The Shared Subjective Frames of Interdisciplinary Practitioners Involved in Function-Focused Care in a Nursing Home: Q-Methodology

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Introduction

The world population is aging rapidly, with the percentage of those over the age of 65 years expected to increase from 8.5% in 2015 to 16.7% in 2050 (He, Goodkind, Kowal, & U.S. Census Bureau, 2016). The older adult population in Asia, which is growing at a much faster rate than in Europe or North America, is an increasing social burden. To ameliorate this problem, Japan in 2000 became the first country in Asia to introduce a long-term care insurance system. South Korea introduced its long-term care system in 2008; as a result, the number of nursing homes (NHs) has risen by 135.4%, from 1,332 in 2008 to 3,136 in 2016 (Statistics Korea, 2017).

In general, older adults residing in NHs are frail and have chronic illnesses and complex health statuses (Congressional Budget Office, 2013). Several studies have recommended an interdisciplinary team-based approach to prevent or slow functional decline, with teams including nursing staff (advanced nurse practitioners, registered nurses, and nursing assistants), geriatricians, pharmacists, psychologists, dietitians, physical therapists, occupational therapists, and social workers (Aniemeke et al., 2017; de Mazières et al., 2017; Eckstrom et al., 2016).

Function-focused care (FFC) is a philosophy that focuses on assessment of the underlying function-related capabilities of older adults to assist these individuals optimize and maintain their remaining abilities through continual increases in the time spent performing physical activities (Resnick & Galik, 2013). Many long-term care settings such as NHs attempt to implement FFC programs to help residents optimize performance across a broad range of functional abilities.
The core members of the interdisciplinary team working in NHs include physical therapists, who restore, maintain, and promote physical function of NH residents; occupational therapists, who develop, recover, and improve skills necessary for daily living; social workers, who provide psychosocial assessments and interventions to maintain and enhance physical and mental health; and nursing staff, who help maximize residents’ remaining functional abilities through systematic assessment and individualized interventions (American Physical Therapy Association, 2019; Lim et al., 2014; Vongxaiburana, Thomas, Frahm, & Hyer, 2011).

Interdisciplinary practitioners use their subjectivities to provide care for residents and to promote functioning. The subjectivities of a practitioner reflect philosophical viewpoints, values, attitudes, and experiences (Akhtar-Danesh, Dehghan, Morrison, & Fonseka, 2011; Simons, 2013) and have the characteristics of a self-directory (Doo & Lee, 2016). Thus, the FFC provided by interdisciplinary practitioners in NH settings reflects both individual and shared subjectivity among interdisciplinary practitioners. Shared cognition in realms such as knowledge, information, beliefs, and attitudes shapes explanations and expectations of tasks, which may in turn coordinate behaviors and ultimately help shape an effective interdisciplinary team approach (Razzouk & Johnson, 2012; Washington et al., 2017). No prior study has examined the shared FFC-related subjectivities of interdisciplinary practitioners working in NHs. Therefore, the purpose of this study was to explore the shared FFC-related subjectivity of these practitioners.

**Methods**

**Research Design**

This study used a Q-methodological approach to explore and describe the FFC-related subjectivities of interdisciplinary practitioners working in an NH setting. The Q-methodology, developed by Stephenson (1935) to explore individual subjectivity, combines the strengths of qualitative and quantitative research to enable individuals to express their subjectivities and perspectives on an issue (as cited in Simons, 2013). The Q-methodology has been broadly applied in healthcare-related research (Spurgeon, Humphreys, James, & Sackley, 2012).

**Procedure**

Data were collected from August to September 2016. Figure 1 depicts the steps that were used in the Q-methodology for this study.

**Concourse and Q-Sample**

The concourse, that is, the sum of thoughts from the participants, was developed using interviews with 30 interdisciplinary practitioners (nurses, physical therapists, occupational therapists, and social workers) working in NHs. In-depth interviews were conducted with NH interdisciplinary practitioners on FFC-related assessments and interventions until theoretical saturation was achieved. The statements of the participants were recorded and analyzed to construct a Q-population, and their identified subjectivities were re-confirmed. The questions used to develop the Q-population included the following:

1. What considerations affect your assessment of resident function in NH settings?
2. What subjective framework do you use to select and implement interventions for the remaining functional abilities of the residents in NHs?

Eighty-one statements comprising the concourse used in this study were obtained, and two research nurses assessed the content validity of these statements. To select the self-referencing statements (Q-samples), the 81 Q-samples were...
read repeatedly until the researchers confirmed and categorized the viewpoints regarding interdisciplinary FFC in NHs into 34 Q-statements. Six practitioners were recruited for a pilot study to test the validity and reliability of the items. Vague or ambiguous statements were eliminated or modified to ensure the clarity of each Q-statement.

**P-sample**

Q-methodology does not require large or representative samples (N = 20/40 is normal) because the intent is to select participants with various subjectivities and key viewpoints (Spurgeon et al., 2012; Watts, 2015). As shown in Spurgeon et al. (2012), 23 participants responding to as few as 39 statements are sufficient to provide valid results. Therefore, a purposive sample of 30 interdisciplinary practitioners from five NHs was recruited for the Q-population and Q-sorting procedures. As interdisciplinary practitioners have been identified in literature reviews as critical providers of FFC to residents of NHs (American Physical Therapy Association, 2019; Bureau of Labor Statistics, U.S. Department of Labor, 2019; Vongxaiburana et al., 2011), they were presumed capable of providing sufficient data on the research topic addressed in this study. The P-sample in this study consisted of 10 nurses, 10 social workers, nine physical therapists, and one occupational therapist, with 1–15 years (mean = 5.5 years) of experience providing FFC to older adult residents of NHs.

**Q-sort**

Thirty interdisciplinary practitioners produced 34 Q-statements, each of which was rated on a scale of 1–9. Practitioners of Q-sorting read the cards with the Q-statements and classified them into agree (+), disagree (−), or neutral feelings (0). Simultaneously, each Q-statement was placed in a sorting grid with nine tiers, shown in Figure 2. Follow-up interviews were conducted to discern the reason and meaning of the practitioner’s choices for the Q-statements that were extreme (−4, +4). Each practitioner spent approximately 30 minutes completing the Q-sorting procedure.

| Strongly Disagree | Disagree | Neutral | Agree | Strongly Agree |
|------------------|---------|--------|------|--------------|
| -4               | -3      | -2     | -1   | 0            |
|                  |         |        |      | 1            |
|                  |         |        |      | 2            |
|                  |         |        |      | 3            |
|                  |         |        |      | 4            |

**Figure 2.** Q-sort grid with array position value.

**Data Analysis**

**Q-factor analysis**

A proprietary software package (PQMethod Version 2.33; Peter Schmolck, formerly of Military University Munich, Germany) was used to establish a shared subjective framework for FFC interdisciplinary practitioners who care for NH residents. Each practitioner’s score was entered into the software by recording the number of the card allocated to each of the 34 Q-statements. Thus, 30 Q-sets of data were entered, and the PQMethod was used to analyze the sort. The analysis was conducted to identify groups of Q sorts with similar configurations. In the factor analysis phase, the software automatically creates a factor array, consensus statements, and the significantly distinguishing statements to represent that factor (Watts, 2015).

**Q-factor interpretation**

The factor arrays formed the basis of the different Q-factor interpretations. The purpose of factor interpretation is to understand and explain the shared subjectivity of the participants who were captured in one factor. The significant statements form the basis of the interpretation but do not explain the factors completely. Therefore, when interpreting the results, statements showing strong agreement or strong disagreement for each factor presented in the Q-factor analysis, consensus statements, statements with more agreement or less agreement than other factors, supporting reasons for the most strongly agree or disagree statements of the P-samples in a Q-sort, and existing literature and general characteristics data were used (Kim, 2008; Watts, 2015).

The participants were asked to provide more information regarding Q-statements that they had placed at the extreme ends of the sorting grid (Simons, 2013). Follow-up interviews may significantly improve the ability of researchers to interpret emergent viewpoints, identify shared viewpoints, and gain deeper insights (Watts, 2015). In this study, in addition to interpreting the reasons why participants assigned most agree/disagree judgments to the Q-statements, the Q-factor was analyzed using a word cloud analysis on follow-up interview
texts that reflected their decisions. A word cloud is a combination of words that appear in different colors and sizes that depict the frequency of occurrence of each word. The size of a word correlates with how frequently it is used. The validity of the factor interpretation was validated using visualization that focused on extracting repeated and meaningful keywords.

Ethical Considerations
This study was approved by the institutional review board of the university (1040548-KU-IRB-16-201-A-1), and each participant provided permission for their involvement. The purpose and process of this study were explained to the participants. All of the participants volunteered to participate. Participants were assured that the information they provided would be kept confidential.

Results
A Q-factor analysis of the subjectivity related to FFC for residents of NHs using the PQ-Method 2.11 program resulted in four frame-of-reference factors, including (a) using a wait-and-see approach to encourage self-care, (b) maintaining interactive communications to identify and respond to changes, (c) reinforcing residents’ inner and outer strengths for homeostasis, and (d) using a tailored approach based on comparisons between the past and the present. These four factors explained 48% of the total variance among the 30 participants (10 nurses, 10 social workers, nine physical therapists, and one occupational therapist), with 17% of the total variance explained by Factor 1, 14% by Factor 2, 9% by Factor 3, and 8% by Factor 4. Of the participants, 10 were classified under Factor 1, six were classified under Factor 2, seven were classified under Factor 3, and three were classified under Factor 4. The remaining four participants were not included under any factor.

Table 1 presents the list of Q-statements with factor arrays. Of the 34 statements, 26 showed significant differences between the factors \( p < .05 \). Next, these 26 statements were analyzed qualitatively in a three-step process to interpret the factors. In the first step, the transcripts of the interviews were repeatedly read and summarized to obtain an overview of the subjectivity of the participants related to providing FFC to NH residents. In the second step, the factors were interpreted using the 26 distinguishing statements and statements showing strong agreement or strong disagreement for each factor presented in Table 1. In the third step, the factors were further interpreted using the reasons for the “most strongly agree” and “most strongly disagree” statements of the P-samples in the Q-sort.

Consensus Q-statements were found for three statements (Q6, Q11, and Q26), of which Q6 showed the strongest level of agreement across all factors. “It is important to remember the common answers and attitudes of the residents. This is because they can be used as criteria to identify changes in cognitive functions of older adults” (Q6). Although the focus of providing FFC to NH residents differed from factor to factor, the importance of comparing the past and present responses of the recipients of care and of identifying changes in their remaining functional abilities was reflected in all of the factors.

Factor 1: Using a Wait-and-See Approach to Encourage Self-Care
The four social workers, three nurses, and three physical therapists grouped under Factor 1 were between 27 and 58 years old and had between 1 year 5 months and 10 years 4 months of experience providing FFC in NHs. In terms of providing FFC, Factor 1 focuses on using the various perspectives of interdisciplinary practitioners to assess the remaining functional abilities of NH residents when these residents have diverse problems (Q3, Q25; numbers in brackets refer to the Q-sort statements in Table 1). Furthermore, to help residents maintain or improve remaining function independently, practitioners should monitor the status of remaining functional abilities and allow self-care, providing instruction, demonstration, and assistance as necessary rather than proactively (Q21, Q20). Participant P-3 had the highest factor weight in Factor 1. P-3 noted, “I think that waiting for the residents to finish their meal or move around regardless of how long it takes is most important when providing FFC. It helps the residents utilize their remaining functional abilities (Q20). They are capable of doing a lot of things if we assist them. We need to wait while supporting and observing their activities, and give verbal/nonverbal cues and demonstrations when they make a mistake (Q25).”

As shown in Figure 3, the word cloud analysis for Factor 1 identified “remaining function” as the most frequently used term, followed by “independently,” “multiple problems,” “depend on condition,” “combining view,” “see,” and “wait.” Thus, synthesizing the perspectives of multiple interdisciplinary practitioners to closely monitor the remaining functional abilities of residents with multiple problems and then waiting and observing to ensure that these residents practice self-care as much as possible constitute key elements of Factor 1.

Factor 2: Maintaining Interactive Communications to Identify and Respond to Changes
The three social workers and three physical therapists grouped under Factor 2 were between 27 and 36 years old and had between 1 year 9 months and 12 years of experience providing FFC in NHs. In terms of providing FFC, Factor 2 focuses on identifying the various needs related to the functional status of the residents through verbal and nonverbal communication with residents and their families (Q21, Q2) and on identifying changes in functional abilities through talking with residents and constantly comparing residents’ reactions with their...
### TABLE 1.

**List of Q-Statements and Factor Arrays**

| Q-Statement                                                                                                                                                                                                 | Factor Array ($N = 26$)                                                                 |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------|
|                                                                                                                                                                                                          | Factor 1 ($n = 10$)                      | Factor 2 ($n = 6$)                      | Factor 3 ($n = 7$)                      | Factor 4 ($n = 3$)                      |
| 1. I think the basic function-focused care approach is administering different function-focused care based on the nursing home resident’s disposition and his or her rehabilitation needs, rather than the individual administering general care. | 3                                        | 4                                        | $-1^{**}$                               | 4                                        |
| 2. I think that, when assessing nursing home residents for admission, the family’s subjective evaluation should only be a reference and that the function status assessment should be based on the data confirmed through a direct encounter with the patient. | $0^{**}$                               | $-3^{**}$                               | 2*                                       | 4*                                       |
| 3. Nursing home residents usually have multiple problems, so the function status assessment of a resident should be judged by combining views from interdisciplinary experts working in the facility who co-manage the residents. | 4                                        | 3                                        | 4                                        | 2                                        |
| 4. Assessing nursing home residents’ spiritual desire to find meaning in life is important. The identification of their meaning in life can work as a driving force for them to utilize their remaining function for the rest of their lives. | 0                                        | 0                                        | $-2^{*}$                                | $-3^{*}$                                |
| 5. Identifying nursing home residents’ MMSE confirms not only dementia but also the subject’s communication function, program participation function, and ability to build social relations. Therefore, it should be the primary assessment factor. | 2                                        | 1*                                       | 2                                        | $-2^{**}$                               |
| 6. It is important to remember the content and attitudes of the resident’s responses to questions in everyday communication. This recollection can be a criterion for identifying cognitive function change. | 2                                        | 3                                        | 1                                        | 2                                        |
| 7. Because pain most affects daily life, ROM and pain assessment of a resident should take place constantly.                                                                                             | $-2^{*}$                                | 2                                        | 1*                                       | 3                                        |
| 8. When a resident with normal physical function and mild dementia suddenly cannot feed herself, this is a clinical indicator of cognitive decline.                                                              | $-2$                                    | 0                                        | $3^{**}$                                | $-4^{**}$                               |
| 9. When a resident with normal physical function and mild dementia begins to have incontinence of urine and stool, this is a clinical indicator of cognitive decline.                                          | 0                                        | $-1$                                     | $3^{**}$                                | 1*                                       |
| 10. When a resident with normal physical function and mild dementia shows a decline in the ability to maintain his or her balance, this is a clinical indicator of physical function decline.                        | $-1$                                    | $-2$                                     | $3^{**}$                                | $-1$                                     |
| 11. For a resident with normal physical function but who has severe dementia, a fall risk assessment should be paired with a walking function assessment.                                                           | 1                                        | 0                                        | 0                                        | 2                                        |
| 12. For a resident with normal physical function but who has severe dementia, a wandering assessment can be a clinical indicator of an anxious mental state.                                           | $-3^{*}$                                | $1^{**}$                                 | $-1$                                     | $-1$                                     |
| 13. In the case of a resident in a bedridden state without severe cognitive function damage, caregiver should focus on the psychosocial factor assessment.                                                  | $0^{**}$                                | $-3$                                     | $-2$                                     | $-2$                                     |
| 14. In the case of a resident in a bedridden state without severe cognitive function damage, caregiver should focus on the remaining muscle assessment.                                                   | $-2$                                    | $-1$                                     | $-1$                                     | $1^{**}$                                 |
| 15. In the case of a resident in a bedridden state without severe cognitive function damage, a decline in communication ability is a clinical indicator of depression.                                      | $-3$                                    | $-3$                                     | $1^{*}$                                  | $-1^{*}$                                 |
| 16. In the case of a resident in a bedridden state with severe dementia, the occurrence of pressure sores is an important clinical indicator of overall function failure.                              | $-4^{**}$                                | $0^{**}$                                 | $2^{**}$                                 | $-2^{**}$                                |
| 17. In case of a resident in a bedridden state with severe dementia, their eye expression, facial expression, and complexion are the main clinical indicators for pain assessment.                           | 0                                        | 2                                        | 2                                        | 0                                        |
| 18. I think that cognitive function intervention with residents should start from having conversations and that these conversations should focus on recalling memories to improve cognitive function.            | $1^{*}$                                  | $-2$                                     | 0                                        | 0                                        |

*(continues)*
normal state (Q6). Because problems may not be attributable to a single change in functional status (Q15), interdiscipli- 
minary practitioners should communicate and share per-
spectives on the physical, cognitive, social, and spiritual 
functional changes of NH residents and provide FFC (Q3).

Participant P-14 had the highest factor weight in Factor 2. 
P-14 noted, “I think that the actions and words of the care-
giver, the care environment, and the mood have greater positive impacts on the elderly than providing one-sided FFC (Q21).”

### TABLE 1.
List of Q-Statements and Factor Arrays

| Q-Statement                                                                 | Factor 1 \(N = 26\) | Factor 2 \(N = 26\) | Factor 3 \(N = 26\) | Factor 4 \(N = 26\) |
|----------------------------------------------------------------------------|----------------------|----------------------|----------------------|----------------------|
| 19. I think that spiritual function intervention with residents should make the continued religious life possible according to their religious preferences. | \(-1^{**}\) 3** \(-4\) \(-4\) |                      |                      |                      |
| 20. I think that residents should work independently when training or doing daily activities to enhance their remaining functional abilities, even if it takes a long time. | 4** \(-2^*\) 1 \(0\) |                      |                      |                      |
| 21. Because the caregiver’s actions or language affects the nursing home resident’s emotional status, they play a critical factor in psychosocial function assessment. | 3** 4** \(-2\) \(-2\) |                      |                      |                      |
| 22. When elderly residents refuse daily activities or training, it is important to invest time and effort to entertain and encourage them. | 1 \(2\) \(0^*\) 1 |                      |                      |                      |
| 23. In order to prevent (joint) contracture, it is important to train residents to get out of their rooms regularly, with the assistance of wheelchairs if necessary, regardless of their condition. | \(-4\) \(-4\) \(-3^{**}\) 1** |                      |                      |                      |
| 24. Environmental intervention such as providing as relaxing an atmosphere as their home is the primary consideration for improving their functions. | 2 \(1\) \(1\) \(-1^*\) |                      |                      |                      |
| 25. For a resident with normal physical function and minor dementia, considering their remaining functional abilities for sustentation is a common intervention practice. | 3 \(-2\) \(0\) 3 |                      |                      |                      |
| 26. For a resident with normal physical function but who has severe dementia, it is most important to intervene by focusing on the individual’s remaining sociopsychological function. | \(-1\) 1 \(0\) \(0\) |                      |                      |                      |
| 27. For a resident with normal physical function but who has severe dementia, providing satisfaction and pleasure through the simplest program possible is suggested. | 0** \(-1\) \(-2\) \(3\) |                      |                      |                      |
| 28. For a resident with normal physical function but who has severe dementia, it is necessary to show them daily activities step-by-step in detail and have them imitate the steps. | \(-2^{**}\) 1 \(-1^{**}\) 2 |                      |                      |                      |
| 29. For a resident in a bedridden state without severe damage to their cognitive function, spiritual and emotional intervention are the most important because their cognitive function still remains. | 2** \(-4\) \(-1^{**}\) \(-3\) |                      |                      |                      |
| 30. For a resident in a bedridden state without severe cognitive function damage, communication intervention for improving social function is the most important. | 1* \(-1\) \(-3^{**}\) \(1\) |                      |                      |                      |
| 31. For a resident in a bedridden state without severe cognitive function damage, sensory stimuli intervention such as watching TV are important for improving their remaining sense functions. | \(-1\) \(-1\) \(-4^{**}\) 1** |                      |                      |                      |
| 32. In the case of a resident in a bedridden state with severe dementia, designing a suitable ingestion method should be considered the priority to prevent nutritional problems caused by cognitive malfunctions or swallowing disorders. | \(-1\) 0 4** \(0\) |                      |                      |                      |
| 33. In the case of a resident in a bedridden state with severe dementia, because the resident has difficulty in expressing his or her opinions, abnormalities in the skin or joints need to be checked for to prevent accidents. | 1 \(2\) \(0\) 3 |                      |                      |                      |
| 34. In the case of a resident in a bedridden state with severe dementia, sensory stimuli intervention such as a body massage are the most important for improving remaining sensory functions. | \(-3\) 0 \(-3\) \(0\) |                      |                      |                      |

Note. Factor Q-sort values were identified by a Q-sort factor analysis and indicated the statements ranked from +4 = most agree to –4 = most disagree. *p < .05; **p < .01.
The word cloud analysis for Factor 2 identified “communication” as the most frequently used term, followed by “needs,” “response,” “compare,” “words,” “actions,” “information sharing,” and “change.” Thus, Factor 2 uses continuous interaction to compare the current and past responses of residents to detect changes over time and better understand resident care needs through information sharing.

### Factor 3: Reinforcing Residents’ Inner and Outer Strengths for Homeostasis

The six nurses and one occupational therapist grouped under Factor 3 were between 31 and 58 years old and had 6 months to 7 years of experience providing FFC in NHs. In terms of providing FCC, Factor 3 focuses on using various methods of ingestion to prevent decreased nutrition intake because of dementia or dysphagia, which may affect physical and cognitive functioning adversely (Q8, Q32). The participants grouped according to this factor expressed the opinion that cues that indicate changes in physical and cognitive functions such as inability to self-feed, inability to control feces, and inability to maintain balance should be taken into consideration when providing FFC (Q9, Q10). Participant P-21 had the highest factor weight in Factor 3. She noted, “There are times when an elderly resident does not eat well or refuses to eat. I chose the No. 32 card as the ‘most agree’ card because malnutrition weakens the bodily functions and eventually inhibits daily life. If residents have dysphagia, I give muscle training by encouraging them to swallow repeatedly.

I also provide nutrition by adjusting portions or altering food shapes for those who struggle to eat although they want to eat. I try to sympathize with their emotional struggles (Q32).”

The word cloud analysis for Factor 3 identified “change” as the most frequently used term, followed by “cognitive function,” “physical function,” “dysphagia,” “supplement,” “nutrition,” “meal,” and “maintain.” Thus, monitoring dietary and nutritional status to help assess physical–cognitive functional status and increase both inner and outer strength for homeostasis is stressed in Factor 3.

### Factor 4: Using a Tailored Approach Based on Comparisons Between the Past and the Present

The one nurse and two physical therapists grouped under Factor 4 were between 29 and 45 years old and had between 2 years 2 months and 15 years of experience providing FFC in NHs. In terms of providing FCC, Factor 4 focuses on comparing the functional status of NH residents at the time of admission with current functional status and on regularly observing changes in physical status such as pain or range of movement problems (Q2, Q7, Q33). Moreover, personalized functional care should be provided based on the remaining functions and needs of the resident (Q1, Q25). Participant P-16 had the highest factor weight in Factor 4. She noted, “I only take the family’s comments as a reference. I assess the resident’s functioning status based on the data acquired from an actual consultation with the resident and an accurate..."
assessment. Remembering the initial state and the normal state is a good basis for being aware of any changes (Q2).”

The word cloud analysis for Factor 4 identified “individualization” as the most frequently used term, followed by “remaining function,” “compare,” “change,” “needs,” and “tailored.” Thus, identifying the remaining functional abilities and needs of the residents through comparisons of current and past functional status and the status of other residents is stressed in Factor 4.

Discussion

This study focused on determining the subjectivity of interdisciplinary practitioners with regard to providing FFC to residents of NH facilities. On the basis of the findings, a shared subjective framework for the management of remaining function of residents in NH facilities should incorporate a wait-and-see approach to encourage residents to self-care. In addition, this framework should provide encouragement; maintain communications with residents to monitor changes; create a therapeutic environment that strengthens physical, cognitive, and psychological functioning from a homeostatic standpoint; and regularly compare residents’ current and previous functional abilities to provide personalized care. Because this study used subjectivity to identify four types of practitioners, this framework may be referenced and adopted by practitioners of different disciplines. Shared cognition is a collective activity that affects overall group goals and activities. In complex settings, higher levels of shared cognition are associated with similar problem conceptualizations and solution approaches (Razzouk & Johnson, 2012). Therefore, shared subjectivity may be presented as a collaborative framework to identify and solve complex and diverse problems related to the functional abilities of NH residents.

Talley et al. (2015) and Galik, Resnick, Hammersla, and Brightwater (2014) suggested that verbal encouragement or physiological feedback that improves self-efficacy should be provided to promote independent living in residents of NHs. This approach will likely be more effective than direct interventions in optimizing FFC. Improving the ability of older adults to live independently is critical to the improvement of remaining functional ability and underpins the practical care philosophies of the practitioner. The related characteristics are incorporated into Factor 1, which focuses on observing the remaining functional abilities of residents with multiple problems for an appropriate period to determine the best approach to providing assistance.

The important role of communication in acquiring and assessing the medical and functional histories and individual needs of recipients of care has been addressed in the literature (Gentleman, 2014; McGilton et al., 2009). Practitioners may assess changes in the health status of older adults with dementia who lack verbal communication skills by observing nonverbal communications such as facial expressions and behaviors (Broughton et al., 2011; Lee & Chang, 2010). The focus of Factor 2 is on the role of verbal and nonverbal communication with NH residents as a shortcut to the identification of their expressed and unexpressed functional needs and on sharing this information among interdisciplinary practitioners to detect unrecognized needs. The findings of this study regarding Factor 2 are unique in that the communications of practitioners were regularly compared to accurately identify changes in the remaining functional abilities of the NH residents over time.

Promoting nutritional balance and physical activity has been noted in several studies as an effective intervention to maintain homeostasis, which becomes difficult as older adults lose remaining functional abilities and grow increasingly frail (Garatachea, Santos-Lozano, Hughes, Gómez-Cabello, & Ara, 2017; Mañas & Sinclair, 2017). Because NHs are residential rather than medical care facilities, promoting stability and improving quality of life are the focus of Factor 3. To achieve this goal, interdisciplinary practitioners must share indicators of changes in physical–cognitive functioning to reinforce the inner and outer strengths of NH residents.

Numerous studies have addressed the need for and effectiveness of the tailored care reflected in Factor 4 (de Mazières et al., 2017; Liebel, Powers, Friedman, & Watson, 2012; Muntinga et al., 2012). Factor 4 recognizes that the needs and remaining functional abilities of each resident are unique and that providing customized care is another focus of FFC. In addition, Factor 4 is unique in recognizing the status of NHs as residential spaces and the embedded nature of practitioners in the daily lives of residents. Thus, the past and present status of residents’ remaining functional abilities and levels of desire may be regularly compared with other residents and addressed.

This study supports the subjective framework of providers as practical in the following ways: First, the findings may be used as a resource to establish communication methods or documentation for sharing among interdisciplinary practitioners in NHs. This study supports the subjective framework of providers as practical because of the focus on intradisciplinary differences rather than interindividual differences. Increasing the number of participants in future studies will permit more subjective frameworks to be identified and more robust knowledge shared. A second limitation is that interpreting Q-factors is as important as the Q-factors themselves in Q-studies. In addition to the traditional interpretation of Q-methodology, the word cloud method was used in this study to visualize the subjectivity of the words that were expressed by the participants. This helped avoid hermeneutical errors and improved the credibility, trustworthiness, and validity of this study. Third, the participants did not include sufficient numbers for each occupational group because four occupational groups were included. Therefore,
the focus of this study focused was on the ideas that were shared among the various subjective frameworks. Thus, the subjective framework from each discipline for FFC for NH residents may exist independently and deserves further study.

Conclusions
This study described the FFC-related subjectivities of interdisciplinary practitioners with regard to NH residents and how these were shared in an interdisciplinary setting. The results may help interdisciplinary practitioners better understand shared subjectivity and enable them to provide FFC more effectively to residents of NHs. Finally, the findings of this study may be used as a resource for developing interdisciplinary FFC practice guidelines.

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