into everyday practice
Villar et al. (2018)	• Three themes: 1) understanding persons with dementia, 2) questioning their practice and improving care, and 3) building interdisciplinary teams
Williams et al. (2015)	• Although staff supported PCC philosophy and the program, PCC program implementation and maintenance were difficult.

Note. CNA, certified nurse assistants; MSE, multisensory environment; PCC, person-centered care; RN, registered nurse.

but also the individual staff. The organization adopted flexibility in care (Chenoweth et al., 2015; Cooney and O'Shea, 2019) because allowing a change in care approach and routine helps develop a clear vision/mission (Boersma et al., 2017; Chenoweth et al., 2015; Quasdorf and Bartholomeyczik, 2019), culture (Quasdorf et al., 2017), and philosophy of care (Cooney and O'Shea, 2019). Such organizational change facilitates the individual staff to change their attitude toward care and overall perceptions. This positive attitude made them conduct an open and flexible approach (Melhuish et al., 2017; Quasdorf et al., 2017). Their focus changed from staff members to residents (Kindblom et al., 2021) because the former need to “be patient” (Chenoweth et al., 2015; Kontos et al., 2010) or should view residents and care for them tenderly (Cooney and O'Shea, 2019; Vikström et al., 2015). Lastly, staff members, including leaders, also mutually aimed for quality care or better practice in dementia (Chenoweth et al., 2015; Quasdorf and Bartholomeyczik, 2019; Rokstad et al., 2015; Vikström et al., 2015).

3.2.2. The care environment

The data highlighted that the care environment included shared decision-making among all staff members in a caring and supportive system.

3.2.2.1. Shared decision-making among staff members. Moreover, the application of person-centered care provided more communication channels to staff members. Consensus and multidisciplinary consultation (Boersma et al., 2017; van Weert et al., 2004) were useful in decision-making concerning daily care among the staff (Røsvik et al., 2011) and stakeholders (Vikström et al., 2015). Following this opportunity, the staff openly communicated their understanding regarding residents with dementia to ensure better care (Kemeny et al., 2004; Røsvik et al., 2011; van Weert et al., 2004). Through communication, they identified residents' needs more quickly and further provided care to fulfill them (Vikström et al., 2015). Discussing care induced improvements (van Weert et al., 2004), further making a change in daily practice (Røsvik et al., 2011). Besides, the decision-making process occurred across multiple hierarchical levels. Staff members in the upper hierarchical level came to listen to the experiences of hands-on staff members, which is crucial for identifying residents' needs and preferences in care (Quasdorf and Bartholomeyczik, 2019; Quasdorf et al., 2017). Hearing and talking to each other helps staff better understand the residents' unmet needs (Vikström et al., 2015; Villar et al., 2018). Through this process, staff members created a caring connection/

network to maintain open, clear effective communication (Mansah et al., 2014; Quasdorf et al., 2017), and for encouragement (Chenoweth et al., 2015).

3.2.2.2. Appropriate supportive system. The supportive system included both software (e.g., the organizational atmosphere (Melhuish et al., 2017; Quasdorf et al., 2017)) and hardware (e.g., structural) changes. The implementation of person-centered care allowed for staff training and education (Boersma et al., 2017; Chenoweth et al., 2015; Kindblom et al., 2021; Lorusso et al., 2020; Williams et al., 2015). Steady support and application of person-centered care to daily practice allowed the physical environment to be more dementia-friendly, resulting in more flexible organizational structures (Quasdorf et al., 2017). A flexible organizational structure enabled staff members to acknowledge each other's roles (Røsvik et al., 2011), eventually modifying the organizational working style (van Weert et al., 2004). Additionally, a structural change was applied to the furnishing and fitting of the ward (van Weert et al., 2004; Vikström et al., 2015), ensuring a peaceful and homely environment (Chenoweth et al., 2015; Kindblom et al., 2021) while securing sufficient space for the implementation of person-centered care when equipment is required (Lorusso et al., 2020). This structural change helped personalize the environment and pursue structural innovation (Cox et al., 2004).

3.2.3. Person-centered processes

The data highlights implementation experiences from knowing to understanding and further applying. It also suggested that the process needs to integrate fundamental person-centered concepts into everyday practice.

3.2.3.1. Understanding and respecting individuals living with dementia. In many studies, staff members stated that person-centered care implementation considers residents' daily patterns, preferences, and unmet needs derived from their background and personal history. While trying to understand the past, both preferences and values allowed staff members to understand the individuals rather than the disease, and to understand the physical and cognitive potential of the present to decipher the person's presence holistically (Boersma et al., 2017; Cooney and O'Shea, 2019; Melhuish et al., 2017).

Specifically, data showed that person-centered care helped staff members gain a deeper understanding (Boersma et al., 2017; Cooney and O'Shea, 2019; Melhuish et al., 2017) by thinking from the perspective of individuals living with dementia and not putting the disease first (Boersma et al., 2017; Chenoweth et al., 2015; Cooney and O'Shea, 2019; Kontos et al., 2010; Mansah et al., 2014; Melhuish et al., 2017; Villar et al., 2018). Furthermore, a timely assessment was essential (Chenoweth et al., 2015; Williams et al., 2015) because unmet needs can induce psychological and behavioral symptoms that further deteriorate the care situation (Chenoweth et al., 2015; Kontos et al., 2010; van Weert et al., 2004; Villar et al., 2018; Williams et al., 2015). Identifying why such individuals become aggressive and how to respond to or lessen the behavioral and psychological symptoms of dementia is vital because staff members encountered these symptoms often in everyday care (Chenoweth et al., 2015; Cooney and O'Shea, 2019; Williams et al., 2015). When care was provided in consideration of the resident, it also made finding answers to these symptoms easier (Cooney and O'Shea, 2019).

3.2.3.2. Interaction with persons living with dementia and their family members. Because a person living with dementia has cognitive impairment, interaction rather than engagement from the original framework in decision-making is a major concept in this review. Interaction between residents and staff occurred at the resident's pace, including rapport building, showing respect to residents, and creating a warm interpersonal relationship (Mansah et al., 2014; Melhuish et al., 2017). Additionally, the role of family members, who serve as supporters and informants in dementia care, was included (Kontos et al., 2010; Vikström et al., 2015). The application of person-centered care application needs a communication tool (Cooney and O'Shea, 2019; Kontos et al., 2010; Melhuish et al., 2017; Swall et al., 2020), which acts as a bridge between staff members and residents (Swall et al., 2020). To assess residents' needs, whose language and expression ability are impaired, interaction, including understanding both verbal and non-verbal cues (Villar et al., 2018), was a key element. Increasing interaction enabled more insight to be gained from residents, allowing the two parties to interact more, and vice versa (Cooney and O'Shea, 2019; Mansah et al., 2014; Melhuish et al., 2017; Villar et al., 2018). Through interaction, staff members could gain personal resonance, emotional connection (Melhuish et al., 2017; Villar et al., 2018), and grow closer to residents (Mansah et al., 2014).

3.2.3.3. Collaboration among staff members. Person-centered care is implemented based on collaboration among staff members, which is a crucial aspect of dementia care. In some studies, staff members stated that they wanted to hear the experiences of other staff members regarding what worked and what did not work (Lorusso et al., 2020). Person-centered care provided a means of communication to discuss residents through meetings (Boersma et al., 2017; Kindblom et al., 2021; Lorusso et al., 2020), and contributes to the provision of the best care, including reducing negative symptoms and improving positive well-being. Such collaboration was not limited to one discipline, encompassing multiple disciplines and staff members regardless of profession or career (Boersma et al., 2017; Lorusso et al., 2020). Particularly, staff members stated that they learned a lot from others who shared their goal of quality care but adopted a different approach. Moreover, staff members reflected on new ways or strategies to make residents more comfortable (Boersma et al., 2017; Melhuish et al., 2017; van Weert et al., 2004).

3.2.4. Outcomes

Staff members experience numerous everyday outcomes by applying person-centered care to residents. The outcomes in this review indicated good care experience among staff regardless of the success or failure of person-centered care implementation.

3.2.4.1. Concern about the well-being of an individual living with dementia. Staff experienced positive changes in the residents' well-being. This reaction seemed obvious when persons with dementia expressed pleasure, such as through a smile. When staff members valued residents' preferences, they appeared happier and more relaxed (Boersma et al., 2017; Cooney and O'Shea, 2019; Cox et al., 2004; Melhuish et al., 2017). Residents with dementia seemed to exhibit a positive mood more often (Kemeny et al., 2004; Lorusso et al., 2020; Swall et al., 2020; van Weert et al., 2004), and remained calm, relaxed, and comfortable (Chenoweth et al., 2015; Lorusso et al., 2020; Swall et al., 2020). Additionally, decreased behavioral and psychological symptoms (Chenoweth et al., 2015; Lorusso et al., 2020; van Weert et al., 2004) were also noticeable during person-centered care implementation. This change may be because staff members recognized the unmet needs or cues of the residents more quickly, which made it possible to determine their current emotional state and the services that they required (Williams et al., 2015). Positive emotional expression may be induced as they were more engaged in activities, social interaction, and conversation (Chenoweth et al., 2015; Cox et al., 2004). Residents could have more autonomy in receiving care (Chenoweth et al., 2015) and express their emotions more freely (Melhuish et al., 2017) under a flexible organizational culture and system.

3.2.4.2. Meaningful relationship between staff members and individuals living with dementia. Forming a meaningful relationship is considered the main outcome of person-centered care implementation, reflecting better quality of the relationship between staff members and residents. Through person-centered care implementation, staff members spent more valuable and relaxed time with residents (Vikström et al., 2015). An increase in interaction (Chenoweth et al., 2015; Villar et al., 2018),

communication (Kemeny et al., 2004; Melhuish et al., 2017), and mutuality (Vikström et al., 2015) was evident. As the members got to know the residents better, they grew closer to the residents (Boersma et al., 2017; Mansah et al., 2014; Swall et al., 2020) and their families (Mansah et al., 2014).

3.2.4.3. Quality care. Quality care refers to the individualization of care, routine changes, the adjustment of care, and heartfelt care provided to residents through a reflection of their preferences and personal values. This notion also includes the delivery of care (e.g., making a care plan customized) (Boersma et al., 2017; Cooney and O'Shea, 2019; van Weert et al., 2004). The number and variety of activities, together with the quality of care, increased upon the implementation of person-centered care (Chenoweth et al., 2015). Staff performed a timely assessment to rapidly identify residents' needs (Chenoweth et al., 2015; Williams et al., 2015), resulting in better care and improvement in practice (e.g., breaking down the task) (Chenoweth et al., 2015; Cooney and O'Shea, 2019; Mansah et al., 2014). Staff members provided individualized quality care (Williams et al., 2015) without relying on control (Chenoweth et al., 2015), and used medication (van Weert et al., 2004) when they encountered behavioral and psychosocial symptoms among individuals with dementia. Flexible ways of providing care were adopted by changing routine times and approach according to the residents' preferences and needs (Cooney and O'Shea, 2019; Kindblom et al., 2021; van Weert et al., 2004), which yielded better results and consequences (Cox et al., 2004; Swall et al., 2020).

3.2.5. Lesson learned

3.2.5.1. Reflections for maintenance. Staff reflected that they needed strategies to maintain the person-centered care intervention. These strategies included coaching and constructive feedback from other staff members and managers (Rokstad et al., 2015; van Weert et al., 2004), follow-up meetings (van Weert et al., 2004), continuity in training, consultation, supervision (Boersma et al., 2017; Chenoweth et al., 2015), and long-term support (Boersma et al., 2017). Receiving a positive response from residents significantly encouraged the staff to continue the intervention (Chenoweth et al., 2015). Additionally, both internal and external facilitators proved to be important (Chenoweth et al., 2015; Lorusso et al., 2020; Quasdorf and Bartholomeyczik, 2019; Quasdorf et al., 2017; van Weert et al., 2004; Williams et al., 2015). They acted as role models, provided feedback to care, in tandem with support and education, and facilitated communication and cooperation among staff members. They also encouraged staff members to deliver appropriate care (Lorusso et al., 2020; Quasdorf and Bartholomeyczik, 2019; Rokstad et al., 2015). Reflection on care was another crucial aspect for the continuation of the intervention. Staff recalled that, in hindsight, they acquired deeper insight, respect, and experience of the residents' lives (Cooney and O'Shea, 2019; Mansah et al., 2014; Melhuish et al., 2017), which drove them to adopt an empathic approach (Melhuish et al., 2017) to providing person-centered care in their practice. The person-centered intervention helped staff members comprehend why residents behaved in certain ways (Kontos et al., 2010), reflecting on how one's approach looks like (Boersma et al., 2017; Kontos et al., 2010; Rokstad et al., 2015; Villar et al., 2018), and how the care approach needs to be changed (Kontos et al., 2010; Mansah et al., 2014; Melhuish et al., 2017; Villar et al., 2018).

3.2.5.2. Barriers to overcome. Table 4 comprehensively describes the barriers. Overall, the hindering factors in prerequisites included lack of motivation (Boersma et al., 2017; Chenoweth et al., 2015; Lorusso et al., 2020) and resistance to new methodologies (Boersma et al., 2017; Chenoweth et al., 2015; Quasdorf et al., 2017; van Weert et al., 2004). Majority studies mentioned that they experienced a variety of barriers including practical issues, such as staffing and workload (Boersma et al., 2017; Cox et al., 2004; Kindblom et al., 2021; Lorusso et al., 2020; van Weert et al., 2004; Vikström et al., 2015), insufficient support of education/training (Chenoweth et al., 2015; Lorusso et al., 2020; Quasdorf et al., 2017; van Weert et al., 2004; Williams et al., 2015), insufficient resources (Lorusso et al., 2020; Røsvik et al., 2011; van Weert et al., 2004), poor communication (Chenoweth et al., 2015; Quasdorf et al., 2017; Røsvik et al., 2011; Vikström et al., 2015) among staff members, lack of facilitators and leadership (Chenoweth et al., 2015; Quasdorf and Bartholomeyczik, 2019; Rokstad et al., 2015; Røsvik et al., 2011; van Weert et al., 2004; Williams et al., 2015), and existence of a hierarchical culture (Kemeny et al., 2004; Quasdorf and Bartholomeyczik, 2019; Vikström et al., 2015), related to the care environmental construct. During implementation, the resident factor was experienced; not all person-centered approaches worked depending on residents as their preferences varied and could be changed (Boersma et al., 2017; Chenoweth et al., 2015; Lorusso et al., 2020; Swall et al., 2020). They also described a lack of cooperation from family members (Chenoweth et al., 2015). In terms of outcomes, staff wanted a maintenance strategy and feedback (Cox et al., 2004; Rokstad et al., 2015; van Weert et al., 2004; Williams et al., 2015) to ensure that the care being provided was appropriate. They also felt disappointed with the outcomes owing to very high expectations (van Weert et al., 2004).

Table 4
The barriers to implementing person-centered dementia care.

Construct	Barrier
Prerequisites	• Lack of motivation • Resistance to the new method - Attitudinal challenges, recognizing new methods as additional work, overwhelmed by too many innovations
Care environment	• Absence of manpower - Frequent changes in staffing and mangers - Lack of time, workload • Insufficient resource - Lack of equipment and space - Little support (e.g., education, meetings)
Processes	• Lack of facilitators, poor leadership • Poor communication - Lack of consensus, networks, and communication - Inconsistency in implementation among staff • Hierarchical culture • Difficult to work with residents' values - Preference varies and changes
Outcomes	• Lack of family cooperation • Lack of maintenance strategy - Back to the old habit, eager for frequent feedback • Very high expectations

4. Discussion

This meta-study scrutinizes the implementation experience of person-centered dementia care among staff members, including mostly the nursing staff in long-care using the person-centered nursing framework. To date, a variety of person-centered intervention types have been applied to dementia care in long-term care settings (Lee et al., 2022). Despite a growing number of evidence regarding its effectiveness in enhancing the well-being of residents with dementia, there is still a lack of synthesis of staff experiences about whether, why, and how the person-centered care was applied. By exploring and investigating the stories told by staff members, who offered the person-centered care in everyday practice, our review provided a more comprehensive, richer, and multifaceted insight into the phenomenon.

Our findings specify that European countries actively attempted to create a person-centered culture for individuals with dementia.

Moreover, most studies were published after 2014. This may be because European Union considered dementia a health priority along with Paris Declaration in 2006 and the Glasgow Declaration in 2014. These declarations included the right to person-centered and quality care throughout the life of individuals living with dementia. They also called for the creation of national strategies for dementia care (Alzheimer Europe, 2014). Specifically, Sweden adopted new national guidelines for persons with dementia in 2010. This review identified the guidelines as among the types of person-centered care in primary studies (Kindblom et al., 2021; Vikström et al., 2015). Other countries, such as Australia, Canada, and the United States of America, also consider dementia a national health priority and have taken an initiative on these perspective shifts to improve patient-centered care (Australian Commission on Safety and Quality in Health Care, 2011; Center for Medicare and Medicaid Services, 2021).

The approaches to person-centered care in primary studies varied from specific programs focused on individual-level outcomes (e.g., life story work, caregiver singing) to those targeted at organizational-level changes, including environments (e.g., multisensory environments, national guidelines). Considering that the philosophy of person-centered care aims to comprehend a person's uniqueness, and one of the core constructs of person-centered care frameworks emphasizes therapeutic environments, various approaches in individual studies appear to commendably follow the suggested practice recommendations for dementia care (Fazio, Pace, Flinner, et al., 2018; McCormack and McCance, 2006).

Considering the theoretical orientation of person-centered dementia care, our review examines ways in how theories are used within research and practice, together with their influence on the nature of the phenomenon. Unfortunately, our data shows that studies rarely described their theoretical orientation. Even when possible, we could undoubtedly assume that most person-centered dementia care was grounded in *personhood* (Kitwood, 1998; Kitwood and Bredin, 1992). As this concept has been introduced to dementia care, relevant endeavors have successfully applied personhood in dementia care (Mitchell and Agnelli, 2015). Nevertheless, a more practically applicable, friendly framework is required (Dewing, 2008). This point is important as the theory needs correspondence to the current situation to make a shift from the task- to person-oriented care in the current clinical field.

Our meta-synthesis shows similarities and differences between concepts described in this study and those suggested in the person-centered nursing framework (McCormack and McCance, 2006). Regarding prerequisites, the original construct was focused on nurses' attributes (i.e., professionally competent, interpersonal skills, commitment to the job, personal beliefs and values, and knowing self); however, our finding emphasized the necessary prerequisites in retrospect after applying the person-centered care. Many studies state that perspective shifts in the institution are necessary along with the shift in individual perspectives. As accomplished by others (Fazio, Pace, Flinner, et al., 2018; Koren, 2010), adopting person-centered care in daily practice is not merely about applying new skills in care but necessitates the entire organizational orientation to be shifted, putting the person first. This process needs agreement from every staff member in the organization. As shown in the barrier analysis, the application of person-centered care was not always optimistic. Although staff acknowledged person-centeredness as necessary and good, there still remains resistance. These results have significant implications for understanding who to target and how to make a change when person-centered care is first introduced in the clinical setting.

Along with individual competency preparation and perspective change, the supportive care environment is essential in providing person-centered care in clinical practice (Brooker, 2016; Brownie and Nancarrow, 2013; Güney et al., 2021). Our outcomes also showed that the scope and context of the care environment were consistent with previous studies that embrace a supportive system and shared decision-making among staff. The most important clinically relevant finding was that the care environment represents a large part of the barriers (e.g., absence of manpower, insufficient resource, poor communication, and hierarchical culture) encountered by staff members. These findings suggest that there is need to take several courses of action to incorporate person-centered care into daily practice. Except for problems that cannot be immediately resolved (e.g., staffing), one issue that emerged from our findings was the lack of facilitators or leadership. This finding is imperative because nurses significantly contribute to providing education, support, and encouragement to staff, and ensuring patient care through collaboration and teamwork with other disciplines. Ensuring appropriate systems, services, and support for the implementation of person-centered care must be a priority to improve the care environment (Brooker, 2016).

Our review describes a person-centered implementation in clinical practice as a process of understanding residents with dementia while interacting and providing nursing care through collaboration with colleagues. This definition shows commonalities in related research in terms of fundamental concepts on person-centeredness (e.g., understanding the person and promoting engagement) (Ebrahimi et al., 2021; Fazio, Pace, Flinner, et al., 2018; Güney et al., 2021; Robinson et al., 2008), which became the main compositing factors of person-centered processes in our review. Compared with the person-centered nursing framework (McCormack and McCance, 2006), working with patients' values, and promoting engagement were replaced with understanding and respecting, and interaction with persons living with dementia and their family members who can inform staff about the resident's background, respectively. Such a change is viable because our population comprises individuals with reduced cognitive function. The relevant models (Brooker, 2016; Fazio, Pace, Maslow, et al., 2018; McCormack and McCance, 2006) include providing hands-on care (i.e., providing for physical needs) as an essential element of person-centered care. Contrary to expectations, this review could not secure enough data on this topic. This may be because our participants perceived person-centered care as a philosophy rather than technical skills in the material aspect of providing actual physical care.

In terms of outcomes, the previous study has expressed outcome factors with regard to care recipients (McCormack and McCance, 2006). As our review collected stories from staff members, the outcomes were also defined in terms of their expressions (e.g., concern about the well-being of a person living with dementia). Despite the impairment of emotional expression owing to cognitive decline, it is obvious that person-centered care has shown remarkable results in improving the well-being of residents with dementia (Brownie and Nancarrow, 2013; Lee et al., 2022; Li and Porock, 2014). Our participants experienced everyday outcomes, witnessed improvement in residents' moods, and reinforced their relationship with them. Therefore, providing opportunities for quality time with residents is necessary.

We included studies wherein a majority of participants were nursing staff, to explore formal caregivers' perspectives about person-centered care implementation, and nurses' standpoints toward person-centered care in particular. However, it was difficult to separate nurses' perspectives from those of other formal caregivers because most studies provided mixed results. Several studies emphasize that the role of the nurse as a leader and communication among staff members were important to build an interdisciplinary team and ensure the successful implementation of person-centered care in long-term care.

4.1. Limitations

This study has several limitations. The study may have reporting bias as non-English and unpublished studies were excluded from the review. We have included English written qualitative studies only. This might omit or result in missing important articles written in other languages. Therefore, future research should consider the global project to comprehend the extensive search to further reflect the global experience of person-centered care. Additionally, most of the studies were conducted in European countries; hence, there might be limitations in the generalizability of the results to other countries.

Although we extensively searched and included the caregiver experience for person-centered care, we did not include informal caregivers. This is because the fundamental concept of person-centered care encompasses a person's values and culture, which is shared within their family. Nevertheless, there is need for future research to include informal caregiver's experiences, particularly in a community setting. Lastly, the meta-theory portion of the analysis was limited because 68% of the studies did not report theories or frameworks. The results of this review were not able to develop a new overarching theory about person-centered care.

5. Conclusions

The findings from this meta-synthesis provide new insights regarding staff experiences after the implementation of person-centered dementia care. Overall, a person-centered nursing framework can be implemented in person-centered care for individuals living with dementia. However, it should be modified based on the characteristics of care recipients (i.e., persons living with dementia). Particularly, respectful treatment of residents with dementia and maintaining close interaction are recognized in the person-centered process. As data were collected from staff members who actually implemented person-centered care in their practice, reflections for maintenance and barriers are supplemented to facilitate successful person-centered care.

Ethical approval

Not applicable.

Data availability

Not applicable.

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CRediT authorship contribution statement

Ji Yeon Lee: Conceptualization, Methodology, Formal analysis, Writing – original draft, Writing – review & editing. **Eunjin Yang:** Conceptualization, Formal analysis, Writing – original draft, Writing – review & editing. **Kyung Hee Lee:** Conceptualization, Methodology, Formal analysis, Writing – original draft, Writing – review & editing, Supervision, Funding acquisition.

Declaration of Competing Interest

The authors declare that they have no known competing financial interests or personal relationships that could have appeared to influence the work reported in this paper.

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Appendix A. Supplementary data

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