ADDRESSING THE CHALLENGE OF ALIENATION, IDENTITYAND MORAL LEADERSHIP IN A SENIORS CARE HOME

by

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ABSTRACT

The purpose of this study was to document, critically analyze and understand both my experiences as the supervisor of the support service workers (SSWs) and the experiences of the SSWs in the context of privatization at a care home. The conceptual framework for this study was developed using chiefly the literature on workplace alienation, identity development and moral leadership. Qualitative research methodology was used to collect data. One source of data was from my self-reflection on my own practice and a second source was from the SSWs through focus group and individual interviews.

The process of privatization of the SSWs jobs and the subsequent significant reduction in wages and benefits was highly alienating. The educational interventions that I developed to involve the SSWs in the care planning process brought significant positive shifts in the SSWs' attitude towards their jobs and their workplace identity, diminishing their sense of alienation at the care home. I also experienced significant positive shifts in my engagement, identity and leadership at the care home.

The findings of this study demonstrates that educational interventions supported the transition of a group of women alienated at work, considered low-status with minimal influence and outside the care planning process to become a team of women who developed a strong sense of belonging and influence at the care home and are now considered insiders and important contributors to the care planning process. The study also demonstrates my own de-alienation and the shift in my workplace identity from an alienated manager with little influence

to an involved leader-educator with significant influence and a healthcare

professional who makes a difference in the lives of both residents and the SSWs.

 The dissertation concludes with a discussion of implications for future

research, for leadership practice in care homes, and for my own leadership

practice.

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ACKNOWLEDGEMENTS

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DEDICATION

To all the Healthcare Support Service Workers dedicated
to excellence in Dementia Care for Residents in care homes

CHAPTER 1- INTRODUCTION

This research study is a story about my struggles to make sense of management and leadership as I take on a new role as manager of a group of marginalized women while also facing my own pay cuts and increased responsibilities in a care facility. This study is also a story about marginalized women who work as support service workers (SSWs) in a care facility and who are struggling to develop a positive identity in the face of privatization, pay cuts and alienation. The SSWs worked in the areas of foodservice, laundry and housekeeping, and I had dual roles as manager of the SSWs and as the facility's dietitian. The care home was a 76 bed facility operating as a not-for-profit organization.

This story unfolds in the context of three policy shifts. The first policy shift was the Bill 29 – Health and Social Services Delivery Improvement Act that allowed the privatization of services in care homes. The second policy shift was the Resident Care Access Policy (RCAP) that changed the eligibility criteria for admission into care homes limiting admissions to only those very frail seniors at the end of their lives. Finally, the third policy shift was freezing the budget of care homes and forbidding them to run a deficit. These shifts ultimately led to the privatization of my job and the job of the SSWs within the context of an otherwise non-profit care home. This study documents and analyzes our experiences, including challenges to our identities and sense of engagement with our work, and how we struggled to diminish our sense of alienation and develop more positive workplace identities.

The transition from unionized jobs in a public care home to non-unionized jobs with a private organization, in early 2003, was stressful for the SSWs. The housekeepers were told they were "overpaid mop swingers" and "toilet bowl cleaners" and dietary staff were told they were "glorified waitresses" and "hospitality" workers. Both groups were told they were "non-essential" workers and an "economic drain on the health care system" by various groups including: their co-workers, their union, healthcare professionals and the government officials.

The SSWs felt humiliated, frustrated and struggled to save their jobs. Many of the women were middle-aged and were worried how they would manage their lives with significant wage and benefit losses. Some SSWs were worried about whether they would even be hired back by the private company in view of their age and health conditions.

As their manager, I too was struggling as my job was the only management job being privatized. Further, I was concerned how I would manage the ninety-day transition period from when the SSWs were laid off and the private company started its operation. How was I going to manage a group of demoralized workers, for 90 days, who may not have a job or have a job paying two-thirds their wages and fewer benefits. Further, if I accepted the job offer to work with the private company, how would I operate the support services department staffed with workers making low wages resulting in high turnover? I was also relatively new and still learning my job and had no previous experience with the privatization process. As a relatively new employee, I was working with

people I hardly knew and who hardly knew me. The thought of walking off the job did occur to me several times as the situation progressed and became harder and harder to manage.

As we moved through the privatization process in early 2003, the SSWs and I began to develop a bond that was emerging from having to go through a similar process together. In this process, it dawned on me that I was a healthcare professional with an obligation to help and care for people not just in the realm of nutrition but beyond, including my role as the manager of the SSWs. This actually made the whole process more difficult for me as I began to hear the workers' personal stories and their commitments to the care home. An emotional bond began to develop and I believed the way the SSWs were being treated was unfair. This was ironic as prior to getting to know the SSWs, my perception of them closely matched that of "overpaid mop-swingers", "glorified waitresses" and an "economic drain on the healthcare system".

Initially after privatization the work of the SSWs did not change. They continued to do similar types of work that they were doing prior to privatization. My work, however, changed significantly through addition of administrative duties, some of which required me to be offsite. As a result, I was not able to interact and observe the residents to adequately develop nutrition and environment care plans for them. To reduce my developing resident-related clinical knowledge gap, I developed and implemented several interventions, with the first intervention in September 2003 and the last one in February 2006, to involve the SSWs in the care planning process. As a result of their involvement

in care planning, I began to notice positive shifts in the SSWs' attitude toward their work, their engagement at work and their self-perception at the care home. The levels of frustration and fear that had intensified during the privatization process were significantly reduced. The engagement of the SSWs in the care planning process positively shifted their status and identity at the care home from being outsiders and non-contributing support workers to the care planning process to becoming insiders, significant contributors and healthcare workers. I also felt their engagement in the care planning increased my level of influence and contribution to the care planning process as I had access to unique resident-related information through the SSWs. This led to a shift in my identity from being a manager-dietitian to an educator-leader. As a result, both the SSWs and I felt an overall increased intrinsic satisfaction from our jobs despite our lower wages and benefits.

These positive changes fascinated me. It was not that long ago the SSWs were humiliated by the government, their union, their co-workers and the public as an "economic drain on the healthcare system". It was not that long ago that the SSWs' jobs and my own job were privatized and our wages and benefits significantly reduced and it was not that long ago since we experienced significant struggles, frustrations and fears during the privatization process. What changed? What happened? I wanted to understand the shifts I was observing and as a result this became the focus of my dissertation.

Context of the Study

To understand the positive shifts I was observing among the SSWs and my own positive shifts of being engaged at the care home resulting in a positive identity, it is necessary to examine the policy changes that enabled the privatization process and created conditions which necessitated me to develop and implement the various interventions to involve the SSWs in the care planning process. In reviewing healthcare reforms around the globe, it became obvious to me that the neo-liberal ideology was at the heart of these reforms. Neo-liberal ideology "has gained the upper hand, persuading officials, parliamentarians and congress that states are inefficient and private markets are more cost-effective and consumer-friendly"(McGregor, 2001, p. 83). "The theoretical assumption of neo-liberalism is that the free functioning of the market forces leads to a better utilization and allocation of resources, guarantees a better satisfaction of the requirements of consumption and bigger balance of the foreign trade and altogether produces higher economic growth and therefore development" (McGregor, 2001, p. 83).

Efficient and cost effective utilization of resources was the rationale used to begin contemplating the privatization of the SSWs' work. The belief was the hospitality industry was better equipped to provide dietary, housekeeping and laundry services compared to the health authorities. To justify the move towards neo-liberal ideology, governments designed policies in ways that produced side effects requiring the move towards privatization as the remedy.

Terris (1990) describes how governments have moved towards creating a

climate that is conducive to neo-liberal ideology.

> In the United Kingdom… with the election of Margaret Thatcher as Prime
> Minister in 1979, [her] Conservative government adopted a deliberate
> policy of starving the National Health Service (NHS) in order to reduce the
> quantity and quality of services and thereby encourage shifts to private
> insurance and private hospitals. Furthermore, it created a market within
> the NHS, made its services available to the private sector, and instituted a
> policy of shifting the funding of new NHS hospitals to private capital
> (Terris, 1999, p. 153).

Similar types of cuts were made to the healthcare budgets by the US Reagan

Administration, starting in 1981. In Canada, both the federal Conservative and

Liberal governments in the late 1980s and early 1990s also made cuts and

legislative changes, promoting a move towards privatization (Terris, 1999). In

2001, the BC Liberal government was elected on an explicit neo-liberal platform.

Six years earlier,

> in 1995 the Fraser Institute, a well-known Canadian right-wing think tank
> headquartered in Vancouver, BC, published a slim five-page 'study'
> comparing the costs of ancillary support services in hospitals – cleaning,
> laundry, food services, trades, and clerical – to 'hospitality' services in
> hotels. On the basis of this comparison, they concluded that hospital
> support workers in BC were overpaid. In distinguishing 'core public
> services' from 'non core domestic services' as a basis for arguing that
> non-core services should be 'market tested', the Fraser Institute was
> articulating a strategy for privatization (Cohen, 2006, p. 630 to 631).

To move on this recommendation, Cohen, a Research Associate at the

Centre for Policy Alternatives (CCPA), a left wing think tank, believes the BC

Liberal government began to till the soil for privatization in health care when they,

> dramatically reduced the number of regional health structures (from 52 to
> 5 health authorities), thereby creating more centralized administrative
> structures and the economies of scale that would be attractive to large
> scale external vendors. To further facilitate the contracting out of support
> services the province refused to fund the second and third years of the

collective agreements which had been negotiated by health care workers just prior to the defeat of the NDP (Cohen, 2006, p. 635).

Cohen argues this study by the Fraser Institute significantly influenced the BC Liberal government in passing the Health Services Delivery and Improvement Act (Bill-29). Bill 29 was passed into law in January 2002 and allowed the privatization of healthcare support workers.

> This legislation unilaterally… removed the negotiated employment security protections and contracting-out protection in [the collective] agreements, as well as substituting language that allowed employers to lay off the existing workforce with minimum notice and avoiding union rights to follow the work. Such a change essentially left the employer free to restructure the workplace with an entirely new workforce paid at much lower rates and with far few benefits (Cohen, 2006, p.634).

Two additional policy shifts influenced the care home operators to use Bill-29 to contract out. The first was the Resident Care Access Policy (RCAP) in April 2002. The introduction of the RCAP changed the eligibility criteria elderly individuals had to meet to receive care home services. Under this policy only the frail and elderly individuals with complex care needs were eligible for admission to care homes in BC. The eligibility changes created by the RCAP essentially resulted in care homes being reserved for more sick, frail and dependant individuals, who were closer to the end of their lives. These elderly individuals required more care and additional clinical monitoring by the care team to maintain stable health. The corresponding resources, such as equipment, to provide care for these high-care need individuals were not provided nor were additional funds provided to increase staffing levels. This created a care home in which circumstances did not meet the healthcare needs of the elderly individuals and created a workplace unsafe for the staff due to heavy workloads.

The second policy shift was the BC government's announcement of providing no additional funds to cover the increased inflationary and wage costs for the 2002-2003 fiscal year. As a result of the increasing number of frail residents due to the RCAP, who required more care and simultaneous budget shortfalls, the care home operators began to privatize services with the SSWs being the first to be contracted out.

The purpose of privatization of services was to force care home operators to remain within their previous years budgets and to increase the staffing levels by reducing the costs of wages and benefits. This was a concern to many care home operators because adding additional staff at lower wages had the risk of reducing the quality of healthcare the elderly individuals would receive, since the new staff might not have the same level of experience or the laid-off individuals who were re-hired to do similar work at two-thirds the salary could be demoralized resulting in a risk of higher turnover. They raised their concerns with the government and the health authorities but with no effect.

Purpose of the Study and the Research Questions

The purpose of this study is to reflect, document, critically analyze and understand the experiences of the SSWs and my own experiences in the context of privatization in healthcare at a particular care home. I hope to make sense of these experiences for my own learning and to allow the SSWs an opportunity to make sense of their own experiences. Our experiences may serve as a possible learning opportunity for others going through similar processes. I began with these broad research questions:

1. What were the SSWs' experiences of the healthcare reforms and the subsequent privatization of their jobs at the care home?

2. What was their experience of going through various interventions employed by me to involve them in the care planning process? What were their views of the subsequent change in their engagement with the residents' care planning process? How did this impact the SSWs engagement at the care home?

3. How did the engagement of the SSWs impact their relationships with their co-workers, the meaning and purpose of their roles and responsibilities, and overall workplace identity?

4. What impacts did the SSWs' engagement in the care planning process have on me in relation to my engagement, my leadership role and my identity at the care home?

Further, as the study progressed it became apparent to me that out of the various lenses I could use to examine and understand my experiences and the experiences of the SSWs, the literature related to workplace alienation, workplace identity development and moral leadership would best suit the development of the conceptual framework for this study. After I read the SSWs' transcripts from the focus group and individual interviews, it became obvious to me the SSWs were alienated from their work prior to the privatization process and their level of alienation at the care home intensified during the process of privatization. The interventions to involve the SSWs in the care planning process facilitated the reduction of workplace alienation. After reading the transcripts of

the SSWs, where they made obvious their sense of alienation, I reflected on my own sense of alienation. The alienation literature provided me with significant insights to understand my own experiences and the SSWs' experiences.

Organization of the Dissertation

This dissertation is organized into five additional chapters. In Chapter Two, I describe the journey I took through the literature to develop a conceptual framework to help me understand my own experiences and the experiences of the SSWs. In this journey, bodies of literature related to moral leadership and caring, workplace alienation and workplace identities, formed the major component of the conceptual framework. Chapter Three provides details of my journey through the qualitative literature and the development of the methodology and research design for the study. Chapter Four describes my reflection on the process of privatization and the subsequent interventions I developed and implemented to involve the SSWs in the care planning process to reduce my developing resident-related knowledge gap. I also describe how I was thinking and feeling at the various stages during the journey, the changes in my commitments towards the SSWs and the shifts that occurred in my leadership practices. Chapter Five presents the experiences of the SSWs in the journey from privatization to being involved in the care planning process. I have used direct quotes to represent the SSWs' experience in their own words. Finally, in Chapter Six, I conclude the study and address the importance of the journey for both myself and the SSWs and discuss implications of this study for both future research and practice.

In the next chapter, I describe my journey through the literature to develop a conceptual framework which serves as the lens through which I make sense of my experiences and the experiences of the SSWs.

CHAPTER 2 – DEVELOPING A CONCEPTUAL FRAMEWORK

My journey through the world of scholarly literature for this study begins with the literature I read in my classes for my doctoral program. Specifically, the body of literature that most influenced my thinking and corresponding actions I took was related to morality, moral leadership and caring. In this chapter, I have raised questions to link the literature to my practice. The questions help me focus the literature to be able to respond to the research questions of this study.

As my non-clinical responsibilities in my job were increasing due to privatization, I had to find new ways to carry out my clinical duties in a satisfactory manner. In addition, many of these non-clinical duties required me to be off-site from the care home, further reducing the time I could spend with the residents and resulting in a growing resident-related clinical knowledge gap for me. One of the ways to carry out my clinical duties differently was to involve the support service workers (SSWs) in the care planning process. This was a reasonable step to take as the SSWs spent a great deal of time with the residents and could take note of changes they noticed among the residents during their day-to-day activities. Further, I knew the SSWs were very disappointed and angry when they were labeled as "hospitality" workers and not healthcare workers during the privatization process. The SSWs countered this by claiming they were in-fact care providers and were important members of the care team. To capitalize on this claim and for my own instrumental reasons, I provided the SSWs dementia care training to sensitize them towards the observations they could make and report to me. Initially there was significant

level of excitement among the SSWs to participate but it was short lived. The SSWs began to resist being involved in the care planning process, citing not having enough time, the disruption it caused to their workflow and implying that it was my job to develop and implement care plans and not theirs. I struggled to understand their resistance to be involved and the in-congruency between their beliefs of being healthcare workers and their actions of being task focused. I was disappointed that they found providing information for care planning a disruption rather than an opportunity.

<div style="text-align:center">Morality, Moral Leadership and Caring</div>

The work of Fenstermacher (1990), Starratt (1996), Noddings (1993) and Strike (1995) heavily influenced my ability to understand the SSWs' resistance and gave me new insights to help me raise questions and begin developing processes and tools to increase involvement of the SSWs in the care planning process. Initially, my efforts to involve the SSWs in the care planning process were motivated by my instrumental need to narrow my growing resident-related clinical knowledge gap. However, as this journey of involving them in the care planning process unfolded, my instrumental approach gave way to a moral and caring approach due to the positive impacts we were having on each other. The details of the shift in my approach are described in Chapter Four.

The insightful component of Fenstermacher's (1990) work is the importance of knowing the moral nature of one's work. He makes this important point salient through the following example:

> Imagine medicine with its extraordinary knowledge base but without its Hippocratic oath. It seems nearly impossible to imagine the field of

medicine without a profound moral commitment to relief from pain and suffering and the preservation of life. If the moral ends of medicine were stripped away, the value and uses of what remains would be most difficult to ascertain. There would be medical tools and technologies, physicians with skills, and a knowledge base. But for what purpose? Of what value would the knowledge and skill of the physician be without any moral commitment to relieve suffering and preserve life? (p. 132).

Fenstermacher (1990) makes the point that knowledge is important but if there is no moral purpose underpinning it, what good would that knowledge be? When I developed and presented the dementia care training, I simply transmitted, to the SSWs, information with no ties to a moral purpose because I was thinking in instrumental terms. Reflecting on my failure to persuade the SSWs to be part of the caring planning process for the resident and taking into consideration the insights from Fenstermacher's (1990) work, I began thinking about what might be the moral purpose of the SSWs' work and the moral purpose of my work? Starratt's (1996) work was relevant in understanding the qualities required to be a moral person and the subsequent creation of a moral community. He argues there are three human qualities necessary for a moral life: autonomy, connectedness and transcendence. He explains autonomy as taking responsibility for our actions, connectedness as being in relationship with others and accepting responsibility implicit in those relationships, and transcendence as taking responsibility to move towards some form of excellence.

Fenstermacher's (1990) and Starratt 's (1996) work guided the development and implementation of interventions to uncover or create the moral purpose of the SSWs duties and to begin developing a department that was morally responsible. To further move in this direction, Nodding's (1993) work on

the ethic-of-care provided additional insights. She further develops the concept of connectedness or being in a relationship as presented by Starratt (1996) by expanding the importance of the entire web of relationships the other person has, the disposition to help, and the acknowledgement of the contribution of the cared-for to the relationship. She supports the concept of transcendence as she argues for the importance of striving for competence.

Noddings (1993) explains the five components of the ethic-of-care. First, it is "a study of relation[s]… [that] is fundamentally concerned with how human beings meet and treat one another" (Noddings, 1993, p. 45). Second, she identifies engrossment as engaging "in a special act of receptivity… [where the] carer hears, sees, and feels what is there in the other" (Noddings, 1993, p. 45). Third, she identifies that the "carer is disposed to help… [they] want to preserve the lives and well-being of cared for [and] promote their growth". Fourth, the carer "strive[s] for competency in whatever reactions or areas their efforts are applied" (Noddings, 1993, p. 48). Finally, she suggests that the "contribution of the cared-for is vital… [as it] sustains the carer in their efforts but it is [also] how the carers monitor the quality and effects of their caring (Noddings, 1993, p.48).

Noddings (1993) also highlights the importance of critiquing the conditions in which the relationships are embedded. How much of the focus is on the tasks which need to be accomplished and how much of the focus is on the people involved? By remaining people oriented, Noddings (1993) argues that the carer will remain disposed to help, be engrossed to where the "carer hears, sees and feels what is there in the other" (p. 48). This also allows the carer to be proactive

and specific with the care they provide rather than be reactive and general. By being more connected to the cared-for the carer is able to attend to other important relationships of the cared-for. Further, the care-giver and the care-receiver roles are dynamic; one may be a care-giver in one circumstance and a care-receiver in another. This dynamic relationship leads to the creation of a caring environment and in a workplace setting each individual would be working continuously towards mutual growth and development of each other to maximize capabilities.

In the case of the SSWs and me, we were more focused on accomplishing our tasks related to cleaning and cooking meals than on the residents for whom we were doing these tasks. Many times the focus on tasks made it difficult for the SSWs to accept changes that could be made to improve the care the residents received. Was the strong focus on tasks creating a disconnection between the SSWs, myself, other workers and residents? How did the privatization of our jobs and reduced wages further impact the disconnection? Was this disconnection responsible for the creation of a less engaged support services department at the care home? Having had insights into the importance of having a moral purpose to one's work, developing the work in a way that promotes the development of a morally responsible department and having the worker focus on the importance of care, how does one lead others to be moral and caring?

To respond to this question, Strike's (1995) concept of common or shared language is relevant. Strike (1995) uses a sports example to demonstrate his thinking about this concept.

Suppose that we wish to teach tennis. Teaching a sport requires more than a set of motor skills. To be able to plan the game one needs to be able to describe it. To do so students will need such concepts as 'serve', 'volley', 'backhand', 'service line', and 'ace'. They will need to be able to construct such sentences as "The depth of her approach shots is the reason her net game is so successful." People who learn to say such things are also learning how to see the game. Concepts are perceptual categories. Those who lack the concept of serve and volley can observe ball swatting and net rushing, but cannot see a tactic in a game. Users of a common language, moreover, are also learning the standards of appraisal that pertain to the game. They are learning how to think about strategy and how to judge the aesthetics of the sport. Without the vocabulary, one cannot play the game. Without the vocabulary, there is no game. One may hit rubber orbs with stringed paddles, but one cannot serve aces or hit backspin orbs. The vocabulary constitutes the game. Learning to play requires learning to talk in a certain way. [Starratt further argues that] when we learn a language – when we learn to think about and to see issues in certain ways – we begin to become part of a community. We begin to feel bonds with other like-minded people. We begin to understand them and they us. We begin to form habits of mind and ways of seeing the world that unite us in a common endeavor (p. 33).

The conceptualization of shared language as a way to teach and learn compelled me to think about introducing the medical care language used in the care home and the language of care and moral purpose as I was learning to the SSWs. Using the work of Fenstermacher (1990), Starratt (1996) and Noddings (1993), I facilitated the development of an "Aim Statement", which provided an overall direction for the SSWs with moral underpinnings, "Desired Practices", which provided the guidance to operationalize the aim statement, "Talk-Talk", which provided space and opportunities for developing caring relationships and the "To Care is To Know" program helped the SSWs understand the care language that existed in the care home and to move towards excellence in dementia care through continuous learning. The details of the development and implementation of these interventions are provided in Chapter Four.

As I moved forward in my doctoral program, my practice became the focus of my dissertation. I noticed significant positive shifts among the SSWs. I was observing a group of workers who seemed happy, satisfied, involved at the care home, who had developed positive relationships with their co-workers and demonstrated a strong commitment and obligation to the well-being of the residents. I too, upon self-reflection, felt a positive shift; I was more happy, satisfied, involved and connected. I also felt a sense of higher status at the care home. I was intrigued. It was not long ago the SSWs were humiliated and told they were not members of the care team and that their work should be privatized. Not long ago we had our wages and benefits significantly reduced as did I. Not long ago the SSWs and I were frustrated and came to work to make minimal effort. What happened? I wanted to understand what was contributing to these positive experiences?

To gain insights, to make sense of what I was observing among the SSWs, to better understand my own experiences and to develop a conceptual framework for this study, I again turned to the literature. My journey through the literature was anything but linear. It was a winding, zigzagging and crisscrossing journey creating a web which I use to interpret the SSWs' and my own experiences. I re-entered the vast scholarly literature by first examining the literature related to knowledge management because my initial purpose of involving the SSWs in the care planning process had been to narrow my growing resident-related clinical knowledge gap.

Knowledge Management

I wanted to understand if the positive shifts I was observing among the SSWs and my own positive experiences were the result of the SSWs creating and sharing resident-related knowledge with me. I reviewed the work of Nonaka and Takeuchi (1995), Alavi and Leidner (2001), Davenport and Prusak (2000) and Sandars (2004). Other than the work of Sandars (2004), much of this literature reflected a technical-rational and instrumental perspective. Most of the literature was about capturing knowledge for the purpose of competitive advantage, innovation and increased productivity. There was little moral discourse or mention of the impact on workers as their knowledge was managed or used. The main phases of knowledge management include: creating, storing, retrieving and transferring or applying knowledge.

Nonaka and Takeuchi (1995) and Alavi and Leidner (2001) describe four main processes for creating knowledge: socialization, externalization, internalization and combination. The purpose of each process is to convert or combine tacit and explicit knowledge. During the socialization process tacit knowledge is converted to new tacit knowledge through conversations and discussions. During the externalization process tacit knowledge is converted into explicit knowledge through articulating experiences and lessons learned. Internalization is the process of converting explicit knowledge into tacit knowledge through habituation and finally combination is where explicit knowledge is converted into new explicit knowledge through activities like a literature survey report. The important points Nonaka and Takeuchi (1995) and

other researchers in this area make is that the process of creating knowledge requires interaction among individuals and dialectical processes involving tacit and explicit knowledge. My interventions increased the degree of interaction the SSWs had with me, among each other and other workers at the care home. During these interactions the SSWs experienced a demystification of some of the health care knowledge related to dementia. Does this explain the positive relationships the SSWs and I developed and our increased involvement in the care planning process?

The storage and retrieval phase is the process of putting information in the organizations' memory for later use and decision-making to avoid repeating past mistakes or replicating what has already been carried out. I developed a new task for SSWs—they were to routinely record their observations about the residents. An important question is what happens to workers, such as the SSWs, whose knowledge is being retrieved? What impact does this have on the worker when the retriever is a higher status worker, for example a dietitian or a registered nurse?

Davenport and Prusak (2004) describe the concept of 'knowledge maps' designed to identify and create a map of persons, groups, or departments who have certain types of knowledge. Knowledge seekers are referred to those persons or groups rather than to a data base. In the case of the SSWs a written knowledge map was not produced, but other workers were beginning to realize that certain types of knowledge was available in the domain of the SSWs. How did being a resource of resident-related knowledge impact the SSWs and me?

The final phase of knowledge management is the process of transferring the knowledge which is having the knowledge available when needed and can be used. The application could include developing organizational policies and other directives. In the case of the SSWs, how were they impacted by having their knowledge transferred and applied? Did the SSWs develop a sense of contribution towards the care planning process? Did this impact their workplace identities?

The knowledge management literature helped construct important questions to understand the SSW's experiences but failed to provide answers to these questions. However, Sandars' (2004) work provided me a direction to explore other bodies of literature to respond to these questions. Sandars (2004) is a medical doctor in the United Kingdom and his work on knowledge management is based in the medical field. Sandars (2004) introduces Wenger's (2002, 2005) concept of communities of practice as an integral component of the knowledge management. His main explanation for the importance of developing communities of practice is "that knowledge is something that is produced in social systems in which individuals and shared processes are of the greatest importance" (p. 210), which is how others have described creation of knowledge.

Sandars' (2004) argument for the importance of connecting people through communities of practice is related to Nodding's (1993) argument for developing relationships to provide care and Starratt's (1996) concept of connectedness for living a moral life. The second important requirement for knowledge management, argued by Sandars' (2004), is the need for strong

leadership that is able to create organizational norms which enable the development of communities of practice. Sandars' emphasis on communities of practice makes the work of Wenger (2002, 2005) relevant to understand its relation to knowledge management.

Communities of Practice, Participation and Identity

To understand the concept of communities of practice and the development of workplace participation and identity, the works of Wenger (2005) and Wenger, McDermitt, and Snyder (2002) are meaningful. Wenger et al. (2002) define communities of practice as a "group of people who share a concern, a set of problems, or a passion about a topic, and who deepen their knowledge and expertise in this area by interaction on an ongoing basis" (p. 4). The most insightful components of the communities of practice literature to provide insights to understand the SSWs' experiences were related to developing meaning of work, learning and developing new workplace identities through participation.

One of the ways individuals can become members of a community of practice is through what Wenger calls peripheral participation. This type of participation offers individuals "various forms of casual but legitimate access to a practice without subjecting them to the demands of full membership" (Wenger, 2005 p.117). Wenger describes several ways in which boundaries to different practices or jobs can be opened up to allow for peripheral participation where one's outsider status is an enabling factor for developing meaning of work, learning and identity development. These ways include: boundary objects, brokering, immersion and overlapping activities.

Wenger defines boundary objects as "artifacts, documents, terms, concepts and other forms of reification around which communities of practice can organize their interconnections" (Wenger, 2005 p.105). He further argues that artifacts are not just designed for use but for participation and, therefore, designing artifacts requires the understanding of various practices and how the artifacts will cross boundaries to connect different practices. In addition to boundary objects, which connect practices through "things", Wenger introduces brokering, which connects practices through people. He defines brokering as "connections provided by people who can introduce elements of one practice into another" (Wenger, 2005 p.105). Wenger defines immersion "as a visit to another practice that provides a broader exposure to the community of practice being visited and to how its members engage with one another" (Wenger, 2005 p.112). Finally, Wenger contends that practices which overlap also enable peripheral participation. Overlapping activities require the various individuals to work together to complete the task at hand. This requires individuals to collaborate with each other helping develop an understanding of each other's role in the task.

Wenger (2005) argues that in peripheral participation there are three major processes in play. The first is the development of meaning of work through the interaction of participation and reification, second is the learning through the interplay between competence and experience and third the development of new workplace identities through the interaction of identification and negotiability.

Wenger (2005) describes participation as "a complex process that combines doing, talking, thinking, feeling, and belonging. It involves our whole

person, including our bodies, minds, emotions, and social relations" (p. 56). He

defines reification as "the process of giving form to our experience by producing

objects that congeal this experience into 'thingness' (p. 58). To clarify this point,

Wenger (2005) provides an example.

> Writing down a law, creating a procedure, or producing a tool is… [reifying
> a] certain understanding. This form then becomes a focus of negotiation
> of meaning, as people use the law to argue a point, use the procedure to
> know what to do, or use the tool to perform an action (p 58 -59).

The interplay between participation and reification is when the meaning of

the experience develops and sometimes this interplay changes the reification

component of meaning development and sometimes it changes participation.

In the case of the SSWs, the interplay between participation and reification

was insightful as it explains the number of times I had to modify the forms the

SSWs used to record their resident-related information. At first, the forms, which

reified the SSWs experience, directed the type and level of participation. As their

competency increased, their level of participation changed and to capture their

new experiences required new forms and this process will continue as long as

the SSWs level of participation changes. The same is true for other forms,

policies and statements that were developed which changed how the SSWs

participated at the care home. Did the interplay between reification and

participation change the meaning of work for the SSWs?

The second major process that occurs in communities of practice

according to Wenger (2005) is learning that results from the interplay between

experience and competence. Wenger (2005) defines competence along three

dimensions: mutuality of engagement, which is "the ability to engage with other

members and respond in kind to their actions". Accountability to the enterprise,

which is "the ability to understand the enterprise of a community of practice

deeply enough to take some responsibility for it and contribute to its pursuit".

Finally, the last dimension is negotiability of the repertoire, which is" the ability to

make use of the repertoire of the practice to engage in it" (p. 137). Wenger

(2005) defines repertoire as "routines, words, tools, ways of doing things, stories,

gestures, actions or concepts community has produced or adapted in the course

of its existent and which become part of its practice" (p. 83). In essence, Wenger

(2005) is suggesting that an individual develops competency by developing a

sense of belonging and being accepted into a group or profession or a

community of practice. Through participation the individual invests him/herself

and takes responsibilities of what the group, profession or community of practice

signifies. Finally, the individual is aware of the resources within the group,

profession or community of practice and is able to use them effectively.

Experience comes from participating in the community of practice at some

level and deriving meaning from that participation. Wenger (2005) argues

learning takes place in the tension between experiences and competence.

Sometimes competence drives experience as in a new employee entering into a

community of practice or an old employee learning a new practice. Sometimes

experience drives competence as in learning a new way of doing a particular

procedure outside of the particular community of practice and then making this

the standard through selling this new way of doing something to another

community of practice. There has to be just the right amount of tension between

experience and competence as "learning is impaired when the experience and competence are too close [due to boredom] and when they are too distant," due to being overwhelmed (p. 140). In the case of the SSWs and I, was there a simultaneous interplay between experience and competence that was allowing us to learn new ways of doing our work at the care home?

The third process in communities of practice as argued by Wenger (2005) is the formation of identity through the interplay between identification and negotiability. He defines identification as "providing experiences and material for building identities through an investment of self in relations of association and differentiation" (p. 188). Identification "is both participative and reificative… It is a reificative process of 'identifying as' something or someone [and] it is a participative process of 'identifying with' something or someone" (p. 191). Therefore, identification is who or what we are and who and what we are not. Wenger (2005) defines negotiability as "the ability, facility, and legitimacy to contribute to, take responsibility for, and shape the meanings that matter within a social configuration" (p. 197). Negotiability is influenced by how much access one has to information, how much one's perspective is allowed to be shared, how much say one has in decision-making. The interaction between identification and negotiability determines one's identity within that community of practice. In other words, identity development is a function of being able to identify 'as' or 'with' a particular occupation or group and then having the ability to participate in and have influence on the occupation or group. In the case of the SSWs and I, did

increased participation in the care planning process and continuous learning help construct new workplace identities?

Returning back to Sandars' (2004) argument of the importance of communities of practice in knowledge management, it appears that the main processes identified by Wenger (2005) which occur in communities of practice, namely the development of meaning of work, learning or sharing knowledge and identity development or sense of belonging, facilitate the phases of creating, storing, retrieving, transferring and applying in knowledge management. As a result, the concept of communities of practice and the processes that occur within it help explain my observations related to the positive attitude towards work among the SSWs. Did the SSWs involvement in the care planning process allow the development of, or create opportunities to join, communities of practice and experience the process in such a community as described by Wenger (2005)?

Continuing with Wenger's (2005) process of identity formation in communities of practice, the works of Ghidina (1992) and Ashforth and Kreiner (1999) extends the process of identity formation by introducing the role of identity management. Where as Wenger (2005) is more focused on the individual identifying "as" or "with" and then negotiating that identity, both Ghidina (1992) and Ashforth and Kreiner (1999) are focused on redefining and renegotiating the work itself through social construction. As a result, social relations are just as important in this process as in the negotiating process described by Wenger (2005). "It is through [social relations] that more glorifying definitions of work are

created and sustained" (Ghidina, 1992, p. 76). Ashforth and Kreiner (1999)

provide three ideological techniques – reframing, refocusing and recalibrating the

work tasks through which new identity is created for both the work and the

worker. Reframing of work involves creating "the occupational mission – the

espoused purpose for which the work was created – in value-laden terms"

(Ashforth and Mael, 1999, p. 421). The occupational mission then becomes the

ends and the occupational tasks become the means to achieving the end which

require refocusing to be congruent with the mission. Refocusing is the process of

shifting attention from "stigmatized features of the work to the non-stigmatized

features" (Ashforth and Mael, 1999, p. 423). The stigmatized and non-

stigmatized features are then recalibrated, which is "adjusting the perceptual and

evaluative standards [to] make an undesired and ostensibly large aspect seem

smaller and less significant and a desired but small aspect seem larger and more

significant" (Ashforth and Mael, 1999, p. 422).

 In the case of the SSWs, did the various interventions allow the SSWs to

reframe, refocus and recalibrate the tasks of their work which they socially

negotiated through the care planning process at the care home? Did this process

contribute to the shift in the SSWs identity toward that of healthcare workers?

 Tronto's (1993) work on caring provides insights to how the SSWs might

be reframing, refocusing and recalibrating the care planning related tasks they

were now involved in. Tronto (1993) states that the type of care provided "defines

who we are as people and as unique individuals" (Tronto, 1993, p. 106). Tronto

(1993) argues "care consists of four analytically separate, but interconnected,

phases. They are: caring about, taking care of, care-giving, and care-receiving"

(Tronto, 1993, p. 105-6).

> *Caring About* involves the recognition in the first place that care is
> necessary. It involves noting the existence of a need and making an
> assessment that this need should be met.
>
> *Taking Care* of is the next step of the caring process. It involves assuming
> some responsibility for the identified need and determining how to respond
> to it.
>
> *Care-giving* involves the direct meeting of needs for care. It involves
> physical work, and almost always requires that care-givers come in
> contact with the objects of care.
>
> *Care-receiving* recognizes that the object of care will respond to the care it
> receives… to know that caring needs have actually been met (Tronto,
> 1993, p. 106-8).

Tronto (1993) argues that there is a "gender, race, and class dimension to

care…[with] caring about, and taking care of, [being seen as] duties of the

powerful [and] care-giving and care-receiving are left to the less powerful"

(Tronto, 1993, p. 114).

In the case of the SSWs, since they did not physically provide care-giving

such as toileting, bathing, dressing, and feeding, did the participation of the

SSWs in various opportunities of continuing education allow the SSWs to be

involved in the process of "caring about"? Was providing resident-related

information to me and other healthcare workers, so we can change the care that

was provided by the care aides, an indication of their involvement in the process

of "taking care"? Did this contribute to the shift in the SSWs' identity to healthcare

workers?

Returning back to Wenger's (2005) work on developing communities of practice and legitimate peripheral participation, Fraser (1997, 1998, 2000) extends the work of Wenger by arguing for the importance of correcting maldistribution of resources to allow individuals to participate in such things as communities of practice. Fraser (1997, 1998, 2000) claims maldistribution results "when economic structures, property regimes, or labor markets deprive actors of the resources needed for full participation" (Fraser, 2000, p. 6). In other words, workers cannot participate peripherally or otherwise without a remedy for maldistribution. In the case of the SSWs, did the various interventions which increased education opportunities, flexible work schedules and opening up spaces to participate in serve as remedies for maldistribution to allow the SSWs to participate in the care planning process? Fraser (1997, 1998, 2000) further argues to achieve participatory parity, which she defines as the "condition of being a peer, of being on par with others, of standing on equal footing" (Fraser, 1998, p. 12) also requires a remedy for misrecognition. Misrecognition "is not simply to be thought ill of, looked down upon or devalued in others' attitudes, beliefs or representations. It is rather to be denied the status of full partnership in social interaction, as a consequence of institutionalized patterns of cultural value that constitute one as comparatively unworthy of respect or esteem" (Fraser, 2000, p. 4). In the case of the SSWs, once the maldistribution they were suffering from was corrected, did their participation in the care planning process serve as a remedy for reduced the misrecognition of the SSWs? Did the correction of maldistribution and misrecognition allow the SSWs to enjoy

participatory parity with the care worker in the care planning process shifting their identity towards that of healthcare workers?

<div align="center">Sergiovanni's Moral Leadership</div>

Returning to Sanders' (2004) work, the second important component for managing knowledge is the importance of strong leadership that creates enabling norms in the organization. Again, Sandars (2004) only touched on the importance of leadership. He argues,

> that the success of knowledge management strategies is to a large extent determined by the support from top and mid-level management. Leadership is essential to stimulate staff motivation to access the various sources of knowledge and to encourage staff to share their tacit knowledge (Sandars, 2004, p. 13).

As I read various leadership theories, I was most drawn to Sergiovanni's (1992) work on moral leadership. The work of Sergiovanni (1992) on reversing goal displacement, reducing trained incapacity and development of leadership substitutes provided insight into the role various interventions played allowing the SSWs to participate in the care planning process and explain my observations related to the SSWs positive shifts in attitude towards their work at the care home.

Sergiovanni argues for the reversal of both goal displacement and trained incapacity as a way to create organizational conditions that promote the consideration of moral imperatives in management decisions. Sergiovanni describes goal displacement as "the tendency [of organizations] to lose sight of their purposes, allowing instrumental processes and procedures to become ends in themselves" (Sergiovanni, 1992, p.5). To minimize goal displacement

Sergiovanni argues for the concept of purposing, which helps staff to understand for themselves and others why they do what they do and its connection to some larger purpose (Sergiovanni, 1992, p.73). Second, Sergiovanni describes trained incapacity as the "tendency to focus knowledge, attention, and skills so narrowly that [staff] become incapable of thinking and acting beyond their prescribed roles" (Sergiovanni, 1992, p.5). To minimize trained incapacity, Sergiovanni promotes the creation of overlapping and multidisciplinary teams, where staff members are aware of each other's duties and capabilities and have opportunities to share ideas and build relationships. This concept relates to Starratt's (1996) concept of connectedness, which is developing relationships with others and accepting the responsibilities in these relationships.

In the case of the SSWs, the completion of a specific and limited set of tasks became the primary purpose of their job. SSWs developed frustration when something impeded their ability to focus and complete their tasks, including participating in the care planning process in the beginning. In addition, as the tasks of the SSWs became more complex due to the increasing needs of the residents, the SSWs' focus was not only on tasks but specific tasks within their own job routines. For example, the dietary aides who worked morning shifts only knew what the resident required during their shift and no other shift. Did the various interventions, developed and implemented to involve the SSWs in the care planning process, facilitate the reversal of both goal displacement and trained incapacity?

Sergiovanni (1992) also speaks of four leadership substitutes in the workplace that a moral leader attempts to create to replace the 'follow me' type of leadership. These include developing: workplace norms, collegiality, professional ideals and intrinsically satisfying work. He argues that substitutes for leadership enhance self-management among staff and allows the leader to worry less

> about setting the direction and then engaging [staff] and others in a successful march (often known as planning, organizing, leading, motivating, and controlling), the 'leader' can focus more on removing obstacles, providing material and emotional support, taking care of the management details that make any journey easier, sharing in the comradeship of the march in the celebration when the journey is completed, and identifying a new, worthwhile destination for the next march. The march takes care of itself (Sergiovanni, 1992, p.43-44).

The first leadership substitute Sergiovanni presents is workplace norms and he suggests the development of these norms requires the creation of metaphors for what people do. Sergiovanni argues that "metaphors are important, for they frame the way we think about managing, leading, and they create the reality" in which staff perform their work (Sergiovanni, 1992, p. 45). Sergiovanni's example of viewing schools as instructional delivery systems creates metaphors of planning, delivering, monitoring and evaluating teaching versus viewing schools as learning communities which creates metaphors of relationships, shared values, purposes, collaboration and obligations. To develop these norms, the work of Fenstermacher (1990) on the importance of having a moral purpose to one's practice is relevant. Understanding the moral purpose facilitates the development of metaphors that capture that moral purpose. Sergiovanni's (1992) suggestion that moral purpose be built into the norms of an

organization would help keep it at the forefront and perhaps reduce the development of goal displacement. Did the interventions allow the SSWs and I to create new workplace norms serving as leadership substitutes?

The second substitute for leadership presented by Sergiovanni is collegiality. Sergiovanni distinguishes between collegiality and congeniality. He describes congeniality as friendly human connections characterized

> by loyalty, trust, and easy conversation among [staff], factors that often lead to the development of a closely knit social group. Collegiality, by contrast, is connected to the existence of norms and values that define the [workplace] as a community of like-minded people bonded in common commitment. Because of shared work goals and a common work identity, they feel obligated to work together for the common good (Sergiovanni, 1992, p. 91).

Sergiovanni argues the more collegiality becomes established "the more natural connections among people become and the more they become self-managed and self-led" (Sergiovanni, 1992, p.86). Further, Sergiovanni argues that to establish collegiality among staff, the need for time and space, mutual respect, and membership is essential.

Sergiovanni incorporates Johnson's (1990) argument for adequate amounts of time and space to achieve collegiality. Johnson concludes "poorly designed schedules, inadequate time…or the absence of meaningful subunits…can discourage new collegial ventures and undo existing ones" (Sergiovanni, 1992, p. 178). Johnson believes that these problems can be remedied by… "leaders who are serious about the value of collegiality…[by providing staff] sufficient time to meet…[develop] schedules arranged to

encourage rather than impede opportunities…to interact…[and modify] pace of [work] to permit reflection" (Sergiovanni, 1992, p.87).

The second component Sergiovanni argues as necessary for the development of collegiality is mutual respect.

> Respect, in this context, means mutual confidence in abilities and intentions [of people, which]…entails acting in ways that rely on [their] knowledge and competence. One who has respect for someone's special knowledge and skills will be confident that he or she will act knowledgeably and skillfully. Respect for a professional's commitment to professional ideals and standards also entails [a] kind of confidence – concerning not the person's capacities, but his or her intentions (Ihara, 1988, p.58 as cited in Sergiovanni, 1992, p.91-92).

The last component Sergiovanni presents for the development of collegiality involves the fulfillment of obligations that stem from memberships in various groups, teams and organizations. Professional and community memberships provide members with certain rights and privileges and exact certain obligations and duties. Members have the right to expect help and support from other members, and the obligation to give the same (Sergiovanni, 1992).

Here Sergiovanni's (1992) concept of collegiality complements Wenger's (2005) concept of communities of practice, which creates space for like-minded people to grow and learn, and foster Noddings' (1993) and Starratt's (1996) notions of developing deep caring relationships and accepting the responsibilities implicit in these relationships. Did I, as a leader of the SSWs, intervene in positive ways to help develop collegiality as a leadership substitute in the workplace through the interventions I implemented?

The third substitute for leadership Sergiovanni presents is professionalism, which is made up of two components, competence and virtue. Sergiovanni defines competence as having the necessary skills and continuous development of those skills through formal and informal training programs. The second component, which Sergiovanni emphasizes more, is the virtue side of professionalism, which means establishing a moral basis for practice. From my perspective, Sergiovanni (1992) combines parts of Noddings' (1993) importance of striving for competence, Fenstermacher's (1992) work on developing a moral purpose and Starratt's (1996) concept of transcendence, in other words, doing the right thing (competence), for the right reason (moral purpose) and for the overall right purpose (transcendence). Did the interventions allow the development of professionalism as a leadership substitute?

The fourth substitute for leadership presented by Sergiovanni is creating intrinsically satisfying work. This type of work is important because it "leads to higher levels of commitment and performance, [which] is the effectiveness side of the equation, [but also] it is right and good for [workers] to find their jobs satisfying and meaningful, [which] is the moral side of the equation" (Sergiovanni, 1992, p.65). Did the interventions allow the SSWs and I to modify our work to be able to derive intrinsic satisfaction from our work?

Using Sergiovanni's (1992) work, did my interventions decrease the goal displacement, reduce the trained incapacity and create leadership substitutes at the care home? To respond to these questions and to better understand my observations of the SSWs, I needed to hear the perspectives of the SSWs about

their experiences of participating in the various interventions and subsequently

the care planning process. As a result, the SSWs were invited to participate in

this study. I have detailed the methodology of how I collected data related to the

SSWs' experience in Chapter 3.

Workplace Alienation

After hearing the voices of the SSWs, it became apparent to me that the

SSWs' journey from pre-privatization to being involved in the care planning was

a process of diminishing alienation. Their alienation led me to reflect on my own

alienation at the care home during these same phases. As a result, it became

important for me to examine the alienation literature to understand alienation and

second to understand how the interventions to involve the SSWs contributed to

the process of diminishing alienation at the workplace. I also wanted to

understand whether the increasing sense of alienation among the SSWs during

the privatization process catalyzed their acceptance of and engagement with my

interventions facilitating their involvement in the care home.

In reviewing the alienation literature related to workplaces, I noted a few

important developments. First, the intensity with which alienation in the

workplace has been studied since the 1950s is important. The study of

workplace alienation "drew a lot of attention especially in the late 1960s and

early 1970s, on the heels of important works by Melvin Seeman (1959) and

Robert Blauner (1964)" (Shin, 2000, p. 7). "Publications focused explicitly on

labor alienation declined through the early 1980s, witnessed a small revival from

mid-1980s to mid-1990s, and have declined steadily ever since" (Damarin, 2005, p.4)

The second movement has been the divide that developed as a result of whether alienation should be conceptualized as an objective state or subjective experience. The view of alienation as an objective state builds on the concepts originally described by Karl Marx. The view of alienation as subjective experience emerges mainly from the works of Seeman (1959). Blauner (1964) attempted to narrow the divide by conceptualizing alienation as both the objective state and the subjective experience by combining the works of Marx and Seeman (1959). Despite this attempt,

> during the 1970s and 1980s, much of the work that was done on alienated labor came to depart significantly from Marx's analysis. There were heated conceptual and methodological debates…Is it an objective feature of the capitalist workplace, regardless of whether workers "feel" alienated or not? (Damarin, 2005, p, 4)

> In this regard a Marxist would argue

> it matters little whether people feel or say they are alienated since the assumption is that structures of capitalism determine the objective state of alienation… Subjectivity is not part of the analysis… People who claim to be satisfied and fulfilled at work are merely expressing a 'false consciousness': a failure to appreciate the objective reality of their position of subordination and exploitation (Noon and Blyton, 2007, p. 242).

Finally, some of the most recent research work on alienation continues to draw on alienation as conceptualized in the earlier works to make sense of various workplaces. Some of this work includes: Shin's (2000) study on the degree of alienation in post-industrial America, Mann's (2001), Case's (2008), Rintoul's (2009) studies in education, Damarin's (2005) study of alienation among web-designers and Tonks' and Nelson's (2008) study on the relationship

of human resources department and employee alienation. Following their

example, I too will draw on the earlier works in the process of developing a

conceptual framework for this study. The works of Marx's (1969), Seeman's

(1959, 1967, 1983), Blauner's (1964) and Kanungo's (1979, 1981, 1982, 1983,

1992) have been particularly insightful to understanding the sense of workplace

alienation among the SSWs.

Marx (1969) argued that workplace alienation was an inevitable part of the

industrial capitalist economy and is an inescapable objective state for all workers

(Noon and Blyton, 2007). He claimed workers had no control over their work

conditions, over the labor process and the workers labored "for the enrichment of

capitalist employers whose goal was maximizing profits through their

exploitation" (Shin, 2000, p. 9). Marx posited four dimensions of alienated labor:

alienation from product, from labor process, from others and from self. First, the

worker is alienated from the product of his own labor. Although the worker has

put in his effort and used his skills to make the product, he does not own it, it

belongs to the factory owners (Shin 2000, Mann 2001, Damarin 2005, Noon and

Blyton 2007).

> The alienation of the worker in his product means not only that his labor
> becomes an object, an external existence, but that it exists outside him,
> independently, as something alien to him, and that it becomes a power on
> its own confronting him; it means that the life which he has conferred on
> the object confronts him as something hostile and alien (Marx, 1969 as
> cited in Noon and Blyton, 2007, p. 239).

In the case of the SSWs, they are not producing products rather they are

providing services. However, if we extend the definition of product using

Wenger's (2005) notion of reification or making a "thing" of an experience we can

see the estrangement towards those products among the SSWs. For example, the SSWs are contributing to creating and fulfilling care plans of the residents but they did not feel part of the care planning process or any ownership of the care plans prior to the interventions. Therefore, as a result of the interventions, did the SSWs develop a sense of ownership of the care plans they were involved in?

Second, the worker is alienated from the work process, that is they have no say in what will be produced, how much will be produced, how it will be produced or when it will be produced. "A complex division of labor broke work into segments, reducing the role of any individual worker in the production process" (Erikson, 1998). As a result, the

> work is external to the worker, that is not part of his [*sic*] nature; and that, consequently, he [sic] does not fulfill himself [sic] in his work but denies himself [*sic*], has a feeling of misery rather than well-being, does not develop freely his [*sic*] mental and physical energies but is physically exhausted and mentally debased. The worker therefore feels himself [sic] at home only during his leisure time, whereas at work he [sic] feels homeless. His [sic] work is not voluntary but imposed, forced labor. It is not the satisfaction of a need, but only a means for satisfying other needs (Marx, 1844/1932 as cited in Kanungo, 1979 p. 121).

In the case of the SSWs, as mentioned earlier, the SSWs were mainly involved in providing a service for the residents who lived at the care home. The SSWs individualize the food, housekeeping and laundry services they provide based on resident needs, abilities and preferences as much as possible. As a result, the services provided by the SSWs cannot be standardized since the time, frequency and intensity of a particular service cannot not be predicted.

However, the SSWs' work was fragmented and they carried out only parts of the overall task. For example, the task of feeding a resident is a complex one

that includes steps from deciding what food to prepare, purchasing the ingredients, preparing the food, serving the food, feeding the residents as needed and monitoring the residents' ability to tolerate the food. However, this task is subdivided with various individuals carrying out only parts of the process. A similar work fragmentation argument could be made for laundry workers and housekeepers. In the case of the housekeepers and laundry workers, they are expected to clean the beds but not make them, they are responsible for sanitizing the building to minimize infectious outbreaks but have very little information on the active ingredients in the various cleaning chemicals or why a particular chemical is used for cleaning specific surfaces such as counter tops, table tops, handrails, floors and other surfaces. They have no involvement in the development of policies or procedures related to infection control and perhaps many have never seen or read the actual policy. Further, they clean up various bodily fluids but are not trained to monitor abnormalities of these fluids nor required to report their observations to the nurse.

Within this fragmentation there existed an hierarchy in which the group of women who worked as SSWs were worse off economically, more marginalized and more alienated than other women workers at the care home. This could be explained by what Pearlin (1962) called 'positional discrepancy' in his study of the nursing workforce at a mental hospital. He describes positional discrepancy as degrees of separation between the worker and the person who he or she believes to be the most influential in the organization. Pearlin (1962) gives the example of a care-aide who believes the doctor is the most influential as the

widest disparity and most alienating at the hospital. In the hierarchical structure of the hospital it would be a four-step disparity, since between the care-aide and the doctor there is the nursing supervisor, head nurse and the attendant. Pearlin (1962) argues that the more a worker sees their immediate supervisor as influential, the less alienated the worker will be because the worker will be able to influence their supervisor's activities and, indirectly, gain some control over their own work. The greater the positional disparity between the worker and who they believe is in-charge, the higher the level of alienation due to one's limited ability to influence supervisory decisions as they relate to ones work resulting in estrangement from the work process as described by Marx (1969).

Third, the worker is alienated from other individuals, that is "under capitalism all human relations are structured are distorted by class domination" (Damarin, 2005, p. 7). As a result, relationships are not between individuals but positions within the capitalist system. The design of the work is such that it forces competition among individuals and cooperation and companionship are discouraged (Shin 2000, Mann 2001, Damarin 2005, Noon and Blyton 2007).

Finally, the worker is alienated from self or what Marx terms "species being" where "work denies the self-actualization of the worker and the development of his or her full human potential" (Shin, 2000, p. 10). Marx believed that through work individuals should be able to express one's creativity and work should be a free and spontaneous activity. When work becomes forced and coerced, individuals are estranged from their very nature leading to self-estrangement (Shin 2000, Mann 2001, Damarin 2005, Noon and Blyton 2007).

In the case of the SSWs, their work was designed such that their routines were packed with tasks providing little time for anything beyond their tasks. Also, the SSWs had limited access to areas outside where they carried their core duties which confined and isolated them from interacting with workers from other departments during work. The SSWs' work is also considered the least important in the care home and is the most routinized with the least amount of discretion and I perceived my work the same way. Did the design of our work and being perceived as unimportant workers contribute to our estrangement from others and our own self as described by Marx?

In sum, Marx's theory emphasizes inevitable estranged relationships among products, labor processes, workers and the self in an industrial capitalist economy causing an objective state of alienation.

In the case of the SSWs, did the interventions provide individualizing of the services to the residents therefore avoiding standardization? Did the interventions allow the SSWs to be better able to see their roles in the overall task, or what Sergiovanni (1992) describes as the reduction in trained incapacity, therefore reducing the overall sense of work fragmentation? Finally, did my influence and the influence of the SSWs increase at the care homes as a result of the interventions through reduced positional discrepancy?

Although Marx's theory provides a powerful tool to understand worker experiences under industrial capitalism, however, its applicability to understanding the work experiences of the SSWs is stretched at best. Marx assumes that all work produces standardized products, the goal is to produce

products as cheap as possible, the means of production are owned and controlled by the capitalists and the only relationship that matters is between capitalists/owners and the workers (Damarin, 2005).

Further, for Marx the remedy for diminishing alienation would emerge from the collapse of the capitalist system. He believed that under the capitalist system, workers would be impoverished, unhappy, and unfulfilled, and as they became aware of their position within the system and aware of how to change it they would rise, perhaps with violence, and call for a social revolution. Marx believed that human beings could be complete or whole only when their actions were unregulated and uninhibited and that "social structures do not impede the innately creative and aesthetically curious dimensions of human nature" (Acevedo, 2005, p. 80). In other words, the worker needs to be in control of both his/her labor and the product of his/her labor. It has been over 150 years since Marx made these arguments, and we have yet to witness large-scale revolution in which workers rise up against the capitalist system and take over the means of production. However, it is important to mention here that unions have been at the forefront of efforts to reduce alienation and exploitation of workers and to help them gain greater autonomy and control over their work practices partially supporting Marx remedy for alienation.

Having said this, it is important to shift from Marx's conceptualization of alienation as an objective state to exploring conceptualization of alienation as a subjective experience as argued by several scholars for understanding the process of diminishing workplace alienation. Assuming that work has different

meanings for different individuals suggests it is inadequate to conceptualize alienation as only an objective condition and subjective experiences need to be considered (Noon and Blyton, 2007).

The study of subjective work alienation is grounded in the seminal work of Melvin Seeman (1959). The purpose of Seeman's (1959) model was "to make a more organized sense of one of the greatest traditions in sociological thought and make the traditional interest in alienation more amenable to sharp empirical statement" (Seeman, 1959, p. 783). Seeman (1959) presents five dimensions to examine alienation: powerlessness, meaninglessness, normlessness, isolation and self-estrangement. Blauner (1964) also uses these dimensions with similar definitions in his effort to build on Marx's objective conceptualization of alienation and Seeman's (1959) subjective conceptualization of alienation. Blauner (1964) however leaves out the dimension of normlessness "because of Seeman's difficulty in pinpointing the work-related roots of normlessness and also for its close conceptual to the notion of isolation" (Shin, 2000, p. 22). I will be presenting what Blauner (1964) identified as the modern day objective workplace conditions contributing to the development of each of the dimensions of alienation.

Seeman (1959) argues his dimension of powerlessless "can be conceived as the expectancy or probability held by the individual that his own behavior cannot determine the occurrence of the outcomes, or reinforcements, he seeks" (Seeman, 1959, p. 784). "This is the notion of alienation as it originated in the Marxian view of worker's condition in the capitalist society: the worker is alienated to the extent that the prerogative and means of decision are

expropriated by the ruling entrepreneurs" (Seeman, 1959, p. 784). Blauner

(1964) argues that the objective state of alienation results from workers being

controlled by other workers through impersonal systems such as technology.

Blauner (1964) looked at the amount of freedom the workers had to move around

in their workplace, determine the rate of work, quality and quantity of work. The

more freedom the worker had in these areas the less powerlessness they felt.

The second dimension, meaninglessness occurs as a result of the worker

not able to see how his involvement at work contributes to the production of the

final good. This results from the increasing specialization and division of labor.

> When the work process is broken down into simple minuscule tasks, and
> when such simple tasks involve no real responsibility and decision
> making, the work situation robs the worker of any sense of purpose. The
> job becomes meaningless for the worker (Kanungo, 1979, p. 123).

Blauner (1964) also looked at the level of standardization of products and

division of labor as the objective contributors to this dimension of alienation. The

meaninglessness dimension is related to Marx's ideas of estrangement from the

production process as a result of division of labor.

The third dimension, normlessness and fourth dimension isolation are

related. Normlessness is when there is "high expectancy that socially

unapproved behaviors are required to achieve given goals" (Seeman, 1959, p.

788). Normlessness occurs when one finds previously approved social norms are

no longer effective in guiding behavior for the attainment of personal goals and

one needs to achieve those goals through socially unapproved behavior. Since

one can no longer share the normative system, one may develop norms of his or

her own to guide behavior and as one's norms differ from those of others, the individual may eventually perceive oneself as being separate from society and its normative system. The dissociation of oneself from others results in the perception of social isolation. Blauner (1964) identified the lack of ability of workers to have conversations and interact at the workplace as an objective contributor to the dimension of isolation. He looked at the level of noise at the workplace, the distance at which the workers worked from each other, rules of talking while working and the level of bureaucracy at the workplace.

Finally, in Seeman's model, a person is self-estranged when he or she is engaged in activity that is not rewarding in itself, but is instrumental, a means to an end in satisfying extrinsic needs such as the needs for money, security, and so on. According to Seeman (1959) the degree to which one works for extrinsic-need satisfaction, is an index of self-estrangement. Blauner (1964) expands this definition by arguing that a job encourages self-estrangement if it does not provide the opportunity for expressing "unique abilities, potentialities, or personality of the worker" (Blauner, 1964, p. 26). For the objective conditions, Blauner (1964) looked at the opportunities of growth and development that were present and the degree to which the above three dimensions of alienation were minimized.

In our case, as we became significantly more involved in many different types of decision-making processes did our sense of power change? Did the new ways of doing our jobs change the meaning of our work? Did being part of the problem-solving processes allow us to demonstrate our unique abilities and

reduce our sense of self-estrangement? Did being more involved at the care home in activities outside our core duties and increased communication with other workers reduce our sense of normlessness and isolation? Did the interventions help diminish our sense of alienation?

As mentioned earlier, there has been a steady decline in the amount of research investigating alienation at the workplace. However, interest in how to reduce alienation has not disappeared; instead, an emerging body of literature de-emphasizes the discourse of 'alienation' and 'diminishing alienation' and instead, emphasizes management of workplace identity and identification with the organization. That said, concepts such as worker empowerment, upskilling, innovation, job enrichment, participatory decision-making, egalitarian workplaces, quality improvement programs and identity management are still centered around minimizing workplace alienation (Kanungo, 1992, Barker 1998, Damarin, 2005). However, "the primary purpose of managerialism is economic efficiency or pursuit of maximum output with minimum inputs" (Edward, 2010 p.5). These management techniques do not have a moral imperative built into them for the growth and development of workers. Therefore, within most of the management literature, diminishing alienation in the workplace and empowerment of workers is not a moral end in itself, but a means to achieving an economic end. To understand the concept of the manager's moral imperative in the process of diminishing alienation, Kanungo's (1992) work on the motivational approach to diminishing alienation was insightful.

Kanungo (1992, p. 419) takes the approach that a manager has a moral obligation to workers to "promote their capabilities". He argues manager's obligation should "not stem from the pragmatic considerations of the bottom line or similar organizational interests" (Kanungo, 1992, p. 420). Kanungo (1992) states, "to human beings, work is more than a means of earning one's livelihood. It is an essential means of self-development…[and] work acquires its value from the dignity of the human being as a 'person'… work, should, therefore promote rather than damage the dignity of the human being" (Kanungo, 1992, p. 419-20). As a result, a manager should "not regard employees as mere instruments in the production process" (Kanungo, 1992, p. 420).

Kanungo (1979, 1981, 1982, 1983) builds on Seeman's (1959) conceptualization of alienation by reconceptualizing each of the components of alienation using motivational terminology and calling this the "motivational approach" diminishing alienation. He further introduces the concept of 'work involvement' as the opposite of work alienation. Kanungo (1979, 1981, 1982, 1983) moves in this direction because he perceives a strong cultural bias in the existing alienation models used in the Western world. He argues that alienation due to lack of autonomy and lack of control or power, which are assumed to be the causes of alienation in current Western models, are not applicable to individuals coming from Eastern or collective societies. This is particularly important in Canada, which is increasingly multicultural.

Kanungo further argues that current models have created a significant level of confusion in operationalizing the concept of alienation for empirical

studies. He attributes much of the confusion to the different ways sociologists and psychologists have conceptualized alienation.

> Sociological and psychological explanations of the phenomena seem to run parallel courses of their own without any serious attempt at integration. In fact, if one puts together the various explanations of the phenomena advanced by these writers, one ends up with greater conceptual fuzziness rather than clarity or understanding (Kanungo, 1979, p. 119).

As a result, some sources of confusion include: application of alienation sometimes to groups and other times to individuals, sometimes to objective social conditions and other times to subjective psychological states. Further, there is no separation between the causes of alienation, the state of alienation and the effects of alienation; they are all combined into one single measurement tool producing questionable data. There is also no effort made to distinguish between the cognitive (belief) and affective (feeling) state of the individual in regards to alienation. Finally, there is confusion between the two kinds of causation of alienation, historical or past history and contemporaneous or present experiences at work (Kanungo, 1979).

In proposing the motivational framework, Kanungo hopes to clarify these sources of confusion. Kanungo's approach identifies the state of alienation as a cognitive belief state of the individual. His approach redefines the components of alienation described by Seeman (1959).

> In defining the concepts [alienation and involvement], the motivational approach views alienation as a cognitive state of psychological separation and involvement as a cognitive state of psychological identification. The state of alienation or involvement results from the perceived potential of the contexts (work, job, and organization) to frustrate or satisfy a person's salient needs and expectations of outcomes, be they intrinsic or extrinsic. At any given moment the need saliency within people depends on their

previous socialization process and on the perceived potential of the job environment to satisfy their needs. The saliency or the importance of different intrinsic or extrinsic needs for individuals is determined by their past experiences with groups of which they were members (cultural influence) and with jobs that they have held (Kanungo, 1983, p. 133-134).

As described earlier, Seeman (1959) presented five different components of work alienation: powerlessness, meaninglessness, normlessness, isolation and self-estrangement. Kanungo argues that each component refers to a different subjectively felt psychological state of the individual caused by different environmental conditions. He redefines these components in motivational terms since each one represents a situation that frustrates some salient need of the individual worker.

Isolation becomes alienating for workers who have a salient need for a sense of belonging and they find their work not able to satisfy this need. Normlessness becomes alienating for workers who need feedback and information to evaluate their current performance and be able to change it as needed in the future. A worker who has a salient need for information may feel normlessness when they do not know how performance is appraised and rewards administered. This may be alienating particularly for workers who have high achievement needs. Meaninglessness may be alienating for individuals with a salient need for personal responsibility. When the work is broken down to simple tasks the worker may be robbed of having to exercise any real responsibility. Kanungo (1979, 1981, 1982, 1983) argues that powerlessness becomes alienating for those workers with a salient need for autonomy, control and self-esteem but find their work incapable of fulfilling these needs. According

to Kanungo, self-estrangement at work is experienced by people who have high salient self-actualization needs such as the need for achievement, and who find the work situation limits the realization of their potential.

Dickson (1981), who agrees with Kanungo's motivational framework for diminishing alienation, adds to its operationalization that a worker first must become aware of his or her salient workplace needs and expectations and have them well articulated and, secondly the worker must be able to conceptualize activities at their workplace that can fulfill these needs and expectations. Managers and organizations need to take a lead on having conversations that uncover the workplace needs of workers and make the commitment to the employees to help meet those needs. Further, the organization and the managers then need to take the responsibility to make organizational changes allowing workers to be able have their salient needs met at work.

Kanungo (1992) also argues that managers need to focus on the moral justifications of managerial techniques to avoid manipulation and exploitation of the workers in the process of determining their salient needs and modifying the workplace accordingly. Kanungo is particularly interested in the concept of worker empowerment. Conger and Kanungo (1988) propose that empowerment be viewed as a motivational construct to enable workers rather than simply a means for delegating tasks. Enabling is defined as creating the necessary conditions which increase the motivation for task accomplishment through the development of a strong sense of personal capability. "The moral justification for empowerment strategies lies in viewing empowerment as an enabling, rather

than as a delegating process", which allows the growth and development of the worker (Kanungo, 1992, p.418).

Conger and Kanungo (1988) have proposed a model that might help managers develop effective empowerment strategies. The first step is the diagnosis of conditions within the organization that are responsible for feelings of the powerlessness among workers. The second step is the use of empowerment strategies such as participative management, goal setting and modeling for not only removing some of the external conditions responsible for alienation but, more importantly, but also aimed at providing workers with self-efficacy. A number of management practices can be identified that can heighten a sense of self-efficacy among workers. Kanungo argues that at the organizational level, selection and training procedures can be designed to ensure the right individual is selected and receives the proper orientation to the company. The company philosophy and culture should emphasize values and norms such as: self-determination, collaboration rather than conflict or competition, high performance standards, non-discrimination, and meritocracy. Reward systems should be designed to emphasize innovative performance, high levels of performance, contingent and valued rewards. Jobs should be designed to provide task variety, personal relevance, appropriate autonomy and control, low levels of established routines and rules, and high advancement prospects. At an interpersonal level, management should express confidence in workers accompanied by high performance expectations, encourage worker participation in decision-making,

provide autonomy from bureaucratic constraint and set inspirational and/or

meaningful goals (Kanungo, 1992)

> As a result of receiving self-efficacy information from the management
> practices outlined above, workers feel empowered, that is, the belief in
> their own capabilities is strengthened, or the belief in their powerlessness
> is weakened. The behavioral effects of empowerment as a de-alienating
> experience results in workers, both initiating and persevering in work
> behavior, and thereby makes the quality of their work life more rich, active
> and dynamic" (Kanungo, 1992 p. 419).

Kanungo (1992) does not use the language of relationships and caring

like authors such as Noddings (1993), Starratt (1996) and Sergiovanni (1992).

Nevertheless, Kanungo strongly suggests the need for ethical imperatives for the

manager to empower his or her subordinates for reasons well beyond the

practical considerations of the bottom line. In other words, he argues, the

manager has the moral obligation to empower his/her subordinates and, thereby,

promote their growth and development to the limits of their capabilities, even if

such development leads to the employee leaving the organization to join its

competitors. In other words, what is important is to be concerned about the well-

being of the workers and make efforts to help them maximize their potential.

By emphasizing the moral purpose of management decision making and

action, Kanungo's (1992) work is, in my view, compatible with, and even

complementary to, the works of Sergiovanni (1992), Wenger (2005),

Fenstermacher (1990), Starratt (1996) and Noddings (1993).

Kanungo's emphasis on empowerment of workers and the moral

obligation of the manager are suggestive of the need of moral leadership to

change organizational conditions and reduce workplace alienation. This notion is

supported by the work of Sergiovanni (1992) who speaks about reducing goal displacement, trained incapacity and creating an organization that has built in leadership substitutes. It is also supported by the work of Wenger (2005) who talks about communities of practice that create space and opportunities to help each employee grow and reach their maximum capability. Kanungo's work also complements the work of Fenstermacher (1990) on the importance of having a moral purpose, Starratt's (1996) emphasis on autonomy, connectedness and transcendence, and Noddings' (1993) ethic-of-care. All these concepts are necessary, in my view, to create conditions to grow workers in the pursuit of some form of excellence without regard to the bottom line or fearing the worker will become over qualified and leave for another job. The common theme is that morally-driven, caring environments that emphasize the importance of relationships and provide opportunities for all workers to grow and succeed are less alienating.

 In the case of the SSWs and I, did the various interventions allow us to clarify our workplace needs and facilitate the modification of our workplace to meet those needs? Did the interventions empower and create an enabling workplace?

Chapter Summary

My review of the literature helped me develop insights and raise questions to understand my informal observations of the SSWs' shift from being unhappy and angry to being happy, satisfied, engaged at the care home, developing positive relationships with their co-workers and demonstrating a strong

commitment and obligation to the well being of the residents. As I made my journey through the literature, I noticed some common themes emerging and natural connections developing between the different bodies of literature. I started with the moral literature and then shifted into knowledge management literature. From here I went to explore the concepts of communities of practice and identity and finally ended at the alienation literature. It is evident to me that the workplace alienation literature has important connections to the moral leadership literature and the application of these bodies of literature leads to the development of new identities as workers are supported to be all they can be.

Synthesizing the literature, I learned that developing a moral basis to one's work is an important process as described by Fenstermacher (1990). Having a moral purpose allows the development of mutually caring relationships as described by Noddings (1993) disrupting the rigid, power-laden and alienating hierarchies that exist. The state of reduced hierarchy gives way to the development of communities of practice with more individuals feeling part of the core of the practice rather than just visiting at the peripheries as described by Wenger (2005). This begins to reshape the work structures and gives away to new ways of doing work in new settings. When communities of practice operate with a sense of moral purpose as described by Fenstermacher (1990), they allow for the growth and development of all members and demand pursuit of excellence. The new ways of doing work allow previously misrecognized workers to be recognized and the shift in resources to allow participation corrects the maldistribution leading to participatory parity as described by Fraser (1997, 1998,

2000). The new ways of doing work also allow new identity formation as described by Wenger (2005) and identity management through reframing, refocusing and recalibrating as described by Ashforth and Kreiner (1999). Participating in an egalitarian workplace that increases ones influence at the worksite and allows one to fulfill their salient workplace needs decreases the sense of alienation as described by Kanungo (1979, 1981, 1982, 1983). Finally, the manager plays an important role in designing work such that it enables workers to self-actualize and has a moral commitment to do so as described by Sergiovanni (1992) and Kanungo (1992).

Having developed these understandings, I wanted to examine my own experiences and those of the SSWs in a more systematic and rigorous manner. The next chapter describes the methodology and methods I used to achieve this.

CHAPTER 3 – RESEARCH METHODOLOGY AND DESIGN

Research Paradigm and Approach

In view of the purpose of this study, the qualitative research paradigm and

the interpretative case study approach within this paradigm is an appropriate

selection. Various scholars have attempted to define qualitative research. In my

view, a good generic definition is offered by Denzin and Lincoln (2005).

> Qualitative research is a situated activity that locates the observer in the
> world. It consists of a set of interpretive, material practices that make the
> world visible. These practices transform the world. They turn the world
> into a series of representations, including field notes, interviews,
> conversation, photographs, recordings, and memos to self. At this level,
> qualitative researchers study things in their natural settings, attempting to
> make sense of, or interpret, phenomena in terms of meanings people
> bring to them (p. 3)

In other words, researchers enter the world of research participants and attempt

to understand a phenomenon through various methods such as observations or

interviews. In this study, I was interested in understanding the SSWs'

experiences of the journey they have been through -- from having their jobs

privatized with a significant decrease in wages and benefits and having their

responsibilities increased, to being involved in the care planning process and

demonstrating a significant amount of satisfaction from their work. I wanted to

understand what was happening with the SSWs.

It is important to highlight my understandings of some of the strengths,

weaknesses, assumptions and critiques of the qualitative paradigm. "No single

research method is inherently superior to any other; rather the appropriateness

of the method must be appraised in relation to the research question" (Jootun,

McGhee, and Marland, 2009, p. 42). The research questions of this study could be best answered through a qualitative study as the research questions are designed to understand and make meaning of what was happening with the SSWs and myself as their leader in the context of privatization in healthcare.

The goals of qualitative research are to understand and make meaning of a phenomenon, the design is flexible and emergent, the research is carried out in natural and familiar settings, samples are small and purposive, the researcher is the primary instrument for data collection and findings are presented in a holistic and comprehensive manner that is richly descriptive. The ontological assumption is that reality is holistic, multidimensional, and ever-changing, and it could be understood from multiple perspectives and multiple personal interactions and therefore is highly subjective and requires interpreting rather than measuring (Merriam, 1988).

Since the purpose of the current study was to understand the experiences of the SSWs, I needed to hear each SSW's story. These stories provided richly descriptive data, which allowed me to develop insights into how the SSWs made sense of their experiences. Further, I did not have a theory or hypothesis which I was testing, rather I took an inductive approach which required the design of the study to be flexible to allow the research strategies to be adapted as insights were gained as the study progressed. Finally, I needed to reflect on my own experiences and perspectives during the same period.

Interpretive Case Study

Within the qualitative paradigm, the current study was conducted using the interpretative case study approach. Interpretive case study is less of a methodological choice than choosing 'what' to study. The 'what' is a bounded system with finite qualities of time, space, and components comprising the case (Merriam, 2002). "A case study is an examination of a specific phenomenon such as a program, an event, a person, a process, an institution, or a social group" (Merriam, 1988, p. 9). A case study researcher gathers as much information as needed to be able to theorize about the phenomena.

This approach lends itself to the current study as I am interested in understanding the SSWs' experiences and my own experiences. An interpretative case study allows for in-depth exploration and interpretation of a phenomenon, and provides information that is vivid, concrete, sensory and contextual. Case studies also provide insights which expand the reader's knowledge and the reader can extend their interpretation to the reference population and beyond, thus extending the applicability of the case to other cases. This can occur through the concept of naturalistic generalization advocated by Robert Stake (1994) or a similar concept of transferability advocated by Lincoln and Guba (2000). Hellstrom (2008) summarizes the concepts of naturalistic generalization or transferability as

> principles for assessing how well the results from one context or case
> applies to another, that is without assuming that this relationship can be
> captured in a universal valid, axiomatic form… The reader of the case
> study should be able, on the basis of a thick description and the provision
> of a vicarious experiential account, to determine if and how these
> experiences can be used to understand a new setting… So, the 'burden of

generalizing' is not placed on the researcher producing the first case description, but on those trying to apply these constructions in their own circumstances, whether as a theoretical framework for a new study, or in real life setting (Hellstrom, 2008, p. 324).

Further, the case study could also be used to construct tentative hypotheses to help structure future research. The insights and understandings from case studies can be used to improve practice particularly if a new or innovative program is being studied.

In this study, I have provided detailed descriptions of both the interventions I developed and implemented in chapter four. I have also provided details of how the data was collected and analyzed later in this chapter. Finally, I have provided my assumptions underpinning this study and have taken a reflexive approach to clarify my thinking. These steps should facilitate the applicability of this study to other similar settings.

Some limitations of case studies include potential oversimplification or exaggeration of a phenomenon, which could lead to erroneous conclusions drawn by the reader. There is the risk that the case is presented as a whole when in fact the data only represent a part of the whole. There are also risks of unethical behavior by the researcher by selecting only data that supports what the researcher wishes the outcome to be and, therefore, the sensitivity and integrity of the researcher are important and must be established. Finally, the reliability and validity remain as limitations in case studies. In this study every step will be taken to provide a transparent account to enhance the trustworthiness of this study (Merriam, 2002). These steps are discussed later in the chapter.

Research Design

Setting

This study took place at a 76 bed, not-for-profit, publicly funded care home in British Columbia, Canada. The jobs of the SSWs at this care home were privatized in March 2003. There were 16 permanent part-time and full-time SSWs and 4 casual SSWs employed by the private company, ten of whom worked for the care home prior to the privatization process.

In addition to the SSWs jobs, the maintenance department was privatized to another private company in May 2003. In September 2003 both the care and recreation aides' work was privatized to a third private company. The only two departments that are currently staffed directly by the care home are the nursing department and the administrative department. In other words, the individuals who work at the care home, work for one of four different companies operating at the care home, which created very complex working relationships.

Recruitment and Selection of Study Participants

The sample for this study was recruited from SSWs who were employed prior to September 2003 with the private company and had gone through the privatization process. This date was used as a cut-off as this is when the first intervention was implemented and this was the date the privatization of the care services was also completed. This cut-off date made this study open to only those individuals who had been working at the care home and had participated in the initial dementia workshop I delivered in September 2003. These individuals

were able to share with me their experiences prior to the interventions and after the interventions as well as their experiences of privatization. Under this requirement ten SSWs qualified to participate. Initially there were nine participants in the study, however, one participant dropped out of the study after the first focus group leaving eight participants who completed the entire data collection process.

To reduce the potential for coercion and ensure the participation of research participants was voluntary, a third-party facilitator was hired to take responsibility for the recruitment and interview processes. Flyers were used to recruit participants. The SSWs were clearly informed through the recruitment flyer and the consent form that there was no pressure or obligation for them to participate and if they did participate they could withdraw from the study at anytime without any negative consequences.

Profile of the Participants

The participants of this study were all Caucasian women. The age range of the group was between 38 and 55 years with the majority of the participants in the late 40s. All women had completed a high school diploma and some had taken additional training at their previous workplaces. All the participants were married and had children. All the participants lived in the same community in which the care home was located. The range of years at the care home for these participants was 5 to 20 years with an average of about 8 years.

Ethical Considerations

Approval was obtained from the university's ethical review board for this study (see Appendix A). All efforts were made to protect the rights of the participants and inform them of the level of anonymity and confidentiality that would be provided. Even though my leadership style is one of collaboration and coaching, in which I minimize hierarchy, there still exists a power differential. To ensure the ethical principles established by the Tri-Council were fully maintained, a third-party facilitator who had no relationship with me or with the potential participants of this study was hired and was responsible for recruiting participants, carrying out both group interviews and individual interviews, transcribing the interviews, revising transcripts with feedback from the participants and removing all information that would identify the participants. In addition, the third-party facilitator directly provided all the consent forms and the audiotapes to the research supervisor for secure storage at the university. My ability to identify participants was minimized as a result of not having any direct involvement in the recruitment, data collection or transcription processes and no access to the consent forms and the audiotapes. Despite the attempts to maintain participant confidentiality and anonymity, due to my close working relationship with the SSWs, there was a risk of me being able to identity some participants from their style of speaking or from the stories they shared. However, the third-party facilitator repeatedly reminded research participants that their participation was voluntary.

In addition, as described by Coupal (2003), face-to-face contact in participant recruitment was avoided in favor of open invitations for volunteer participation (Coupal, 2003). A flyer was placed in the communication books of the SSWs with information about the research study, who qualified to participate, time commitment to the study, the time and location of the first focus group session and how to contact the third-party facilitator to participate in the study. Along with the flyer, the consent form and the focus group interview questions were made available next to the communication book (see Appendix B and Appendix C). The interested individuals were able to pick up a copy of the consent form and the focus group interview questions and were asked to return a signed copy of the consent form in a sealed envelope at the focus group meeting and submit it to the third-party facilitator. The facilitator delivered the consent forms to the research supervisor at the university. It was stressed in the consent form that there was no pressure or obligation on the SSWs who qualified to participate in the study and that participation or non-participation was completely voluntary and had no effect on their work in any way. It was also stated in the consent form that participants had the right to refuse participation at anytime during the study and that they could withdraw at any point without any consequences or penalty. The third-party facilitator was instructed to verbally review the purpose of informed consent and the above rights with the participants prior to beginning the focus group interview session.

Training of the Third-party Facilitator

The third-party facilitator had a master's degree in education, had recently taken a course in research methods and had completed a two-hour tutorial in research ethics on the Office of Research Services website. I provided the third-party facilitator with a copy of the research proposal and provided a detailed overview of the study. I explained to the third-party facilitator her responsibilities, which included: collection of consent forms and submission of the same to the research supervisor, data collection (two focus group interviews, and up to ten individual interviews), verbatim transcription of all interview data, return of transcripts to the participants for feedback on accuracy and comprehensiveness of what was stated in the interviews, removal from the transcripts any references to individual names or type of work they do to protect the identity of the participants, and forwarding the audio tapes after transcription to the research supervisor. Those participants who could not attend the second focus group interview had the option to provide additional written feedback on the transcripts they were provided. No participant chose this option as all participated in the second focus group interview.

I shared with the third-party facilitator the type of settings that have been successful for me when involving the SSWs in an interview process. This included the use of the boardroom of the care home. The boardroom, a private room, located on the second floor of the care home that housed all the offices, was used to conduct the focus groups. The setting was made as comfortable and as informal as possible through arranging the seating close together in a circle, providing snacks and beverages, and using the first few minutes of the

focus group meeting for small talk. The third-party facilitator was instructed to use question-asking strategies such as responding with an "'uh-huh' or a nod of the head to encourage the person to continue talking, reflecting back what the participant just said to encourage talking, or asking for more information on a particular topic" (Jacob, 1987 as cited in Stainback and Stainback, 1988 p. 52). However, at the same time, I reminded the third-party facilitator that she would have to be very careful not to bias the SSWs by any evaluative responses through either agreement or rejection of their responses. The third-party facilitator was flexible in the group interviewing approach and used open-ended questions while avoiding closed questions. She was asked to use, when necessary, interview responses to determine further questioning aimed at expanding or deepening the information that was being presented.

Finally, I had the facilitator practice the focus group and individual interview questions with me. I also met with the facilitator after two individual interviews had been conducted to discuss how the interviews were going and how well the questions were being received by the participants. From the review of the first two individual interviews, I felt the questions were being well received and did not require any revision.

Anonymity and Confidentiality

In addition to informing the participants of their rights in the consent form, the third-party facilitator was instructed to explain to the participants the extent to which the anonymity and confidentiality of the participants would be protected. The third-party facilitator pointed out to the participants, as suggested by Hockley

and Froggatt (2006), that risk of breach of anonymity and confidentiality exists if some participants choose not to respect the anonymity and confidentiality of other participants and the third-party facilitator will have very little control over this type of breach. The meaning of anonymity and confidentiality was explained to all the participants and participants were asked to respect each other's anonymity and confidentially when interacting with others beyond the participants of the study. Further to this, the participants were told that their real names would not be used and all information such as job titles, departments or work tasks that could identify them will be removed prior to submitting the transcripts to the researcher. In addition, neither names of participants nor the name of the care home would appear in the final report. The third-party facilitator was also instructed to inform the participants that all data would be stored in a locked cabinet in the office of the university supervisor and the copies on the computer will be protected by a password. No one other than the research committee members had access to the data.

To further maintain the anonymity of the participants, I was not present in the building on the days the focus group interview and the individual interviews were scheduled. I requested that the third-party facilitator attempt to cluster the individual interviews in ways that reduce the number of days this process would take. I asked the facilitator to notify me two days in advance of those days when interviews were scheduled. I made arrangements for the facilitator to have access to the building and the boardroom on the days of the interviews and made arrangements for the refreshments. The third-party facilitator was able to

conduct the two focus group and eight individual interviews in five days spread

over a three week period from February 19, 2008 to March 11, 2008.

Data Collection

In this study, there were two sources of data. One source is my own

reflections on my leadership practices and the other source was the focus group

and individual interviews with the SSWs. To systematically reflect on my practice

and my actions, I used the work of Mezirow (1991) who

> distinguishes between three kinds of reflections: on content, process and
> premises. In clarifying the distinction between them he contends: 'We may
> reflect on the content or description of the a problem…, the process or
> method of our problem solving, or the premise(s) upon which the problem
> is predicated'. Simply put, when engaged in content reflection we ask
> 'what do I know?' and when involved in process reflection we ask 'how do
> I know my method of problem-solving works/if I am effective with what I
> do?'. Finally, when engaged in premise reflection we question the
> presuppositions underlying our knowledge. We… ask 'why does it matter
> that I attend to this problem, does it matter that I chose this problem, is
> there an alternative?' (Mezirow, 1991, p. 17).

Kreber (2004) draws on the work of Mezirow (1991) and distinguishes between

different levels of reflective thinking which progress from descriptive to analytical

and critical. The extent to which personal meaning making and the development

of new perspectives are evident, deepen with each level (Kreber, 2004).

As I began to reflect on my leadership practices, I first put all the events

and interventions that had occurred from when I began my job in January 2002

to the end of the study period in April 2008 in chronological order. After this step,

I reflected and described these events in terms of what I was thinking at that time

and how I was feeling. I subsequently reflected and described what concerns or

problems I was trying to resolve and the actions I took which increased the

richness of the chronological events. I then turned to the literature to further make sense of my experiences and be able to understand the broader changes that were emerging and critically analyze the ethics of my actions. Finally, through the process of reflexivity, I was able to critique my actions and thoughts to make more clear my thoughts and perspectives during the various events and interventions and the shifts in my thinking that occurred. This process allowed me to present a comprehensive account of my experiences at the care home. This data and its analysis are presented in Chapter Four.

As noted, the data related to the SSWs experience was collected in three phases by a third-party facilitator. The first phase was a focus group consisting of eight participants who met for approximately 90 minutes. Prior to coming to the focus group session each participant was given a copy of the focus group questions to think about. The second phase of the study included individual interviews, each one being approximately 60 minutes in length. The third phase of the study was an optional 90 minutes follow-up focus group session where the third-party facilitator solicited feedback from the participants related the previously collected data. Each session was audio taped and transcribed by the third-party facilitator.

For both focus groups there were six main questions with some sub-questions. The first three questions related to the SSWs' experience prior to privatization and during the privatization process. The last three questions related to the experiences of the SSWs after the privatization and their involvement in the various interventions aimed to increase their involvement in

the care planning process (see Appendix D). The individual interviews consisted of ten questions related to the SSWs' experience prior to, during and after privatization (see Appendix E).

A focus group interview was an appropriate first approach for this group of workers since much of the work that was carried out to involve the SSWs in the various interventions involved group learning and discussion and were familiar processes to the workers. In addition, this method was appropriate because the focus group interview method assumes that an individual's attitudes and beliefs do not form in a vacuum. People often need to listen to others' opinions and understandings in order to form their own. This can also help stimulate or trigger individuals to recall other related points that further make the focus group interview generative.

> Some disadvantages of focus group interviews are that the facilitator:
>
> has less control over a group interview than an individual interview, which can result in lost time while dead-end or irrelevant issues are discussed; the [group interview also] requires the use of special room arrangements and highly trained observer moderators; the groups can vary a great deal and can be hard to assemble; and finally, there are logistical problems arising from the need to manage a conversation while getting good quality data (Marshall & Rossman, 1999 p. 115).

Further, the group dynamic could impact the discussion if one participant dominates the discussion or participants are uncomfortable speaking because they may perceive their comments will not be kept confidential. In addition, in focus group interviews, there is the risk of group-think developing or hierarchies developing which reduce the amount of data shared by the participants (Hennik,

2007). The facilitator has to have the skills necessary to manage a group of people and also create a setting that is conducive to allow all participants to be able to express their thoughts and opinions.

My experience with the SSWs has been that they rely on each other to present and develop their ideas. I had seen their confidence level increase when they are together and their ability to disagree and challenge ideas is greater, leading to richer and deeper discussions. Conducting the focus group interview first enhanced the one-to-one interviews as participants had heard from other participants during the first focus group and possibly had reflected on their own experiences after that. In this study the focus group interview also oriented the third-party facilitator to the overall experiences of the participants, which improved the third-party facilitator's ability to probe for additional information at the individual interviews. When individual interviews are conducted after a focus group, data that was not completely collected in the focus group could be collected in the one-to-one interviews. Some advantages of individual interviews over focus groups alone include:

> some people will be more shy than others in expressing their opinions publicly; people with more extreme or unique views may be reluctant to expose them to possible ridicule; and people will undoubtedly be more concerned about maintaining their image in a public setting than in a one-to-one interview (Palys, 1997 p. 157).

For these types of participants the individual interview opportunity will allow them to express themselves. Further, during individual interviews one participant's opinion does not influence others' as could be the case in a focus group. The interviewer can ask more probing questions for more in-depth responses.

However, there are some disadvantages of individual interviews such as the individual feeling that he or she is under a microscope and therefore being uncomfortable with the process. The individual also may not be able to articulate their thoughts without some triggers they would get in a focus group. In this study, I have combined the focus group interviews with individual interviews to minimize the shortcomings of one over the other.

Further, I suspected most of the participants had not reflected on their experiences and more than five years had passed since the privatization of their jobs and first intervention to involve them in the care planning process. The intent of providing the focus group interview questions in advance was to create space and time for the participants to reflect on their experience. As a result the participants engaged in a deeper and richer discussion regarding their experiences during both the focus group session and individual interviews. This reflection in advance reduced the pressure on the participants to think on the spot and helped them feel more comfortable and confident of their responses. Further, this reflection in advance allowed the participants time to think about their more challenging experiences and have an opportunity to frame those experiences in their own words.

Data Analysis

Data analysis is the process of bringing order, structure, and interpretation to the mass of collected data. Qualitative data analysis is a search for general statements about relationships among categories of data. In qualitative studies, data collection and analysis typically go hand in hand to build a coherent interpretation of the data (Marshall and Rossman, 1999 p. 150-151).

Creswell (1994), Hammersley (1995), Merriam (2002) are in agreement that data analysis should occur simultaneously with data collection and data interpretation. Hammersley (1995, p. 205) admits, "this commitment to a dialectical interaction between data collaboration and data analysis is not easy to sustain in practice". This was even more difficult for me to do as I was not involved in the process of collecting data from the SSWs. However, I did have access to the transcripts after the participants had checked them and made and all necessary changes. Since the data was collected over a short period of time, it was not always possible to seek additional clarification where needed from specific participants. However, I was able to add additional questions to the final focus group interview to seek clarification. Further, there was little information in the transcripts related to body language, emotions and the atmosphere of the interview, which are important components in the process of data analysis that were missing in this case and will be a limitation of this study.

I used the data analysis guidelines developed by Creswell (1994), Hammersley (1995) and Marshall and Rossman (1999) to analyze my data. Hammersley (1995) suggests, "the first step in the process of analysis is… a careful reading (indeed probably several readings of the corpus of data in order to become familiar with it. At this stage the aim is to use the data to think with" (Hammersly, 1995, p. 210). He suggests looking for interesting patterns, surprising or puzzling pieces of data and how data relates to what was expected as a result of common sense, theory and whether there are contradictions or inconsistencies. Hammersley (1995) using the work of Blumer (1954) explains

that the next step in the data analysis process is to begin searching for

'sensitizing concepts' the purpose of which is to "give the user a general sense of

reference and guidelines in approaching empirical instances… [in other words]

sensitizing concepts merely suggest directions along which to look" (Hammersly,

1995, p. 212). As the data analysis continues and the sensitizing concepts are

investigated and defined, this will lead to the emergence of 'definitive concepts',

which provide more clear definition of what the data is suggesting. The next step

is to take the definitive concepts that are central and begin "clarifying their

meaning and explaining their relations with other categories" (p. 213).

> One strategy here is what Glaser and Strauss (1967) call the 'constant
> comparative method'. In this procedure the analyst examines each item of
> data coded in terms of a particular category, and notes its similarities with
> and differences to other data that have been similarly categorized. This
> may lead to vaguely understood categories being differentiated into
> several more clearly defined ones, as well as to specification of sub-
> categories. In this way, new categories or sub-categories emerge and
> there may be a considerable amount of reassignment of data among the
> categories (p. 213).

Creswell (1994) and Marshall and Rossman (1999) present a similar process for

analyzing data but explicitly suggest that during data analysis the researcher

needs to be able to search for alternative explanations especially when there are

pieces of data that are not being supported by the emerging themes and

patterns.

In the current study, to analyze the data, I started with the transcript of the

first focus group. I read the transcript several times to develop a good

understanding of the overall story being told by the participants. I then searched

for common ideas, thoughts and experiences, which resulted in the emergence

of 32 themes or what Hammersley (1995) calls sensitizing concepts. I then looked for relationships among the themes, which led to the convergence of these 32 themes into seven broad categories or what Hammersley (1995) calls definitive concepts. These categories included: 1. Perceived lack of respect. 2. Experience of privatization of the SSWs' jobs and subsequently the care-aides' jobs. 3. Interaction with individuals. 4. Use and development of knowledge. 5. Continuous learning. 6. Positive self-perception. 7. Improved quality of work life (see Appendix F). I organized the data by theme category. I continued to do so until I was satisfied that I had captured as much of the data as possible in the focus group interview. The data that was not captured was small talk or tangential conversations.

Keeping the themes that emerged in this analysis in mind, I began to analyze the individual interview transcripts. I first read each transcript several times to develop a good understanding of the story each participant was telling. As I read through the transcripts, I noted that participants told similar stories. To confirm the similarity and commonality between each participant's stories, I reorganized the data by interview questions and compared responses across participants. I read through the responses looking for repeated words, repeated thoughts and repeated experiences each participant had said or described. This confirmed for me that the stories the participants told in the interview were very similar. From this analysis, the same seven broad themes or definitive concepts, as from the focus group interview, emerged. I then went back to the individual transcripts to determine how much of the data in each transcript was captured by

these seven broad categories. Again, the data that were left out were not related to the interview questions and consisted of small talk or tangential conversations. The optional focus group was analyzed the same as the first focus group and did not add any additional themes or categories to the research study, but the second focus group added additional stories supporting the previous themes or categories that had emerged.

Validity and Reliability

In the positivist tradition, the definitions of reliability and validity are less contested but these terms are more contested among qualitative researchers, which has resulted in a large amount of literature on the subject. Social scientists doing qualitative research have argued for new ways to reconceptualize the positivistic terms reliability and validity so they are relevant to qualitative research. Several scholars have provided different concepts to address the reliability and validity of qualitative research. However, there is little consensus regarding what terminology should be utilized. For example "Lincoln and Guba (1985) argue for 'trustworthiness' as the regulative standard, Hammersley (1992b) prefers the 'plausibility' of knowledge claims, and Lincoln (1995) argues for 'authenticity' as the standard for constructivist research" (Smith, 2000, p. 142). Further, Lincoln and Guba (1985) have proposed the terms credibility, transferability, dependability and confirmability as a way to enhance trustworthiness of a study. Denzin and Lincoln (2005) propose fairness, ontological and educative authenticity, and catalytic and tactical authenticity. Smith (2000) has proposed the terms transparency, reflexivity, moral reasoning,

and persuasiveness. For the purposes of this study, I will use the reconceptualization of validity and reliability put forward by Smith (2000) as his four criteria cover many of concepts introduced by the other scholars.

Transparency

Smith (2000) describes transparency as,

> being quite explicit in delineating how particular understandings were derived, especially in recognition of the problems encountered in the fieldwork. The write-up of… projects should include not only one's interpretation but also a discussion of how and why that interpretation was arrived at. Transparency carries implications for the structure of an account, the links between analytic coding categories and specific words and phrases and the writing style employed. Researcher clarity about the intended audience of the research account will be one variable influencing the researcher's decision about how to be explicit (p. 144).

This definition of transparency suggests that it would be possible to assess and determine the credibility, dependability and confirmability of the study if all the details needed to make this determination are available. The extent to which the study is seen as credible, dependable, and confirmable will depend on each reader's interpretation; the researcher's role is to make decision making transparent to the reader.

In this study, I have made explicit my perspectives, biases, values and beliefs. I have also made clear the data collection and data analysis procedures I used and how I arrived at the interpretation I did. I have used direct quotes to represent the SSWs' voices and have provided the context for the quotes where needed. These efforts contribute to increasing the trustworthiness of this study.

Reflexivity

The next criteria Smith (2000) presents to enhance trustworthiness is reflexivity. In the process of understanding and trying to engage with the process of reflexivity, my experience is nicely captured by Finlay's (2002) sentiment that "the process of engaging in reflexivity is full of muddy ambiguity and multiple trails" (p. 209). Indeed, the concept of reflexivity is ambiguous and different scholars have different ways of defining and using it. Some of the phrases that began to orient me to the process of reflexivity were "thinking about thinking" (Maranhao, 1991 as cited in Alvesson and Skoldberg, 2000 p. 5), "the interpretation of interpretation" (Alvesson and Skoldberg, 2000 p. 6) and who I have become to the participants in the process of becoming myself (Denzin and Lincoln, 2005).

Jootun et al. (2009) further oriented me to the concept. They explain,

qualitative studies are prone to a degree of subjectivity because interpretation of the participants' behavior and collected data is influenced by the values, beliefs, experience and interest of the researcher. Reflexivity, characterized by an ongoing analysis of personal involvement, helps to make the process open and transparent. Awareness of the reciprocal influence of participants and researcher on the process and outcome is vital part of ensuring rigor in qualitative research (p. 45).

Jootun and associates' (2009) suggestion that reflexivity makes the research process open and transparent relates back to Smith's (2000) suggestion about the importance of transparency.

Bourdieu and Wacquant (1992) further added to my understanding of the concept of reflexivity. They argue there are three main aspects about which a researcher should be reflexive. First are the social origins and categories that include: gender, race, religion, culture, class etc. This is an expansion of Jootun

et al.'s (2009) list, which includes: values, beliefs, experiences and interests. The second aspect is the position the researcher occupies in the field to which he or she belongs as this determines how much influence and power the researcher has in the field or the field has on the researcher. This aspect further expands reciprocity beyond the level of reciprocal influence between researcher and participant, as explained by Jootun et al. (2009), to include the reciprocal influence between the researcher and the field he or she belongs to. Finally, the third aspect is 'intellectual bias' where researchers from the academic field see the world "as a set of significations to be interpreted rather than as concrete problems to be solved practically… [this leads to the] risk of collapsing practical logic into theoretical logic" (Bourdieu & Wacquant, 1992, p. 39-40). This point of Bourdieu and Wacquant clarifies that it is not just beliefs, values, experiences and interests that we need to be reflexive about as we make interpretations, but that our perspective could limit what it is that we are trying to make an interpretation of and, therefore, we need to take a reflexive stance to make this positioning clear. For Bourdieu and Wacquant (1992) reflexivity is "the systematic exploration of the 'unthought categories of thought which delimit the thinkable and predetermine the thought" (Bourdieu and Wacquant, 1992, p. 40).

The work of Finlay (2002) also added to my understanding of reflexivity. Finlay (2002) presents five variants of reflexivity. Her first variant is similar to Jootun et al.'s (2009) and Bourdieu and Wacquant's (1992) suggestion of being aware of one's own attitudes and social origins. The second and third variants are similar to Jootun et al.'s (2009) work regarding the reciprocal influence of

researcher and research participants on the research. Her fourth variant extends

Bourdieu and Wacquant's (1992) suggestion of being aware of the power and

influence one has in their field and vice versa, but also recognizing the power

differentials between the researcher and the research participants because this

power differential can enable or disable what can happen in a research study.

The concept that added additional understanding of reflexivity from Finlay's

(2002) work for me was 'discursive deconstruction' where "attention is paid to the

ambiguity of meanings in language used and how this impacts on modes of

presentation" (p, 222). Here the focus is "more explicitly on deconstructing the

language used and its rhetorical functions… Researchers for this tradition would

notice how both participants and researchers are engaged in an exercise of

'presenting' themselves to each other" (Finlay, 2002, p. 223).

Going back to Smith's (2000) work, he uses the work of Altheide and

Johnson (1994) to identify "five dimensions of qualitative research where the

demand for reflexivity is necessary" (p. 144), which further contributed to my

understanding of reflexivity. The first dimension is the need to be reflexive

regarding the relationship of what is being observed and the larger context in

which this observation is embedded. This extends the point that behaviors

observed are not only affected by our beliefs and values but also by the context

and its constraints or freedoms. The second dimension, the relationship between

the observer, observed and setting and the third dimension related to how the

interpretation of the data was rendered are covered by Jootun et al.'s (2009) and

Bourdieu and Wacquant's (1992) work related to influence, power differentials

and the intellectual bias. The fourth dimension is the manner in which the author decides to present the data and their interpretations of it, and the fifth dimension is the role of the reader as the audience of the final report. Both of these dimensions extend Finlay's (2002) suggestion of discursive deconstruction by adding the importance of not only being reflexive of the language used and the ambiguities inherent in language just between the researcher and participants but also the researcher needs to be reflexive of the language used to present the research to the reader.

Based on the work I have reviewed, I engaged in the process of reflexivity to make my thinking and actions in regards to all aspects of this research study as transparent as possible. In Chapter Four, I reflect on my own experiences and perspectives during the various phases of involving the SSWs in the care planning process. This included: being reflexive about my emotions, attitudes, social origins, categories and viewpoints and how they influenced the interpretations and meanings I have made of my own experiences and the experiences of the SSWs. I have also presented the shifts that occurred in my beliefs and interpretations of events as a result of being reflexive. I took a reflexive stance on my position of power both within the research and my position in the field of dietetics and the care home to understand the power shifts that were taking place. Finally, I took a reflexive stance on the language I used and the language used by the SSWs and the language used to write up the final report to understand, interpret and make clear who is saying what and why.

Moral Reasoning

The third criteria Smith (2000) presents that contributes to developing the trustworthiness of the study is moral reasoning. By moral reasoning, Smith (2000) means the extent to which the researcher makes explicit his or her struggles, being conscious of and applying the process of reflexivity to develop their methodologies to move towards a more just and equitable reality. This concept of moral reasoning takes into consideration fairness, which is one of the criteria of trustworthiness described by Denzin and Lincoln (2005). Fairness is "a quality of balance; that is, all stakeholder views, perspectives, claims, concerns and voices should be apparent in the text" (Denzin and Lincoln, 2005, p. 207). In other words all voice should be heard and integrated into the research study.

In the current study, in the development of interventions to involve the SSWs in the care planning process and in the development of my conceptual framework, I used the literature related to morality and caring. I have presented the moral shifts I have made, in particular, the shift in my moral commitment as a leader to enhance the working conditions of the SSWs through developing an enabling workplace. I have taken into consideration the needs of the SSWs, other staff members, residents and my own needs in this process. The future research recommendations I make have an element of humanizing working conditions for the SSWs and living conditions for the residents.

Persuasiveness

The fourth and final criteria Smith (2000) presents is the concept of persuasiveness which is,

> the degree to which we can rely on the concepts, methods, and inferences of a study, or tradition in inquiry, as the basis for our own

theorizing and empirical research. If our overall assessment of a study's trustworthiness is high enough for us to act on it, we are granting the findings a sufficient degree of validity to invest our own time and energy and to put at risk our reputations as competent investigators (p. 147).

In the current research study, I have provided detailed descriptions of my interventions and their effects resulting in positive experiences and perspectives as evidenced by the use of direct and rather longer quotes of the SSWs. I have also discussed the positive shifts that occurred for the residents, other staff members and myself at the care home. These detailed descriptions and supporting evidence should enable readers to identify those parts of this study where they see patterns that resonate with their own experience. The process of going through the data collection phase allowed the SSWs to become more consciously aware of the shifts in their roles at the care home, particularly with respect to their contributions to the care planning process. The participants of this study will also be able to see their journey acknowledged and documented.

Reporting the Findings

The data relating to my reflection on my practice and actions are located in Chapter Four and is arranged in chronological order. The data from the participants are located in Chapter Five. Since the experiences of all the participants were very similar, I described thematically the data in a single narrative of the overall experiences of the participants. Direct quotes have been used to present the experiences in the participants' own voices.

Study Limitations

Despite attempting to increase the trustworthiness of the study there still remain some limitations. First, the study includes only the perspectives of the SSWs and myself. The perspectives of other staff members, management, residents and residents' family members' perspective have not been included. Therefore, the story presented is a particular and partial understanding of the phenomena being explored.

The second limitation of this study is the power differential between the researcher and workplace supervisor (myself) and the participants and workplace subordinates (the SSWs). Despite my attempts to minimize the power differential there remains potential that some staff members may not have felt comfortable fully sharing their experiences with the third-party facilitator due to fear of being identified. Judging from the transcripts, though, it seemed that the participants were open and comfortable sharing their experiences.

The third limitation of this study is related to my perspectives, biases, vested interest, subjectivity and the theories I used to make sense of my experience and the experiences of the SSWs. I have consciously approached my practice and this study reflexively through which I have made my thinking clear in regards to the above points through this dissertation. One of my perspectives, which influenced this study are my values on leadership and life-long learning. I believe every worker is a leader in his or her own job and knows best how to carry out their own work, when to modify it, and when to completely transform it. Therefore, I believe in providing as much autonomy to the worker as

they can manage and simultaneously empowering them to manage additional autonomy. In addition to leadership, I believe life long learning is an essential component to living. I believe all workers in healthcare should not only be learning from their day-to-day practice but also taking responsibility for engaging in formal learning opportunities regardless of their professional status. This perspective may have influenced the literature I selected to develop my conceptual framework, the interpretations I made of the transcripts, and the quotes I selected all of which impacted the conclusions I have drawn.

Further, my interest in this study was not just to understand the SSWs experience of being involved in the care planning process and their subsequent high level of motivation and expanded identities, but to also better understand and maintain my own elevated sense of contribution and higher professional status within the care home. As a result, I was careful when I analyzed the data not to overlook or reject data that did not support this vested interest of mine. I minimized the risk of imposing my own framework or meaning rather than understanding the perspective of the SSWs and the meanings they attach to their words and actions by being aware of my assumptions and biases.

Finally, the fact that a third-party facilitator collected the data is a limitation of this study for a few reasons. Although the facilitator was a female, which may have been comforting for the participants since they were all women also, the third-party facilitator was from an ethnic minority group and spoke English as a second language, which raises the possibility of a language barrier. The facilitator's visible minority status also raises the possible issue of personal

reactivity, which is how the characteristics of the researcher might have impacted the participants. The third-party facilitator was oriented to the overall purpose and context of the study but there was the possibility that she was not able to ask the right probing questions at the right time to seek clarity where it might have been useful. Further, the focus group and individual interview questions were designed to be open ended and semi-structured but according to the transcripts the third-party facilitator used the questions in a more structured way than was intended, which could have affected the way the SSWs told their stories. Finally, all I had access to were the transcripts with few insights into the body language, emotions or the atmosphere of the interviews, which limits my ability to interpret of some of the comments.

<div align="center">Chapter Summary</div>

The review of the qualitative research methodology and the interpretative case study approach has put me on solid ground and enabled me to conduct this study. I am aware of the advantages and disadvantages of the qualitative methodology and interpretative case study approach. Further, I am clear about the concerns of validity and reliability and how these concepts have been reconceptualized to be congruent with the philosophy of qualitative research. I paid particular attention to presenting my thinking as transparently as possible and engaged in the process of reflexivity to maintain this transparency. I am aware of my moral imperative of ensuring that my conclusions and recommendations are fair and in the direction of creating a just and equitable reality for the participants of this study. In this process of being transparent,

reflexive and morally conscious, I hope the conclusions of this study are persuasive.

In the next chapter, I will provide reflections of my journey and my leadership practice related to the development and implementation of various interventions to involve the SSWs in the care planning process and the impact of the SSWs being involved in the care planning process.

CHAPTER 4 – FROM ALIENATION TO MORAL AND IDENTITY-BASED
LEADERSHIP: MY EXPERIENCE

Using the work of Kreber (2004) and Mezirow (1991) described in Chapter

3, I began to reflect on my own experiences, my practice and my leadership

actions before, during and after the privatization at the care home. In this

chapter, based on my self-reflection, I will describe my work responsibilities prior

to privatization, the various policy changes and their impacts on my work and the

work of the SSWs, followed by a description of the privatization process and the

subsequent changes to my work responsibilities resulting in the development of

resident-related knowledge gap for me. I then provide details of the interventions

I used to involve the SSWs in the care planning process to minimize my resident-

related knowledge gap. Finally, at the end of the chapter, I present the shifts in

power and obligation as a result of the privatization legislation and the

subsequent interventions and conclude with a reflection on the ethics of my

actions. As I proceed, I will share my thoughts and feelings at the various stages

of the journey. I will also be taking a reflexive stance through out this chapter as

described in Chapter 3 to clarify my thinking and how my thinking shifted over

time.

My Job Responsibilities

Prior to taking the position of Director of Support Services and Clinical

Nutrition at the care home in 2002, I worked as a Clinical Dietitian at a hospital

Metro Vancouver and as a Health Care Consultant at various care home

facilities. In 2001, I graduated from a Masters program with a combined focus on

Dietetics and Health Care Management and in 1998 I completed an undergraduate dietetic program.

As the Director of Clinical Nutrition and Support Services, I was responsible for four departments, which included: clinical nutrition, foodservices, housekeeping, and laundry. These services were provided to the 75 residents of the care home. The clinical nutrition and foodservices were also provided to about 36 to 40 elderly community members through the Adult Day Program, 1 elderly community member through the respite care program, and approximately 30 to 35 elderly community members who received meals through the meals-on-wheels program on a weekly basis. The majority of my time, approximately three of my five days per week, was dedicated to tasks related to my clinical responsibilities.

My clinical responsibilities could be broken down and categorized into five areas, at least on paper. First, I was responsible for the management of the medical nutrition therapy for each resident. This required me to work with the medical team composed of nurses, physiotherapists, physicians, pharmacists, geriatricians, and geriatric psychiatrists. As part of this team, I was responsible for managing each resident's nutritional status through medical nutrition therapy.

Second, I was responsible for the therapeutic meal management of each resident. This required me to work closely with the care team composed of nursing aides, recreation aides, rehabilitation aides, cooks, dietary aides and housekeeping aides. As part of this team, I was responsible for managing appropriate texture and portion sizes of meals, appropriate table and seating

arrangements, appropriate nourishment, appropriate use of functional foods (eg. natural laxatives, therapeutic use of juices), feeding techniques, and use of specialized serving dishes and utensils.

Third, I was responsible for providing nutrition education and current best practices in geriatric nutrition to both the medical and care teams and sometimes to the residents and their families. This information had to be shared with the teams described above in ways and at levels that were relevant to their practice and knowledge. This required me to develop short fact sheets or mini-in-services.

Fourth, I was responsible for the development of the nutrition and environment care plan upon admission of each new resident. I worked with the admission team, which is composed of the resident case manager, director of care, admitting nurse, family physician, dental hygienist and the family. I gathered information from various sources and developed an initial nutrition and environment care plan. This plan was then shared with the care team to implement and had to be reviewed with the medical team within 14 weeks of admission and at least annually thereafter.

Finally, as a health care professional, I served on committees that were responsible for developing and/or modifying care home policies and procedures related to clinical practice. Some examples of these committees include: professional advisory, dementia care, dining experiences, occupational health and safety, and research committees.

Approximately two of my five days per week were dedicated to managing foodservices and housekeeping. This included: recruiting and hiring employees, employee evaluations and conflict resolution among employees. I was also responsible for working with suppliers and sales representatives, procurement of food items and supplies, maintenance of foodservice and housekeeping equipment and development of the menu. Finally, very little of my time was spent on administrative tasks such as scheduling, payroll, or matters relating to budgeting and accounting as the care home had other staff responsible for these tasks.

Although I had a good job with a title, which I thought was impressive, I was frustrated by the lack of influence I had in my job. I had very little influence on the work of the SSWs since most of their tasks and duties were clearly determined by the collective agreements. As a result, I carried out my practice independently of the SSWs leading to minimal work related interactions. I did not develop any meaningful relationships with the SSWs. The workload pressures on the SSWs and myself as a result of provincial government policy shifts (described later), began to further deteriorate my relationship with the SSWs. I began to take a more authoritative role in which I ignored the concerns raised by the SSWs or attempted to resolve them without their input, which sometimes created larger problems. As my frustration grew, I began to develop the idea of "just doing my job" and going home. This attitude of mine impacted how I viewed other workers at the care home, particularly the SSWs whom I supervised. It appeared to me that the SSWs were even more involved in "just doing their job"

and going home and while at work, on a continuous basis pointed out problems without any suggestions or recommendations to resolve them. To me it seemed as though the intent was just to maintain a chaotic workplace where no one knew what was going on. As a result, I began ignoring the problems that were being raised altogether.

In addition to the frustrations I was experiencing in my department, I also believed I was the least important member on any team or committee at the care home. My contribution to the care planning process consisted of providing basic information such as residents' weight or their food intake, which did not impact the care planning process. Other healthcare professionals and staff members did not appear interested in such basic information as they already knew this information or could get it from the care aides who could provide it more accurately. Reflecting on this situation, I do not blame the care team members for perceiving my skill set the way they did. I made no effort to use skills beyond my narrow focus on nutrition and when I did, it was at a primitive level. Many of the front-line workers knew the residents more than I did and were more familiar with the type of care they needed, the foods they tolerated and the activities they enjoyed.

Reflecting back on my frustrations, I now see that they were signs of my own sense of alienation at my workplace. I did not feel my work responsibilities were representative of my perception of the job title 'Director of Support Services and Clinical Nutrition'. Further, I was not making a significant contribution to the care planning process and the contributions I did make were not respected.

Finally, the fact that I was associated with the SSWs, the low-status workers, contributed to my personal sense of low status.

Just as I was recognizing my own sense of workplace alienation, I began to think about the level of workplace alienation among the SSWs. In the beginning, just as I had not recognized my own sense of alienation, I did not notice or recognize the degree to which the SSWs were alienated from their jobs either. Although, I would hear comments such as "we are the lowest on the totem pole", "no one listens to us" and "we are just here to do the bull work", I just took these comments as them complaining or whining. Thinking back, some other indicators which were signs of alienation included the SSWs watching the clock and leaving the care home the minute they were off shift, the excessive amount of time taken off and showing no interest in on-site in-services or participation in committee work unless they were paid to attend.

About six months into my job, around the time that discussions related to privatizing services were taking place, the levels of frustration among the SSWs significantly increased, which, in retrospect, I see as the intensification of their alienation. The sense of workplace alienation among the SSWs was also evidenced by their engagement in "work to rule" and increasing verbal comments such as "this is not my job", "I am off", or "I don't know". Further, I recall the divide between me and the SSWs becoming wider as they saw me as a representative of the board of directors and administrators (BDA) and they perceived me as contributing to the potential privatization of their jobs. Though I was a participant at the BDA meetings, my influence was minimal. As a result, in

this dissertation when I refer to the BDA, I am not including myself in their

decisions. The increased level of workplace alienation can be attributed directly

to the provincial new healthcare policies, which were driving the care home

operators towards privatizing the SSWs' jobs.

<div align="center">Policy Changes</div>

<div align="center">*Health and Social Services Delivery Improvement Act (Bill 29)*</div>

In January 2002 the Health and Social Services Delivery Improvement Act

(Bill 29) was passed into law. The BC provincial government passed this bill to

address rapidly increasing costs of healthcare worker wages and benefits. The

government claimed Bill-29 would enhance health care services for patients and

clients by focusing healthcare dollars on core health services. Second, Bill-29

would help enhance flexibility for service providers to ensure proper

management of resources (Ministry of Skills Development and Labor, 2002).

These two purposes could be achieved by allowing the privatization of the work

of all workers in a care home.

<div align="center">*Resident Care Access Policy (RCAP)*</div>

The second policy shift was the RCAP introduced in April 2002. The

Ministry of Health Planning implemented the RCAP to address the lengthy

waiting-lists for access to care home facilities. Under this policy the eligibility for

placement would no longer be based on the date an individual registered on the

waitlist for a care home. Penny Ballem, Deputy Minister of Health Planning

argued that under the previous method of access individuals did not always

access the care home when they needed it. As a result, some individuals were

entering the care home before they needed the service, while others in declining

health were kept waiting and often in an inappropriate setting such as an acute

care hospital or worse, at home alone. The RCAP would now allow individuals to

be placed at a care home when they needed to be placed. Although placement

would now be faster, it would be at the cost of the individual's choice of facility.

The individual would be offered the first available bed in any care home close to

the area where the individual lived. After placement, individuals would be given

the option to place their names on a waiting-list to be transferred to their facility

of choice (Home and Community Care Services Policy Manual, 2002).

Along with the change of method of access and placement, the criteria for

eligibility were also changed. To be eligible for access to a care home, the

individuals now had to have complex care needs, which could not be met in their

home through home care or other supportive living environments such as

assisted living. These needs include but are not limited to: dependency on

activities of daily living such as toileting, bathing, dressing, feeding, and mobility;

advanced stages of cognitive impairment, multiple diagnoses with multiple

medications which were not being appropriately managed, and challenging

behaviors, some of which include: aggression, wandering, and socially

inappropriate behaviors (Care Home Administrator, Personal Communication,

May 2002).

Budget Freeze

The third governmental policy shift which contributed to the privatization

of the SSWs' jobs and intensified their sense of workplace alienation was

notification to the care home in late spring 2002 that they would not be getting any increase in their budgets despite increasing costs. The decision had debilitating financial impacts on the care home, as the care home already experienced underfunding under the existing funding formula .

These three policy shifts created a significant level of fear among the SSWs as rumors circulated about losing their jobs to privatization, working for significantly lower wages and benefits, and increased workload. These policy shifts and their possible impacts were heavily covered by the local media which created a sense of the unknown leading to more fears and frustrations.

Impact of the Policy Changes

Reaction of the Care Home Operators to the Policy Changes

Keeping with historical tradition, the BDA's first reaction to manage the financial challenge was to reduce cost by reducing the hours in the housekeeping department. This was the next stage where I began to witness increasing fears and frustrations among the SSWs and increasing workplace alienation. However, the BDA determined that the reduction of hours in housekeeping alone would not be enough and that further action would be needed. One major option they explored was closing some beds at the care home to concentrate resources, with the hopes the health authority would not claw back any funding. The second option was to reduce costs of wages and benefits by privatizing services and use the savings to increase staffing levels to meet the complex care needs of the residents. The BDA presented both options as ways to increase the staff to resident ratio, to reduce workload issues for the

staff, and deliver better care for the residents. The BDA involved the care home staff in exploring both of these options.

The option of closing beds at the care home was stemming from the regional health authority's formula of having 85 beds per 1000 individuals over the age of 75 in each community of the health authority. According to this formula the community where the current care home is located had an oversupply of 22 beds. Therefore, theoretically an argument could be made to decommission 22 beds at the care home (Fraser Health Authority, 2002).

In a series of several staff meetings the BDA explained to the staff the BDA's perspective that closing beds would not be an suitable option for several reasons. BDA claimed, first, there was no understanding or commitment between the health authority and the BDA of the care home to review and change the method of funding for the care home to cover the actual staffing costs in the future. Therefore, the BDA felt that by closing beds they would be back in the same situation within the next few years. Second, since the collective agreements would expire in March 2004 and the current animosity and hostility between the union and the government could create a lot of uncertainty, instability and possibly a lengthy strike. Third, spreading the current staff over fewer beds through bed closures would not improve the staff to resident ratio to the level needed. It would, however, allow for better staff replacement coverage and full staff coverage on the weekends and evenings, but the staff would continue to have heavy workloads that would create risk of injuries both to staff and residents. Higher injury rates will continue to increase the use of sick time

and higher worker compensation board premiums, both of which would continue to add significant costs to the care home. Finally, there would be no guarantees or agreements from the health authorities that they would not claw back any funding if the number of beds were reduced.

In addition to the above concerns, the care home BDA, despite the health authority's bed-formula, did not want to be held responsible for decreasing the accessibility to community individuals requiring care home placement. Reducing accessibility to care home placement could lead to increased pressure on family physicians and other health care professionals, emergency rooms, hospital beds, and family members, causing further deterioration of the healthcare system. Furthermore, elderly individuals or their families would also be required to bear out-of-pocket costs for medications and medical equipment that would otherwise be covered in the care home setting.

Decertification Attempt

Although the BDA made a compelling case to privatize services, the SSWs saw it as a direct hit on them since many recognized that it was their jobs that would be lost to a private company. The privatization decision further exacerbated the sense of alienation among the SSWs as they were the only group being privatized. Many of the SSWs could not believe the position the BDA had taken. As the level of alienation intensified, the SSWs began to show their emotions, their fears, their frustrations and their anger towards the potential privatization process. They spoke about the rejection they felt and how their loyalty to the care home, in some cases more than 20 years of service, meant

nothing. Further many feared the personal financial disaster that would result when they lost their jobs. As I reflect back to this time, this was approximately when the SSWs began to take a stand with the attitude of "enough is enough". They unified and aligned themselves with some sympathetic care-aides and raised the possibility of decertifying the union so all staff could keep their jobs and a new wage and benefit schedule could be negotiated directly with the BDA. This decision of the SSWs frustrated their union and the union began to develop and implement strategies to stop the decertification process. Further, most of the care-aides, who made up the majority of the staff, did not feel their jobs could be privatized since there were no existing private organizations that provided care-aide services on contract bases to care homes. As a result, the effort to decertify the union was unsuccessful and, initially, just the work of the SSWs was privatized. The lack of support from the union and the care-aides towards the decertification process had alienated the SSWs from both their union and the care-aides.

<div align="center">Privatization Process</div>

<div align="center">*My View of the SSWs prior to Privatization*</div>

Prior to the privatization process, I too shared the broader view that SSWs were overpaid, unskilled, easily replaced and not important contributors to the healthcare system, not recognizing that I too might be perceived the same way by other healthcare professionals and government members.

> The British Columbia Medical Association argued that the high wages
> paid to the 'non-professional' and 'non-essential' health support
> 'hospitality' workforce were starving the province's health system of

resources that should more rightly go direct to patient care and to health care professionals (Palmer, 2000 as cited in Cohen, 2006).

The Liberal government at that time also took a similar view towards the support service workers. In the government's view:

> Whereas health professionals were essential to the health care system and in short supply, health support staff were simply unskilled hospitality workers in ready supply, a view graphically expressed by Kevin Krueger, the Liberal MLA from Kamloops, who has referred to hospital housekeepers as merely 'toilet bowl cleaners' (Beatty, 2004 as cited in Cohen, 2006).

Further, the SSWs were all women with no more than a high school education. The SSWs were rarely provided any onsite educational opportunities for self-development and they were not consulted in any decision-making processes. My association with them made me feel unimportant and invisible.

In addition, I perceived the SSWs to be extremely rigid, self-serving and resistant to any change even when the change had significant and direct positive impacts on the residents. One example was resistance by the dietary staff to making the noon meal the main meal of the day and serving a lighter dinner in the evening. I explained this change would allow residents to consume the majority of their nutrients and calories early in the day when they were most alert, least tired, and not experiencing sun-downing, a state of confusion which develops in the evenings among residents with dementia. This change would significantly help with unwanted weight loss and the corresponding complications. The dietary staff resisted this change as it meant changes in the tasks during their shifts, changes in hours of work, and changes in who prepared the main meal of the day, terms of work they did not want changed. I attributed

my unhappiness to my association with the SSWs which was resulting in me not having influence at the care home.

As I reflect back, I am taken back by my thought process and how I made sense of my lack of satisfaction at the care home. Further, I am surprised about the kind of person and leader I had become and my view of my co-workers. The work of Kanungo (1979, 1981, 1982, 1983) on the socialization process, brought insights to the importance of salient needs and having these needs met at work. I am now able to better understand that my negative perceptions of the SSWs and the care home were more closely related to not being clear about my workplace needs than to my association with the SSWs.

Being born to and raised by immigrant parents who had to abandon their education and who took on low wage jobs with the hopes of developing a better life for their children, I was constantly exposed to the concept that good education would lead to a good job and subsequently to a good life. I thought I had accomplished the education component by completing my master's degree, the highest level of education in my family, and I expected a satisfying job, which was not the reality at the care home. At that time, I was not aware what my salient workplace needs were. Reflecting back, the privatization process unexpectedly necessitated and allowed me to be more involved in tasks that were meeting my underlying workplace needs. Ironically, as the privatization process moved forward, the more involved I became at the care home. I now understand the positive experiences were resulting from having my underlying needs met, which included: my need for respect, my need to be resourceful, my

need to provide care and support, my need to create mutual opportunities for growth and development and my need to be doing exciting work. The fulfillment of my needs was contingent upon me working with SSWs.

Privatization Process and Shift in my View of the SSWs

During the months leading to the private company beginning its operations, the SSWs began to show their emotions to me, their fears, frustrations and anger regarding privatization. Until this point, as mentioned earlier, my interactions with the SSWs were minimal, However, as a result of these types of very personal stories, I began to see the SSWs differently. I was able to relate to the SSWs feelings of rejection because I was the only one of the management personnel whose job was privatized. Though I had been on the job for slightly less than a year and half, I felt terrible for the fact that the average SSW had committed more than 15 years to the care home and their jobs were contracted in mere months. Many were also single mothers, some relied on their benefits packages for their healthcare treatments, and others were middle-aged primary income earners for their households. I began to understand that the SSWs were aggressive with management and workers from other departments not because they were mean people, but because they were trying to protect themselves from being pushed around as had historically been the case. I could empathize with them because I also wanted to protect myself from being further marginalized. I could not help but ask myself, if I was in the same situation as these workers, what would I do? Where would I go to find work if I had spent

most of my working years with one organization and all I ever knew was being taken away from me?

These types of questions allowed me to reflect on what my role was as a healthcare professional in this difficult process. I was trained to care for and help people. I believed my responsibility transcended the domain of nutrition and I wondered if this was my opportunity to provide meaningful support to the SSWs. As the months went on, my relationship with, and my sympathy for, the SSWs continued to develop and I sought ways to support and be a resource to them. I was aware the private company that was awarded the contract would recruit first from the laid-off employees before recruiting from the community. I used this information to create hope and minimize some of the anxiety among the SSWs that they would lose their jobs and not be hired back. However, I thought that hiring back had both positive and negative consequences. It was positive in that there was still hope that staff would keep their jobs, but it was negative in that they would be paid significantly less to do more or less the same work. In addition, the care home had made it widely known that part of the decision to privatize was to increase staffing levels to reduce workload pressures and to improve the care the residents received. This also provided me with some comfort that the BDA were conscious of the SSWs' workload and the residents' welfare. I used this information to help minimize their hatred towards the care home leaders. I reasoned the BDA were not attempting to get rid of the SSWs but were sympathetic to their growing workload and the needs of the residents.

As I reflect, I did not at first view my actions to minimize the SSWs' fears and frustrations as interventions which would eventually facilitate the SSWs' involvement in the care planning process. I further did not see these as interventions even after I began to implement the interventions directly designed to involve the SSWs in the care planning process. I now see the importance of these interventions in developing the relationships which were necessary for the support I needed from the SSWs to continue to do my job.

Privatization of the SSWs Jobs

After the support service jobs were privatized, I was offered a managerial position with the private company two months before they started their operation at the care home. My role was to help set-up and, thus, I became a middle person or a resource person between the private company and the care home management. In this role, I developed a significant amount of influence in the private company since contracting to a care home was new to them. I used this influence to have some of the private company's practices modified prior to beginning operations at the care home.

The private company's practice of recruiting and hiring the laid off employees concerned me. I feared the possible negative outcomes of bringing back individuals to do the same or similar work, but at significantly lower wages. In addition to wages, the staff were also losing benefits, including: pay for two statutory holidays, three super statutory holidays, evening shift and weekend premiums, sick pay, education pay, special leave pay, hundred percent employer

paid premiums for medical, extended health, dental, and group insurance, superannuation, and severance allowance.

I convinced the company to minimize the reduction in the take-home pay by offering positions to qualified individuals that moved them from casual positions to permanent positions, from part-time positions to full-time positions, and from lower-wage positions to higher-wage positions. I also recommended the private company change their pay periods from bi-weekly to bi-monthly. This created 24 pay periods in a year compared to 26 pay periods under the bi-weekly system. This led to each pay period being composed of more days and hence larger pay cheques. I was able to minimize the benefit losses by ensuring that the maximum of number employees qualified for benefits with the private company. To qualify for benefits the employee had to be in a position that was scheduled to work a minimum of 25 hours per week. Therefore, positions were created to ensure as many positions as possible met the 25 hours minimum requirement per week. Of the 15 positions created, 14 positions qualified for benefits. The combination of these recommendations meant the loss of wages and benefits was somewhat minimized.

My efforts with the private company to minimize the financial impacts on the SSWs is another example of what I now consider to be interventions, which eventually facilitated the SSWs' involvement in the care planning process. Despite my efforts, the SSWs were aware they were being paid significantly less per hour than before to do similar work. As a result, the sense of alienation among these individuals continued to develop.

For one employee in particular, the pay cheque was a continuous reminder of her compensation losses, which contributed to her sense of alienation and dissatisfaction with her work and led to poor performance. Having had my own compensation reduced, I could understand what this employee was feeling. I shared with her my experience of coping with my compensation reductions, but she was at a different stage in her career than I was, so this attempt of mine did not work. I suggested and offered her the employee assistance program but she declined. I also provided a small wage increase of $0.50/hr and an opportunity to do more interesting work, but this employee's wage and benefit reductions were too significant for her to cope with and I ultimately had to terminate her employment due to poor performance.

Thinking back on this event, I question myself. Did I terminate this employee for resisting lower wages or contributing to negativity among the workers or both? This was a critical event for me and has significant ethical implications. I can understand that what I was doing was trying to make this individual accept what her current situation was. The various interventions I used, including giving her a small wage increase, providing her more interesting work or referring her to the employee assistant program, all were directed towards helping her to accept her current reality. I assumed that part of her concern was money, or boring work or psychological disturbance of having lost her union job. I never did ask her what she was looking for. In a similar circumstance in the future, I would certainly do things differently. Rather than work to convince the individual to accept their current reality, I will take the

approach of working with the individual to determine what it is they are looking

for and what would bring them satisfaction. I would then work with the individual

to help them reach their goal. This may include providing support for additional

training or helping the individual search for other opportunities that would meet

their needs. I certainly would not take the role of convincing the individual to

accept their current situation nor would I terminate the individual. I would leave

that decision up to the individual with the expectation that they continue to meet

the minimum standard of their current position and not negatively impact the

work environment for other workers. I would let the employee know they have my

full support in helping them reach their goals that would bring them satisfaction

from their work.

This particular employee's reaction, though more extreme, was not

different from other workers. Despite my efforts to minimize the compensation

losses for each re-hired individual and empathize with their concerns, I often

heard comments about the wage and benefit losses. Many of these comments

were repeats of what was being reported on the news regarding the privatization

and the union's position on this matter. I was concerned that such comments, if

unquestioned, could possibly intensify negative feelings among the remaining

staff and could lead to chaos and significant challenge in operating the support

services departments (SSDs). It was not that I did not want the staff to talk about

their feelings and concerns of the wage and benefit reductions; I just wanted

them to focus on how the changes impacted them concretely versus abstractly.

The reason for this was because a majority of the SSWs who were re-hired had,

while taking wage reductions, gained something in the process, such as moving from part-time work to full-time work, or moving to part-time work from casual work, or moving to a cooking position from dietary aide position, or daytime work hours from evening work hours. As a result, I began to question the negative comments, particularly regarding wages and benefits, by asking the staff member making the comment to think about how the change impacted them personally and what their own losses or gains have been instead of speaking about wage and benefit reductions in general terms.

This strategy worked and gradually the SSWs were not as negatively vocal about the privatization process. Most staff recognized that despite the wage reductions, the change actually had a positive impact for most workers. They recognized that they had a permanent job with benefits versus casual job with no benefits; they had more scheduled hours than before; their workload was reduced because of increased staffing and they were in positions that they would otherwise have had to wait for years due to seniority rules under the union.

Upon reflection, I still struggle to make sense of it. Should I have continued to allow the SSWs to express their feelings and observed what the outcome would have been or did I do the right thing by diverting the SSWs attention to their personal gains? I wonder if my intervention was a silencing process and a sign of the power differential between the SSWs and myself.

Though I still struggle to make sense of this, I do recognize my action of encouraging the SSWs to focus their attention to their own personal gains in view of wage reductions is another intervention which would eventually facilitate

the SSWs involvement in the care planning process. This intervention along with the others mentioned previously are also examples of my caring and concern for the SSWs as I wanted them to be as happy as possible despite the circumstances they were in. Thinking back on this, another reason I wanted the SSWs to focus on their gains was to receive recognition and validation for what I had done for them to fulfill my need to be recognized. It was not a simple task to convince a private company interested in making a profit to change their policies and payroll procedures to soften the financial impacts for workers they did not know.

Development of My Resident-Related Knowledge Gap

The outcome of privatization had a significant impact on my job. Prior to privatizing, the administrative and human resources functions were centralized in the care home and I played a minimal role in this area. However, after contracting out, these functions became my responsibility as the site-leader for the private company. As a result, I became completely responsible for tasks related to payroll, scheduling, and all other human resources management functions and the finance management functions. These administrative responsibilities were in addition to my clinical and supervisory responsibilities. In addition, part of my job was to function as the chief corporate dietitian. Under this function, I became responsible for being part of the development and presentation of proposals for new contracts. I was responsible for developing policies and procedures for the company and representing the company at their various contract sites to help them comply with provincial regulations. I

welcomed these growth opportunities despite my reduced wages. However, to fulfill these duties, I often had to be away from the care home and this meant I had less time to spend with the residents and less time to observe them. This reduced my ability to observe and notice changes among residents and to meaningfully contribute to their nutrition and environment care plans and the care planning process.

In order to carry out the tasks related to my clinical responsibilities to the best of my ability, I needed to spend time with various other healthcare workers (HCWs), such as nurses, doctors, and care-aides discussing, developing and implementing comprehensive nutrition and environment care plans. I needed to spend time with the residents and observe them and make recommendations to the different teams as I noticed changes. I also needed to keep myself current with the most recent research and best practices in geriatrics and dietetics to provide the highest quality of care. However, I was spending more time carrying out my administrative duties versus my clinical duties, resulting in the development of a resident-related clinical knowledge gap for me. This clinical knowledge gap meant less information in the areas of residents' cognitive functioning, adequacy of fine and gross motor skills, bowel and bladder functioning, pain control, meal management, energy level, senses, and other behaviors.

As I tried to determine how to minimize my resident-related knowledge gap, I thought to involve the SSWs in the care planning process. I hoped that this would create two outcomes. First, it would minimize my resident-related

knowledge gap and second, it would provide the SSWs opportunities to be involved in interesting tasks and help them feel good about their jobs.

My initial attempt to minimize my resident-related knowledge gap and to include the SSWs in the care planning process was to deliver a workshop on the basics of Alzheimer's Disease (AD) to the SSWs in September 2003, a few months after their jobs were privatized. This workshop covered the basic information on AD, its stages, anticipated changes among individuals with AD, and its management and treatment options. The purpose of this workshop was to sensitize the SSWs to recognize, monitor and report particular changes in residents' behaviors and abilities in the course of their day-to-day activities. I would collect, interpret and use the SSWs observations to develop or modify the nutrition and environment care plans as needed.

I saw the benefits of the AD workshop shortly after it was delivered. The SSWs appeared excited and in possession of valuable information that I could use for the care planning process. However, the excitement and enthusiasm faded quickly and the SSWs moved back to their task oriented routines and I began having difficulty procuring the resident-related information from them. When I would approach the SSWs for their observational data on a particular resident, they complained of not having time to remember and/or share information with me, they complained they fell behind in their work when they had to stop and provide this information to me and it was disruptive to their job routines. There was no excitement or enthusiasm from the SSWs about being involved in the care planning process and certainly not to the level I saw a few

days after the AD workshop. Further, the SSWs were implicitly conveying to me that it was not part of their job to participate in the care planning process and that I should be doing it as part of my job. This was confusing for me because on one hand the SSWs claimed that the residents were their priority and they had showed great excitement only a little while ago, but on the other hand they did not want to be part of the care planning process because they have no time. I felt I had further frustrated the SSWs as they perceived my actions as downloading my work onto them.

Thinking back because this intervention failed I did not consider it an intervention at the time. However, now I see this failed intervention as a pivotal point in my journey of trying to carry out my work duties by involving the SSWs in the care planning process. First, in the process of developing the dementia care workshop I had to do a significant amount of learning about this disease. Prior to developing this workshop I only knew the basic facts. As a result, the development of this workshop set in motion additional and continuous learning in gerontology. Second, the failure of this intervention evoked in me the curiosity to understand why the SSWs were not interested in participating in the care planning process.

As I grappled to understand the SSWs thoughts and feelings about participating in the care planning process, I was being greatly informed and significantly influenced by the resources I encountered in my doctoral program in educational leadership and policy. I began to ask myself what type of process would bring about a shift among the SSWs so they would value their knowledge

and its potential positive implication in the care planning process. The challenge

was to help the SSWs recognize that their engagement in the care planning

process is congruent with their beliefs of wanting the best for the residents. In

addition, being part of the care planning process would increase their influence

at the care home making their work more enjoyable. One way to address this

challenge was to use the ideas of Fenstermacher (1990) and Starratt (1996) to

shift the SSWs' instrumental approach to work to a moral orientation towards

work.

Development and Implementation of Educational Interventions

Development of the Aim Statement (AS)

For the development of my first intervention, I used the work of

Fenstermacher (1990) and Starratt (1996) to help the SSWs develop an "Aim

Statement". I was particularly influenced by Fenstermacher's following

statement:

> It seems nearly impossible to imagine the field of medicine without a
> profound moral commitment to relief from pain and suffering and the
> preservation of life. If the moral ends of medicine were stripped away, the
> value and uses of what remains would be most difficult to ascertain. There
> would be medical tools and technologies, physicians with skills, and a
> knowledge base. But of what purpose? Of what value would the
> knowledge and skill of physicians be without any moral commitment to
> relieve suffering and preserve life (Fenstermacher, 1990, p. 132)

Reading his work and this passage in particular triggered me to ask the question,

what was the moral commitment of the SSWs?

To further explore this, I used Starratt's (1996) work on the three

foundational human qualities for a moral life – autonomy, connectedness and

transcendence. I developed three open ended questions directly related to each of the three foundational qualities of a moral life. The three questions were: 1) Why do you come here to work? 2) Who are you here for? 3) What do you want your workplace to be like? A staff meeting was planned in March 2004 and all staff invited to participate. Nearly all permanent full-time and part-time staff members attended the meeting. These questions were used to engage the SSWs in a group conversation and I pushed for an exhaustive list of ideas. Eventually, even the care home cat was mentioned as something the staff came to work for at the care home. As the SSWs provided their perspectives for each of the questions, I noted their responses on large poster sheets. Once all the questions were discussed, I proposed that we develop a statement that summarizes all that has been discussed. After reviewing their responses and further discussing those as a group, the SSWs were able to develop a statement by selecting the core concepts from their responses to each question and grouping these concepts together to form a statement. After the initial statement was developed, it was modified several times over the next few weeks by the staff until they arrived at one that seemed to have captured their discussion and represented what they believed. This process lead to the development of the following statement:

> We will work collectively with other individuals to build a home-like environment, create home-like experiences and adapt to the changing needs of individuals to provide the Best Quality of Care and Best Quality of Life at [the] Care Home. For us these individuals include: residents, residents' families, co-workers and staff of partner organizations, and members of the community.

The process used to develop the statement made explicit the existing implicit moral commitment the SSWs had for the residents, and it now extended to include other individuals as well. The statement clearly identifies who and what the SSWs feel they are responsible for, which includes working collectively, creating a home-like setting and home-like experiences, and adapting to change. These responsibilities represent the concept of autonomy as presented by Starratt. The concept of connectedness is evident in the clear call for developing relationships with residents, residents' families, co-workers and members of the community. Finally the concept of transcendence is apparent, or the SSWs' grander purpose is to provide services so that the residents enjoy the best quality of care and best quality of life. The SSWs supported me in labeling the statement the 'Aim Statement' (AS).

In talking with the staff on an informal basis over the next few weeks about the AS, my impression was that the statement resonated with the staff. Many said they enjoyed the process of the AS development and were happy that the statement captured what they felt and believed for a long time, but had no prior opportunity to express openly. The next intervention to engage the SSWs in the care planning process was to put the AS into practice.

Development of Desired Practices (DPs)

I used the work of Noddings (1993) on the ethic-of-care to explore how the practices of the SSWs could be critiqued and modified to put the AS into practice. I felt that Noddings' (1993) work on the ethic-of-care and its five components: relationships, engrossment, disposition to help, competency and

contribution of the cared for would be helpful in initiating the necessary changes of practice to implement the SSWs' AS. For this purpose, a staff meeting was planned and all staff again invited to attend in April 2004. Again nearly all permanent full-time and part-time staff members attended. During this meeting, I presented the five components of Noddings' (1993) notion of ethic-of-care and provided a definition for each of the components. A conversation ensued among the SSWs to figure out what these five components would look like in practice. I next asked the staff to discuss the connections between the components of the AS with the components of the ethic-of-care. Next, I asked the SSWs, how congruent their current practices were to their AS and they began to see what they believed and what they did were two different things. I have summarized this discussion in the table below.

Table 4.1

Development of Desired Practices

Components of the Ethic-of-Care	Corresponding components of the Aim Statement	Current Practices	Desired Practices
Relationships	Work Collectively	Not working with staff from other departments	Develop relationships with staff, residents, families
Engrossment	Best Quality of Life	Task Orientation, Depersonalized	People Oriented
Disposition to Help	Home-like Setting	Formal, restricted/segregated areas, work/institutional	Informal, sense of belonging and ownership
Competency	Best Quality of Care	Reactive, depend on direction	Proactive, innovative, risk-taking behavior, continuous learning
Contribution of the cared for	Meeting changing needs	General, routine, structured, automated	Particular, specific, individualized, flexible

This meeting concluded with a commitment from the SSWs to engage in activities that would implement their AS. There was recognition that the new activities would need to emphasize relationship development and engagement in continuous learning. The SSWs appeared excited to engage in these new activities.

Development of the Talk-Time (TT) Program

Over the next few weeks, I encouraged the SSWs to spend time with residents and others to build relationships. However, despite the SSWs excitement to engage in relationship development, the SSWs repeatedly identified the challenge of not having adequate time to do so.

To address this challenge, I worked with the SSWs to prioritize practices, the frequency of certain practices, and elimination of redundant or unnecessary practices to create time. Furthermore, work tasks were reorganized, re-grouped, and the start of shift and stop of shift times of some positions were modified as needed. After this process, new job routines were developed and presented to the SSWs for their feedback. Once developed, these new job routines allowed each position approximately 15 to 20 minutes daily to purposefully interact with residents, resident's family, staff and/or members of the community above and beyond the interactions that occurred during the day-to-day activities.

During these interactions SSWs were expected to share information about residents, observe residents and spend quality time with them. It was an opportunity for the SSWs to engage in activities that were not part of their regular job routine. This included things such as playing a card game with a resident, or watching TV with them, having a cup of coffee with a resident family member, or talking to a staff member about a resident-related concern. This program was labeled the Talk-Time (TT) program.

Impact of AS, DPs and TT Program

Although it was the work of Fenstermacher (1990), Starratt (1996) and Noddings (1993) which helped me formally begin the process of involving the SSWs in the care planning process, it was the work of Kanungo (1979, 1981, 1982, 1983) and Sergiovani (1992) that shaped my understanding of how this process contributed to the diminishing of workplace alienation among the SSWs. Kanungo (1979, 1981, 1982, 1983) hypothesized that to reduce workplace

alienation, first one needed to be aware of his or her salient workplace needs. Second he argues that one needed to be able to conceptualize activities in the workplace which would lead to the fulfillment of these identified salient needs.

In the case of the SSWs, the development process of the AS began to address the underlying needs of the SSWs, which included the need to be recognized, respected, growing at work and to be happy. The DPs and the corresponding changes that were made to the SSWs' work and routines allowed the SSWs to develop the expectation that they will be able to meet the needs they expressed in the AS. Kanungo (1979, 1981, 1982, 1983) argues these two processes are fundamental to connect staff to the workplace and help them overcome workplace alienation.

The AS and DP not only clarified the SSWs' needs at work and their workplace's ability to meet their needs, but also were the beginning of developing new ways of doing work with moral underpinnings. Using the work of Sergiovanni (1992), the development of the AS can be seen as a reversal of goal displacement and the DPs can been seen as reversing trained incapacity. In the case of the SSWs, the development of the AS connected the SSWs to the larger purpose of providing care to the residents during the course of their day-to-day work by becoming part of the care planning process. The DPs the SSWs identified included being people oriented, developing relationships with various groups in the care home and continue learning to be adaptable to the changing needs of various individuals.

Development of the To Care is To Know (TCTK) Program

The SSWs' level of motivation to be involved in the care planning process

was evident from their increased interactions with residents, residents' families

and other staff members. However, the more the SSWs became involved, the

more they realized that there were many concepts, procedures and protocols

that they were unfamiliar with. They were not familiar with what was documented

in the resident's medical charts, what kind of information was discussed at

resident care team conferences (RCTCs), or what the specific role was of

different health care professionals. They were also not familiar with terms such

as 'care levels', 'two-person assist', 'sundowning', 'levels of intervention',

'cognitive status', 'ADLs', and many other words and phrases commonly used by

the healthcare workers (HCWs). There was also a sense of frustration among

the SSWs about feeling inferior because the HCWs did not always show interest

in the SSWs resident-related information. Though I had increased the

involvement of the SSWs in getting to know the residents, I had in some ways

contributed to a situation that was alienating for the SSWs when they interacted

with the HCWs.

As I attempted to reduce this challenge to prevent the development of

alienation among the SSWs, I was reminded of the concept of 'common

language'. I was particularly drawn to and influenced by the work of Strike

(1995). Strike claims that for full participation in an activity one must be able to

speak the language of that activity. Strike (1995) goes on further to say that

teaching about anything can be seen as teaching a language, which will allow

one to connect whatever is being taught "to important points about how people

learn to see and interpret their world" (Strike, 1995, p.33).

To explore what this language should encompass, I conducted a small

research project in July 2005. This research project investigated the kinds of

observations regarding residents' health the SSWs were making and could

make, the kinds of information they wanted to share and could share with other

departments, and other medical terms and conditions they needed to be familiar

with to enhance their interaction capabilities. The data in this project was

collected through a focus group interview. The research question that

participants were responding to was, what kinds of behavioral changes or other

changes are you noticing about the residents, which could be related to the

change in their health and/or cognitive condition? The responses to this question

identified nine areas related to the residents' health or care needs the SSWs felt

they could contribute to if they were provided appropriate and ongoing training.

These areas included: communication abilities, state of bedroom/closet, memory,

senses, behavior and mood, sleep patterns, activities of daily living, and clinical

indicators.

I combined the data the SSWs shared with me in the research project with

the initial Alzheimer's Dementia workshop that I had developed to create a

comprehensive training program for the SSWs. This training program provided

the foundational language skills necessary to enhance the interaction capabilities

of the SSWs. This training program was labeled "To Care is To Know" (TCTK)

program. I provided all SSWs this training in a 2-hour interactive session in September 2005 and annually thereafter. In addition, there were short, 15 to 20 minutes long, ongoing weekly education sessions focusing on certain components of the larger training program.

In addition to the educational sessions, which included geriatric information and personal development information, the TCTK program was expanded to include the SSWs in the resident care team conference (RCTC) on a weekly basis, which required about 15 to 20 minutes to complete. The SSWs pre-RCTC meeting is an opportunity for me to learn about the residents from the SSWs and incorporate their information into my assessments and share this information with the medical team. It also provided an opportunity for me to share my knowledge with the SSWs regarding the health changes they are noticing among residents, their possible implications and the kind of recommendations I would be making to the medical team. Further to this, this session was an opportunity for the SSWs to learn from each other.

The third component of the TCTK program was the weekly SSWs' staff meeting requiring an additional 15 to 20 minutes, which was designed for all the SSWs to make a contribution to problem solving related to any concerns or challenges in the previous week. The SSWs were asked to write down, in question format, any issues that arose that they wanted to discuss. From the questions they generated I created an agenda for our meetings.

The combination of the educational program, pre-RCTC and staff meeting, which together formed the TCTK program added to an hour of work

once a week. Meeting with the SSWs was held on Tuesday mornings when there was an additional staff member present to help staff prior to and after the one hour meeting so no staff fell behind in their job.

Development of the Documentation System (DS)

As a result, the daily TT program and the weekly TCTK meeting became major opportunities for the SSWs to participate in resident-related knowledge development and the involvement in the care planning process. The participation of the SSWs in additional activities outside their core duties supplemented the resident-related information they were already collecting during their day-to-day core activities. This created a vast amount of resident-related information that significantly reduced my resident-related clinical knowledge gap. However, I was not always immediately able to use the information the SSWs collected and therefore it was lost as there was no system in place to store it. To capture, in written format, the increased resident-related information, I introduced a documentation system (DS), which is similar to the one used by the nursing department, called the Kardex system, to record the resident-related information. All SSWs were trained and required to document their observations and information into the DS. All SSWs were responsible for reading the Kardex notes at the beginning of their shift. The information in the DS was presented by the cooks at the nursing report at shift change and they were responsible to bring back additional resident-related information they had learned at the shift change and document it in the DS to make it available to other SSWs.

Legitimizing SSWs' Participation in Care

As the SSWs' interaction with the various groups of individuals increased there was resistance developing among the HCWs toward allowing the SSWs to participate in tasks outside the core job duties of the SSWs. As I examined this situation more closely, I was able to conclude that the issue was related to territoriality. Each of the HCWs had areas of the care home they viewed as exclusively their own domain where only 'they' performed tasks. These included: the nursing station where nurses managed resident-medical information; the care aide station, where care aides managed resident-care information; the activity room for where activity aides provided social activities. The rehabilitation clinic appeared reserved for rehabilitation aides where only they provided rehabilitation services. The kitchen was seen as an area only for cooks and dietary aides for meal preparation, and the laundry room was the domain of the laundry aides. These territories had existed for years and were reinforced by collective agreements. The presence and participation of workers in these areas and the activities carried out were legitimized by job titles.

As the SSWs involved themselves in tasks outside their core job duties in these territorialized domains, the SSWs were viewed by the HCWs as a threat to the existing boundaries and rules. This disturbance to the status quo by the SSWs led the HCWs to protect their spaces by marginalizing the SSWs and delegitimizing their participation. They did this through raising questions related to the SSWs educational and experiential qualifications, showing concern for the risk of harm to the residents and presenting concerns about the SSWs' core

work duties not being carried out adequately. Again, although some aspects of my interventions were helping reduce the sense of workplace alienation among the SSWs, at the same time there were some processes that were creating additional alienation among the SSWs. Marginalizing and delegitimizing the SSWs' involvement in the care planning process was one of those consequences.

However, the more I could see how the residents benefited from having the SSWs participating in the care planning process, the more I wanted to support the SSWs' participation in activities beyond their core job duties. Further, I saw the SSWs' participation as contributing to the team-building process and ongoing mutual learning for both the SSWs and HCWs. The work of post-structuralist scholars Bush (2002) Fenwick (2000), Pierre (2000) and Usher (1995) on the concept of 'self' provided me the lead I needed to support the SSWs' participation in activities outside their core work duties. These scholars challenged the traditional construct of the 'self' as no longer being "conscious, stable, unified, rational, coherent, knowing, autonomous and ahistoric" (Pierre, 2000, p.500). Instead they present the "post-structural self [as] incoherent, disunified and in effect 'decentered' (Bush, 1995, p.2). In the post-structuralist view the traditional concept of single self is restrictive because "the 'self' cannot be 'fixed' but slides, as meaning changes from one moment in a particular community to another" (Fenwick, 2000, p.4), hence the emergence of the concept of multiple 'selves'. I was particularly influenced by Usher's (1995) argument that:

> People should let go of their fixation on the 'central' definable self, and celebrate the shifting layer of their multiple selves. Such a view opens identity choices and playful experimentation for those who feel oppressed by the limited, conventional options defining self in the workplace according to hierarchies, competencies, and job descriptions (Usher, 1995 as cited in Fenwick, 2000, p. 4).

My interpretation of this quote was that the SSWs were more than just their job titles and their work was only one aspect of their lives. The SSWs had other roles they played outside of work in their personal and social lives. This made me wonder what would happen if the SSWs were allowed to be more than just their job titles at work and they were able to justify and support their more holistic selves while at work.

To pursue this thought, I engaged the SSWs in questions at a staff meeting in February 2006 about who they were at work, at home, in their community and in other parts of their lives? To help the SSWs respond to this question, I introduced my interpretation of the post-structural discourse on the 'self' at a staff meeting. The SSWs identified various 'selves' they played in the various parts of their life. Some examples of these 'selves' included: advocate, teacher, learner, care provider, care receiver, friend, relative, worker, companion, and listener. My purpose of this meeting was not to identify an exhaustive list of all the 'selves' the SSWs could identify nor was it to have the SSWs well versed in the concept of post-structural theory, but to motivate and encourage each SSW to find their multiple 'selves' and bring them together to create a more holistic self at work. Further, I wanted them to become aware that engaging in duties outside their core-work does not mean engaging in unfamiliar tasks as

they were already engaging in many of these tasks in other parts of their lives. This would help them legitimize their involvement in activities outside their core duties and justify their involvement.

I believe this post-structural notion of 'self' played a significant role in diminishing workplace alienation but more so in the development of a new identity for SSWs. The SSWs' ability to bring together their different 'selves' and create a more holistic self at work increased their confidence. This concept of whole-self provided a strategy for the SSWs to respond to individuals who showed concern for their participation in tasks outside the core duties of their jobs. They were now able to respond with comments such as:

> "I played this game with my kids for years"; "I used to provide care and support to my parents"; "I am in a leadership role at my child's after school program"; "I love talking to my grandparents"

I believe these types of responses put into perspective that providing care is a human activity and should not be limited to individuals with particular job titles. It became difficult for the other workers to argue against having a cup of coffee with a resident in the living room or playing a board game in the recreation room or having a conversation in the resident's room or providing encouragement to the resident in the rehabilitation clinic. These types of interactions did two things for the SSWs. First they created opportunities that allowed the SSWs to learn about different departments. Second, these opportunities allowed the SSWs to observe residents in different areas, at different times, and engaged in different activities, therefore providing a more complete picture of the residents and a better understanding of their abilities and capabilities.

Role of Privatization in the Interventions

Privatization itself was not responsible for the development and implementation of these interventions nor the positive shifts I was observing among the SSWs. Eventually it became clearer to me that the conditions of privatization allowed opportunities for me to develop and implement the interventions. Previously, I was unclear about the role of the privatization process and the role of my interventions in the process of involving the SSWs in the care planning process and subsequent positive attitude shifts. I had erroneously concluded privatization was the major contributor to the SSWs involvement and positive shifts. Thinking back, part of this confusion was related to the amount of change that came about as a result of privatization at the care home. My need to involve the SSWs in the care planning process was due to the changes in my job under privatization. As a result, it had appeared to me that the involvement of the SSWs in the care planning process was related to privatization.

Overall Impact of the Interventions

Contribution of Interventions on Diminishing Workplace Alienation

Using the work of Fraser (1997, 1998, 2000) the TT, TCTK and DS could be seen as correcting the injustices of misrecognition and maldistribution. The participation of the SSWs was decreasing the differentiation between the SSWs and the HCWs. Both groups were working to improve the quality of care the residents received. SSWs were being seen as important contributors to that process and this was reducing the misrecognition of the SSWs. Fraser (1997, 1998, 2000) speaks about redistribution of resources, such as money, to correct

the injustice of maldistribution. In the case of the SSWs the process of redistributing resources included: time created to spend with the resident and participate in the care planning process, ongoing education and my support. The minimizing of misrecognition and maldistribution for the SSWs moved them towards participatory parity in the care planning process. This involved shifting the identities of the SSWs from being outsiders to the care planning process to being part of the care team as healthcare providers.

Further, using the work of Dickson (1981), the TT program, TCTK meeting and DS played significant roles in the process of diminishing alienation by allowing the SSWs to participate as healthcare workers. Dickson (1981) describes four stages of participation, which include: interaction, communication, influence and determination of outcomes. In the case of the SSWs, the TT program, which was designed to interact and develop relationships with residents, their families and the staff members at the care home, allowed the SSWs to develop a sense of belonging and affiliation with the care team. The TCTK meeting allowed the SSWs to develop and prepare their resident-related information to share with the care team at the care home. Having both the opportunity to interact and something to communicate allowed the SSWs to exercise their influence in the care planning process and observe the importance of their contribution in determining the outcomes. This involvement contributed to the development of new workplace identities and reducing workplace alienation for the SSWs. Finally, the SSWs' level of influence and determination of the outcomes was also growing as they were able to provide greater and more

complex resident-related information. This is evidenced by the increasing length and complexity of the forms the SSWs used to document their resident-related information.

The increased influence on outcomes could be explored using the work of Wenger (2005) on the meaning of work developing as an interaction between participation and reification. The concept of reification "refers to the process of giving form to our experience by producing objects that congeal this experience into a 'thingness'" (Wenger, 1998, p.58). Wenger uses participation to refer "to a process of taking part and also to the relations with others that reflect this process" (Wenger, 2005 p. 55).

In the case of the SSWs they were not only participating in the various activities and practices congruent with the HCWs, they were now also required to document their observations, information and experiences and make a 'thingness' out of it. The SSWs' level of engagement in the care planning process was initially driven by what they were expected to complete on the original forms. However, as their competency to participate in the care planning process improved, their original forms could no longer capture their increased resident-related information and needed to be changed to capture their enhanced participation. The modifications to the forms, to capture the SSWs' increased resident-related information is a sign the SSWs were learning more about the residents and were having greater influence on the care planning process.

Identity Development of the SSWs

Wenger (2005) also expands Dickson's (1981) notion of participation as not only a remedy for reducing workplace alienation but also in shaping one's identity as "participation shapes not only what we do, but also who we are and who we are not" (Wenger, 2005, p. 4). Wenger introduces the concept of peripheral participation as a type of participation that offers "various forms of casual but legitimate access to a practice without subjecting them to the demands of full membership" (Wenger, 2005 p.117). Wenger describes several ways in which boundaries to different practices or jobs can be opened up to allow for peripheral participation where one's outsider status is an enabling factor for identity development. Opening up processes include: boundary objects, brokering, immersion and overlapping activities.

In the case of SSWs, the forms from the DS, such as Kardex notes, nutrition care plans, and care conference forms served as boundary objects as they became part of each resident's medical file. As a result, the documents were accessible to various other HCWs to use. The sharing and use of these forms with the HCWs contributed to opening up and connecting the practice of the SSWs with the practice of HCWs. The SSWs' attendance at the nursing report at shift change served as a brokering opportunity. The SSWs were sharing information present in their domain with the HCWs and at the same time bringing back and sharing the information from the domain of HCWs with other SSWs. The involvement of the SSWs at the pre-RCTC meeting and the nursing report at

shift change were also opportunities to participate through immersion, and the SSWs were able to assess what type of information was important to HCWs.

Finally, Wenger (2005) argues that practices that overlap also enable peripheral participation where boundary objects and brokers are not needed. The SSWs were previously engaged in, and continue to be engaged in, many activities that overlapped with HCWs' work. However, the peripheral participation was opening up the boundaries of practices of the HCWs and allowing an opportunity to develop new meaning of these overlapping activities.

The tasks of bed making and cleaning up bodily fluids are examples of how the meaning of these overlapping activities was changing for the SSWs as they became more familiar with the practices of the HCWs and participated in the care planning process. The SSWs no longer saw bed making as a simple housekeeping task but a complex care delivery service that was part of each resident's care plan. As a result of their interactions with the HCWs, the SSWs began to appreciate the healthcare significance behind the various items on a residents' bed and more importantly to ensure the various items were placed, positioned, or used to provide maximum benefit to the resident. The SSWs became more aware that the proper placement of incontinence and pressure relieving products on the bed was not only to prevent the bed sheets from being soiled but to prevent or heal skin breakdown. Adjusting the height of the bed, raising or lowering side rails, and placement of bed alarms was not just for aesthetics, but to prevent residents from falling out of their bed. The positioning of the bed was not only to maximize the floor space in the room, but also to allow

the resident to independently and safely make transfers from wheelchair to bed or vice versa. This led to the SSWs recognizing the importance of working closely with HCWs to ensure the resident's bed was made according to the care plan. They also viewed the HCWs as a resource for learning and understanding each resident's care plan to improve the bed making service.

The overlap in the clean up of a resident's bodily fluids can also be seen as contributing to the development of new meanings of this task. When the SSWs report to the nurse their observations related to blood in the toilet or blood on undergarments, or increased urination, or diarrhea or other abnormal bodily discharges, this allows the SSWs to understand that such observations may reveal important information about the state of the resident's health. As the SSWs learned more and had a better understanding of how their information could be used by the nurse, the SSWs provided more detailed information in subsequent interactions and they no longer saw cleaning up bodily fluids as just a mess to clean but an important contribution to the care planning process.

As a result, the opening up of boundaries to the practices of HCWs through peripheral participation allowed the SSWs to also begin to develop a new sense of belonging, which was contributing to the development of new identity. Wenger states

> that we know who we are by what is familiar and by what we can negotiate and make use of, and that we know who we are not by what is unfamiliar, unwieldy, and out of our purview. We not only produce our identities through the practices we engage in, but we also define ourselves through practices we do not engage in (Wenger, 2005 p.164).

Impact of the Interventions on Me

As described, the outcomes of the privatization process significantly increased my resident-related knowledge gap. I realized it would be necessary to involve the SSWs in the care planning process to significantly increase the resident-related information that I could attain. As I worked more closely with them, the SSWs were providing me unique resident-related information they observed in their day-to-day work. I used their information to develop recommendations that significantly changed the care plan of many residents and this gave me an opportunity to make a difference and derive satisfaction from my job. This contributed to positive shifts in my care, concern and commitment towards the SSWs because I needed them.

To continue to make significant contributions to the care planning process, I not only used more of my existing professional knowledge and skills, but I now had reason to seek, on an ongoing basis, professional development opportunities to upgrade my knowledge and skills to help me make sense of the immense amounts of information the SSWs were sharing with me. As a result, I worked more closely with the medical care team professionals since I had important resident-related information to share with them. The increased level of information and my stronger association with the medical professionals enabled me to take a stronger leadership role in the care planning process and shifted my identity to a healthcare professional making a difference in the lives of the residents. In addition, as the SSWs became more involved in the care planning process, they were also being seen as important contributors to the care

planning process and as a result, their status and identities were also shifting in a positive direction. Since feeling better about my job and my contributions to the care planning and delivery process resulted from my partnership with the SSWs, my commitment towards the SSWs continued to develop.

My increased involvement in the care planning process, recognition of my involvement as important by the healthcare team, and my advocacy actions for the SSWs significantly helped reduce my sense of workplace alienation. This can be explained by the work of Kanungo (1979, 1981, 1982, 1983) on clarifying one's salient workplace needs and then conceptualizing one's worksite as a place to have those salient needs met. My needs for respect, to be a resource, my need for growth and development and my need to provide care and provide support for others are all being met at work. Further, there was a shift in my identity from an alienated manager to a leader-educator who was making a difference in the lives of both residents and staff. This shift in my identity could be explained by the work of Fraser (1997, 1998, 2000) on correcting misrecognition and the work of Wenger (2005) on identity formation related to what one does and what one does not do. I was an important member of both the medical team and the leadership team at the care home.

I wanted the SSWs to feel good about themselves and their work and to do this, I offered them privileges I had control over, including autonomy, flexibility, an egalitarian workplace and educational opportunities. To further support the new role the SSWs were playing, I worked with them to develop new titles for the SSD and the jobs of the SSWs. In this process the SSWs developed

the titles "Allied Resident Care" department or "ARC" department instead of support services department (SSD) and "Allied Resident Care" worker or "ARC" worker instead of SSWs. These titles further justified the type of work the SSWs were now engaged in, which included working in collaboration with the care team to meet the needs of the residents of the care home for the purpose of providing the best quality of life and best quality of care. This intervention supported the SSWs in developing and managing their workplace identities through reframing, refocusing and recalibrating tasks the SSWs saw as most meaningful to them. The work of Ashforth and Kreiner (1999) supports this interpretation. When describing their new roles as ARC workers, the SSWs were able to integrate their core duties into the care planning process and speak from that perspective, which enabled the development of positive workplace identities.

Reflecting back, I recall an experience one of the SSWs shared with me. She was at the bank for a loan and had written down allied resident care worker/infection control specialist as her job title. The loans officer made the comment that the job sounds important and inquired what it entailed. The SSW was able to talk about the role she played in the care planning process for the residents and how she worked with nurses, dietitians and other healthcare professionals to meet the care needs of the residents. The SSW went onto tell me that had she simply written down her job title as a housekeeper she would have not had the opportunity to engage the loans officer in a discussion about her job. This opportunity allowed her to construct an authentic workplace identity that she was proud to share.

For the purpose of clarity in this study, I will continue to refer to the ARC workers as SSWs as this is the standard term in the care home industry and it may help to avoid confusing the reader.

In addition to this, as a way to recognize the SSWs contributions to the improvement of care for the residents, I negotiated a 31% wage increase, over five years, for the dietary, housekeeping and laundry staff, taking them from $11.00/hr to $14.45/hr and a 7% increase in the wages of cooks, taking their wages from $17.00/hr to $18.45/hr. I also negotiated additional work hours for the SSD to reduce workload. Finally, I provided the SSWs more control and flexibility over their compensation package, which allows the SSW to earn up to an additional dollar per hour by selecting less paid vacation time, less paid sick time and reduced benefits should they desire to do so. I now see both the change in job titles and department name and my negotiation for increased wages and hours as additional interventions that facilitated and sustained the involvement of the SSWs in the care planning process.

The SSWs Support for Me

As I reflect, the way the SSWs interacted with me, after the various interventions, changed significantly. The original hierarchical, super-ordinate and subordinate relationship shifted to that of partners working in collaboration to carry out tasks, to me becoming an educator and facilitator for supporting the SSWs in creating innovative ways of doing their work. Throughout this process, it has been obvious to me that SSWs desired to achieve success as a group but I also perceived the SSWs' desire to see me be a successful leader. This was

evident from the level of effort the SSWs put into supporting the new ways of doing work even when it was mentally and emotionally challenging and consumed their time in their already busy schedules.

My relationship with the SSWs changed from being work oriented to more 'family' oriented. All the SSWs workers were women, the majority was middle aged (older than me), and I perceived our relationship to be maternalistic. They demonstrated maternalism by: ensuring I was taking my meal breaks, preparing meals for me, giving me surprise birthday gifts and making comments such as "you are just like my boys" or "you have all of us as your moms."

The SSWs' interest and enthusiasm to participate in this study was also evident of the support they had for me and my projects and their desire to see me succeed. The SSWs who participated in this study worked very hard with the third-party facilitator during the data collection process. I could see and feel the excitement of the SSWs during the data collection phase and the third-party facilitator commented that she had not seen such an enthusiastic, excited and committed group of research study participants.

The relationship has been mutually beneficial. I needed the SSWs' cooperation as much as they need me to continuously open-up and legitimize their participation in the care planning process at the care home.

Shifts in Power and Obligation

In reflecting back on the broader journey the SSWs and I have embarked on, I have become aware of several dramatic shifts in power and obligations between various players. The first shift of power was between the health

authorities and the SSWs' union. The introduction of Bill-29 to allow privatization shifted the power towards the health authorities. The health authorities no longer had to work with the unions to negotiate collective agreements and could essentially cancel previously negotiated and signed contracts. The second shift of power was between the Board of Directors and Administrators (BDA) and the union workers. The legislation gave the BDA the power to terminate union workers and privatize services without negotiation. The BDA could now also determine how much they would pay for various services and how they would use the savings. The third shift of power was between me, as the supervisor, and the non-union SSWs. I now had more influence and control of the SSWs' work schedules, routines and tasks. Previously any changes to these had to be negotiated with the union and their approval was required and then the staff members voted on the change. Now I can make these changes without having to go through this process. The fourth power shift was between me and other care team members. I now had more resident-related information that other care team members did not have. This resulted in a significant increase in the amount of influence I had in the care planning process. Finally there was a power shift between the SSWs and the care-aides. The involvement of the SSWs in the care planning process gave them the opportunity to raise questions about the care that was being provided to the residents and to challenge some of the practices they believed were not in the best interest of the residents. The shifts in power as they related to me and the SSWs lead to a shift in the obligation we had for the residents. As my influence increased at the care home, I believed I had a greater

obligation to ensure the residents received the care they needed. I also observed a similar sense of obligation among the SSWs.

Ironically, the increase in obligation towards the residents shifted power to the residents and their families because we wanted to be more responsive to their needs. The residents and their families had more influence in the care delivery process since they could now approach the SSWs and have their concerns raised at care planning and other meetings. They were no longer just limited to taking their concerns to the nurses or management. The humanizing of the SSWs led to the humanizing of the residents.

<div align="center">Ethics of My Actions</div>

As I reflected, several questions emerged for me regarding my actions during and after the privatization process. Were my actions enabling neo-liberal ideology and the movement towards privatization in healthcare? Did my actions enable exploitation and manipulation of the SSWs in the process? Does taking a moral leadership approach under these circumstances justify what I did or is it a rationalization of exploitation and manipulation? Is making people feel good about themselves and their jobs justified while their wages are being reduced and their responsibilities increased?

On the one hand, I feel good about what I did. I saw many positive outcomes including a high level of motivation among the SSWs. The sense of feeling good about themselves and developing a sense of capability, I think contributed to over fifty-percent of the SSWs going back to school for a provincially recognized certificate in healthcare, something I did not foresee. For

many of the SSWs who went back to school, I provided the support that was necessary, such as mentoring and flexible work schedules. I saw a housekeeper go back to school to become a certified level three/red seal chef and then continue her studies, becoming a certified nutrition manager. She now works as the Foodservice Manager for the private company with a 75% wage increase. I saw five dietary aides go back to school for chefs' training; three have become certified chefs and two are still in progress. These dietary aides provide relief for the cooks when they are away. They also make 55% higher wages when they work as relief cooks. I saw a housekeeper go back to nursing school to become a care-aide, and she now works full-time as a care-aide, nearly doubling her wages. I saw two staff members go back to school to take English as a Second Language to improve both their written and oral communication skills. Two staff members were promoted to more senior positions at different sites within the private company and one staff member resigned to start her own business. All these staff members acquired skills that will help them in the future to obtain higher paying positions should they wish. However most of them continue to be employed with the private company and tell me this is the best job they have ever had. This goes back to Kanungo's (1992) notion of a manager's moral obligation to create an enabling worksite that will allow workers to maximize their potential even if the worker decides to leave the job for other opportunities. I feel good about trying to create an enabling workplace for the SSWs.

On the other hand, I wonder, if I had done nothing, would the whole privatization process have failed at the care home, forcing the BDA to review

their decision or would they have carried out their decision as planned, possibly leading to work conditions no different than what Stinson, Pollack & Cohen (2005) describe in their study.

Stinson, Pollack & Cohen (2005) conducted a study titled "The Pains of Privatization – How Contracting Out Hurts Health Support Workers, their Families, and Health Care". Their study investigated the experience of 24 SSWs, most who had lost their in-house housekeeping or dietary jobs as a result of Bill-29 and were re-hired to do the same work for a private company. In this study the researchers found that 75% of the workers were earning incomes below the 2003 Canada poverty line. The workload of these individuals was extremely heavy. In addition, the staff complained about unpredictable work assignments, frequent interruptions from off-site call centers for day-to-day work instructions, and working short staffed when absentee employees were not replaced. Many staff complained of having to take shortcuts to finish their work, putting themselves at risk of injury. Further to this, they perceived their supervisors as "unsympathetic, ill-informed, powerless and unlikely to help with problem-solving" (Stinson et al., 2005, p.8). As a result, over 75% of workers described feelings that ranged from depression to anxiety, powerlessness, frustration, and anger about their circumstances. The researchers argued that "workload is the biggest cause of emotional distress; disrespectful treatment from supervisors is another key source. Among workers who were former in-house employees of their facility, many were dispirited by the severe drop in pay and benefits, loss of rights, separation from co-workers, and increased workload" (Stinson et al.,

2005, p. 6 – 7). This possibly could have been the reality for the SSWs involved in this study if I had not take the actions I did. I will never know for sure.

Chapter Summary

The significant shift in the attitude among the SSWs towards their work and their increased participation in the care planning process intrigued me. It was not long ago that the SSWs felt alienated from their workplace due to having their work hours reduced, receiving little support from their union and the HCWs for the decertification process, being laid-off from their union jobs and re-hired by a private company at significantly lower wages. It was not long ago when they had little interest in the care planning process and viewed it as solely my job. I wanted to understand more formally and comprehensively what led to the diminishing the workplace alienation among the SSWs and their increased involvement and influence in the care planning process and how this changed the way the SSWs viewed themselves?

In this chapter, I have presented my side of the story of the process the SSWs went through that helped shift positively their attitude towards their jobs helping them overcome their sense of workplace alienation. The leadership role I played in this process allowed me to meet my salient workplace needs and reduce my sense of alienation as well. These processes included the various interventions I implemented which enabled the SSWs to become aware of their underlying workplace needs and make changes to their work routines to allow their desired needs to be fulfilled at work. Further, the SSWs had the opportunity

to participate in the care planning process that allowed increased influence on determining the outcomes for the residents.

The process of increased involvement led not only to reducing workplace alienation sensed by the SSWs, but also changed their identity from outsiders to the health care team to insiders and significant contributors to the care planning process. I also described the shift in my workplace identity resulting from increased involvement in the care planning process and from my advocacy for the SSWs. Further, I described the shifts in power and obligation I was observing among the various players who were part of the privatization process. Finally, I have presented my reflection on the ethics of my actions.

I have taken a reflexive approach throughout this chapter to understand and clarify some of my earlier thinking. This included: understanding my frustrations at the workplace prior to privatization, the shifts in my view of the role of privatization and my role as the leader in the development and implementation of the various interventions to involve the SSWs in the care planning process, the broadening of what I now perceive to be interventions which facilitated the SSWs' involvement, the ethics of my actions, and the shifts in power relations between various players directly and indirectly involved in this journey.

In the next chapter, I will present the SSWs' side of the story using quotes from the focus group and individual interviews to represent their voices.

CHAPTER 5 – FROM WORKPLACE ALIENATION TO EMPOWERMENT AND POSITIVE IDENTITY: THE SSWs' EXPERIENCE

This chapter focuses on the perceptions of the SSWs as captured through individual and focus group interviews. Prior to the SSWs having the opportunity to engage in the various interventions that enabled them to become part of the care planning process, they were a group of women alienated from their work, having minimal influence, and perceived by others as low status and unskilled. After the opportunity to engage in various interventions there was a shift from being alienated at work to becoming a team of connected and committed women who were developing gerontology-related knowledge and interpersonal skills. Their new knowledge and skills made them important members of the care team with significant influence in the care planning process. To develop a compelling argument and examine this process of de-alienation and identity development in more complex and sophisticated ways, I will draw on the work of scholars whose work I presented in Chapter 2, integrated with the voices of the SSWs.

The analysis of participant responses revealed a pattern of experiences and perspectives over the course of the period under study. I have organized the data chronologically to reflect events, episodes and issues that occurred over a period of time starting from March 2002 to March 2008. Although the entire journey during this period had been evolving in dynamic ways, I have presented the data in a before and after picture in relation to the formal interventions. I have included SSWs' voices about these events, episodes and issues, using direct quotes as appropriate.

All participants have been given pseudonyms to protect their identities and each individual's quote is referenced by a code with three parts. The first part indicates the page number of the transcript; the second part indicates whether the quote is from the first focus group (fg1) or individual interview (ii) or second focus group (fg2). The last part of the coding system identifies the participant (e.g. pt1, pt2).

Before the Formal Interventions

The SSWs describe experiences of alienation, deskilling, exclusion from the care planning and delivery process, and being perceived as low status workers having no influence. In their narratives it becomes clear that these experiences overlap in significant ways, creating an overall marginalized position for the SSWs within the care home.

Most of the quotes for this section are coming from one participant, Catherine. There could be several reasons why Catherine did most of the sharing of information. She had a leadership role in the privatization process and therefore was more familiar with the process. Another reason could be that she used the interviews to tell her story and the story of the co-workers she led as no other opportunity had been presented to her to do so. Finally, there was some evidence in the transcripts that it was too emotional for other participants to speak about the events and they were more comfortable with Catherine telling the story while they added statements as needed. According to the transcripts, several participants shed tears as they spoke about this stage of the process.

Lack of Recognition

Prior to privatization Catherine talks about the mentality of "who cares?" as prevalent among staff. She links the development of this mentality to the messages from the care home and from their union.

> The care home and the union… encouraged us not to participate… in clinical observations to do with resident care. We were always told we don't get paid to be registered nurses or care aides… we are here just to do bull work. (p2iipt5).

Joanne recalls a union representative commenting to her during preparation for strike action that she:

> can stay off for a while because [you are a] housekeeper and not an essential service and we don't need you to be here. I mean that's the way it was looked at, you are just a housekeeper they can do without us. One of the head Union reps said any idiot can flippin flip a mop (laughed) so we were nobody and anybody can do it (p24fg1pt4).

In these statements it is evident that the care home and the union leadership perceived that the type of work they did was unskilled and the workers were therefore, easily replaceable. Their union told them that their jobs were mainly physical labour that required little or no skill and as a result anyone could do the work. Finally, they were told that their jobs had so little importance in the overall functioning of the care home that they could just stay off work. These statements clearly describe the sense of meaninglessness and self-estrangement that contributed to the development of workplace alienation.

Monika and Catherine shared how they were unable to use skills they had learned in their previous jobs and how they felt like the least important workers and received no recognition of their hard work. Various other participants shared similar stories during the interviews.

When it was unionized people were very much puppets. Pretty much told what to do (p2iipt9).

I wasn't able to express myself or use any skills that I was used to using. (p21iipt5). I have so much to offer because of skills from another job, but you know you didn't count… and [just because you] choose this field and happen to be in housekeeping doesn't mean that you don't have brains. You know that is exactly where you were always placed below others. Every time there were cutbacks anything, housekeeping and dietary work are on the very bottom for anything (p22 fg1pt5).

These are clear examples of the sense of powerlessness and isolation the SSWs had to deal with at the care home. They felt controlled and could not express their uniqueness. Further, the marginalization of the SSWs isolated them from other workers and reduced their opportunities to develop new skills and knowledge outside their core work duties.

The SSWs' comments about their union puzzled me and forced me to think more about the union and its role. I already had a negative impression about the SSWs' union to begin with, as a result of my previous experiences of having to work with the union leaders to make minor changes to the jobs of SSWs. I felt the union made change difficult and sometimes for the sake of making it difficult. Hearing the SSWs' stories about how their union viewed them further reinforced my negative impressions. However, there was something missing. I wondered how an unsupportive union could maintain the SSWs' support for all these years? Was there coercion or were the SSWs happy with the economic benefits and job security the union provided and chose to ignore the negative aspects of the union? As I thought more about this I realized that the SSWs' union had a different understanding of what was in the best interest of their members. The union defined 'best interest' of their members in strictly

economic terms and ignored the importance of meaningfulness of work in determining members' best interests. The union contributed to alienating conditions among the SSWs by pressuring them not to do work for which they were not specifically assigned and paid, contributing to the sense of powerlessness and meaninglessness among the SSWs. This opened up interesting questions for me. Though the role of union is to reduce alienation by providing workers more autonomy and control at work in relationship to management, but a similar reduction in alienation did not occur between union members and the union leadership. What role does a union play for non-professional entry-level workers who expect self-growth and development and more dynamic workplaces? How can unions balance their members' economic interests with their need for meaningfulness in their work? These questions have begun to reshape my negative impression of the unions. I now see them struggling to figure out how to operate in a rapidly changing work environment with expectations of workers that differ significantly from historical ones.

Inferior Workplace Status

The SSWs also reported that the combination of the nature of their tasks and the lack of recognition made them feel like the least important group of workers at the care home. Catherine explains,

> I personally found it difficult to work as a housekeeper as I knew we were considered to be the lowest of importance in the building… You were treated like you weren't more than a toilet scrubber and after a short while my sense of self worth was diminishing. It was especially degrading when you knew some staff from other areas didn't know much more than we did in certain areas but were treated with more respect and were considered to be more intellectual as far as the clinical aspect came into it… I found housekeeping to be very repetitive and meaningless after a while and it

was difficult to motivate yourself and constantly being around negativism didn't help… Sometimes when a great idea would come along that you wanted to share with the team, it would be shut down quickly sometimes because it was your idea and you didn't have as much seniority as some of your co workers and they couldn't be bothered to try it. If you are going to be looked at as a nothing you begin to act like it as well and believe it (p2-3 iipt5).

Catherine then described how residents' family members excluded SSWs when recognizing staff.

You know in the past it was kind of sad because the thank you card always used to come in saying 'Thank You' to the care staff for looking after our mothers or our fathers while they were here. That was devastating, knowing that you put in a heck of a lot of effort as well. Who sits down on their bed and talks about what they did on their farm in the past? We had so much part in their everyday happiness and you were not recognized even that way. So when they passed on, the chocolates or the cakes always went to the care staffs, not other ones and I watched and witnessed that always (p14iipt5).

In these statements several variations of alienation are present. First, Catherine felt that that she could not express herself or use skills because her higher status or more senior colleagues determined what was allowed or not allowed. When the SSWs came up with a great idea, their idea was not accepted because it was theirs. The SSWs were expected to do physical work such as scrub toilets and leave the more intellectual work for others. This was impacting Catherine's self-worth and she was beginning to view herself and act as a 'nobody'. This is a clear example of Blauner's (1964) definition of self-estrangement, where no opportunities are provided for expressing "unique abilities, potentialities, or personality of the worker" (Blauner, 1964, p. 26). Second, Catherine commented that there was significant lack of recognition of the SSWs contribution. The quality time they spent to attend to the residents'

social and emotional needs was not recognized. Their skills from other experiences in life were also not recognized. The combination of powerlessness, meaninglessness and lack of recognition, or what Fraser (1997, 1998, 2000) calls misrecognition contributed to isolation among the SSWs. The SSWs were segregated and separated, classified as the lowest of importance and placed below other workers. They were last to receive increases in work hours and wages and first to experience cuts in hours and wages. .

The opinion that SSWs were unskilled, least important workers and did jobs anybody could do might be explained through the way their work was structured and how the SSWs carried out only parts of the overall task. For example, the task of serving a meal is complex, and includes steps from deciding what to prepare, purchasing the ingredients, preparing the food, serving the food, feeding the residents as needed and monitoring the residents' ability to tolerate the food. However, this task is subdivided, various individuals carrying out only parts of the process.

The dietitian decides what will be prepared and what texture of food a resident receives. The foodservice manager orders the food within their budgetary guidelines. The cooks prepare the food according to pre-determined recipes and methods. The dietary aides deliver the food to the correct resident and the care aides feed the residents, monitor their tolerance and report observations to the nurse. The nurse then lets the dietitian know when a concern arises and the cycle begins again.

In the subdivision of meal service, the various players have various levels of influence and this develops a social hierarchy. The dietitian as the decision maker ends up with the most influence, followed by the care aides who feed and monitor the residents. The cook and dietary aides have the least amount of influence since one prepares the food as directed and the other delivers it in the dining room. As a result, the cooks and dietary aides are the most likely to feel alienated from the meal service. The foodservice manager (FMS) struggles with tensions between what the dietitian has ordered, the quality of ingredients the cook requires and the budget within which they must work. As a result, the FSM is also at significant risk of alienation as this individual has the difficult task of pleasing so many individuals.

Further, as medical nutrition science expands, it makes planning, preparing and serving meals more complex, and knowledge is concentrated in the hands of fewer people who specialize. Dietary staff who prepare and deliver the meals continue to have less and less understanding of therapeutic diets. Their responsibility becomes simply carrying out the directives of others. As a result, the parts of the tasks these individuals are responsible for becomes their focus and they become less and less aware of the other members' roles in the overall task.

A similar argument could be made for laundry workers and housekeepers. First, washing clothes or cleaning parts of the building is a basic task that has, through science and technology, become so complex that the very individuals that carry out the tasks do not have the knowledge to question the tasks or

equipment or chemicals being used. As far as the laundry goes, the family of the resident determines what clothes will be provided for the residents. The care aides determine what the resident will wear and when. The nurse decides if any alterations are needed to the clothes to improve the independence of the resident. Alterations may include pants with elastic waist, or shirts split in the back and Velcro used to fasten. The laundry workers simply wash the dirty laundry and deliver the clean laundry to the resident's closet. In this case the laundry workers have the most routinized job, the least discretion in their work, and the least amount of influence on what the residents wear. In the case of the housekeepers, they are expected to clean the beds but not make them, they are responsible for sanitizing the building to minimize infectious outbreaks but have very little information on the active ingredients in the various cleaning chemicals or why a particular chemical is used for cleaning specific surfaces such as counter tops, table tops, handrails, and floors. They have no involvement in the development of policies or procedures related to infection control and many have never seen or read the actual policy. Further, they clean up various bodily fluids but are not trained to monitor abnormalities in these fluids, nor required to report their observations to the nurse.

As each individual becomes less aware of the whole process the more common it becomes to hear individuals using phrases such as "I don't know" or "it's not my job". This is supported by the comment Joanne makes in her interview, "It wasn't my job to pay any attention to the residents" (p2iipt4). When workers focus narrowly on only those tasks they are responsible for, they are

engaging in what Sergiovanni (1992) calls 'trained incapacity,' or the inability to do or know other workers' roles in the overall task. The increasing specialization and division of labor leads to a distancing of the worker from the overall process leading to estrangement from the labor process, and subsequent workplace alienation, as described by Marx (1969).

<div align="center">During the Privatization Process</div>

<div align="center">*Experience of the SSWs during the Privatization of their Jobs*</div>

As described in previous chapters, once the care home decided to privatize the Support Service Departments (SSDs), the SSWs in collaboration with some care staff, initiated the union decertification process. The idea behind the decertification was to replace the union with a staff association that would directly negotiate a contract with the care home. They hoped this would prevent job losses, retain some control over negotiations, and avoid contracting out services to a private company that would determine who was hired and what wages and benefits would be paid. As the process of decertification and privatization began, the care home became a politically challenging place for the SSWs. Catherine, who was a member of the union executive, describes the experience as "one of the worst experiences of my work life I have ever had to deal with. It was horrible and abusive" (p2fg1pt5). She talks about the various strategies she used to support the SSWs and herself through this process. Her first move was to inform herself and share information.

> I started to attend some union classes about the possibility of contracting out in care homes and started to let the union executive know that the possibility was really there. The areas that were hurting the care home

financially were staff abusing the WCB[1] process and abusing the sick plan (p3fg1pt5).

Catherine's describes how sharing her knowledge regarding contracting out and possible alternatives with other staff members put her in a leadership position.

> I had become the voice for the support workers. I had stressed that we all need to work this out together and look after each other. I said that if she (administrator) has to contract out the support workers first the care aides would be next. I knew as well as other staff that there was no way the administrator would only contract out the support workers and not touch the very group (the care-aides) that was abusing the system. The talk of decertification was starting to arise (p3fg1pt5). Many staff wanted to decertify but the union and some very militant staff fought the whole process. I was kicked off the executive of the union as my voice was being heard and they knew I had great relations with staff (p3-4fg1pt5).

As the process of decertification intensified Catherine describes it as

> so horrible… There were name-callings and bullying going between some staff. I don't usually have any problems with any staff but when I see some staff being picked on I can't help but go into protect mode. The care aides picked on the staff that they knew could not handle themselves. They didn't abuse me to my face but the emotional drain of having to be the contact person for the support workers was exhausting. I would go home at night and sob. My family was affected so much. They were not used to seeing me so involved in this way at the care home (p 4fg1pt5).

It is obvious from Catherine's description how incredibly difficult it was for the SSWs, who on one hand were dealing with the possibility of losing their jobs and on the other hand were being verbally abused at work for trying to save their jobs. When asked if people started to quit their jobs as a result of the difficult

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[1] The WCB premiums and the use of sick time at the care home were significantly higher than industry standards and amounted to a significant cost to the care home already in difficult financial circumstances. Part of the reasons for the higher WCB premiums and sick time use was likely related to the staff being composed of older individuals who required longer time to recover from injuries and sickness. However, some staff also saw WCB and sick time as entitlements and used the programs to their advantage. This was particularly the case among care-aides. The care home had made it very clear that these costs were a significant part of their financial problems

work setting that was developing, Catherine tearfully replied, "No, people did not

quit. They hung in there because we all talked about standing together at least

as support workers" (p4fg1pt5). She continued in an informal leadership position

to address the mistrust and segregation that was developing between the SSWs,

the care-aides and the care home.

Despite the process of privatization moving ahead, the union continued

their message that no contracting out would occur and that management was

using it as a scare tactic, which Catherine did not believe.

> The administrator had been telling us for a year that the home was in
> financial crisis and out of 90 staff you maybe had 20 percent that even
> listened. (p2fg1pt5). Some of us had listened all along and felt we knew
> our administrator well enough to know she was not doing this as a scare
> tactic. There were frustrations building between staff, support workers and
> care aides (p3fg1pt5). The decert vote was sounding very positive all
> along until the union called a special meeting for care aides only which
> was really wrong because we were all still members and you were not to
> exclude anyone. What ever happened at that meeting scared some
> workers into not supporting the decert vote (p7-8fg1pt5). Actually they
> ended at that meeting and that was when they said that they couldn't trust
> her and that she [the administrator] was going to strip everything (wages,
> benefits, job security) (p10fg1pt5).

Catherine continued to share information regarding the decertification process

and her strategy for working with the staff.

> I was not about to tell anyone HOW to vote. All I offered all along was the
> facts that I knew and the rest had to be left up to the staff. I also believed
> if you were in their faces, this would go against you (p 8 fg1pt5). I killed
> them with kindness… and I believe it works. I always said people cannot
> hate people with good attitude and kindness. You just kill them with
> kindness. So that's what I did through that process. It was hard but you
> know it worked (p12-13fg1pt5).

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and had instituted several programs through the Occupational Health and Safety Committee to
reduce injuries and sickness but with little success.

At the end of this difficult and emotionally draining process the decertification

attempt failed and the SSWs' jobs were privatized.

> The vote to decertify and was lost by only three votes. That was
> exceptional considering there were 3 times as many care aides as support
> workers and we came really close (p4fg1pt5). What is done is done but
> deep inside I can't help but feel proud of our efforts (p9fg1pt5).

Joanne emotionally recalls how she was feeling when she heard about the failed

decertification attempt.

> I thought there was a pretty good chance of decertifying. Lot of the care
> staff were on our side. I had talked to few and they had agreed. I was on
> holidays but was in touch through e-mails. Hearing some of the things
> happening in 3 weeks period like meetings being held not including the
> support staff and was strictly care staff… it was a terrible vacation. I spent
> rest of the vacation thinking that I was out of a job. Then I came back and
> found out that we lost by 3 votes. Before I left I tried to make every effort, I
> phoned the notary, I phoned to see if I have witnesses and if I can even
> have a lawyer to witness my signature that I would vote on behalf of
> decert. I wasn't allowed to do anything. I was just an absent. I did lot of
> crying (p6 -7fg1pt4). (The transcript indicates that the participant was in
> tears as she spoke these words).

The failure of the decertification process and the actions of some care

staff reinforced the divide between the SSWs and some of the care staff.

> After the decertification vote one of the care staff members right in front of
> the administrator's office basically goes saying "we won, we won!!"
> (clapping hands!). I said shame back! Somebody that made that comment
> is not thinking about the rest of us at all (p10fg1pt4).

The treatment received by the SSWs from some of the care-aides after

privatization of the SSWs' jobs further encouraged the SSWs to unite and

support each other. Joanne and Beverly shared their experience of working with

the care-aides.

> There was lot of picking on people and if they were reported for discipline,
> the union was there down behind them and nothing happened. They were
> right back slamming doors on your face and calling me stupid, idiot. I just

locked myself in the bathroom and cried… After we were contracted out they were still union and they could do what they want and still get protection. It was pretty tense… In the unit there would be hot chocolate and syrup going right from one end of the floor to the other and we had to sweep it… I go down the halls and you could hear whispering in the rooms and if they knew that I was there they would talk louder… care-aides would come and literally right up to me after we were contracted out and say we were idiots… they just kept at me and at me and at me. I just froze and started shaking and then I turned around and started to cry. I couldn't get out of the unit fast enough and then went to the ladies washroom. I was even having a hard time breathing. I was hyperventilating (cried) (p6fg1pt4). I just tried to ignore them. I tried to stay out of their way. I was scared, period (p11fg1pt4).

I remember that we were trying to figure out how to make the beds and nobody was giving us hint how to do it or what that person liked. We were basically on our own doing our thing and nobody was even giving out suggestion or anything (p12fg1p3).

Experience of the SSWs during the Privatization of the Care-Aide Jobs

Many care aides had supported the SSWs and the failed decertification. However, there was a loud vocal group of care aides who did not support the decertification since they believed their work could not be privatized. When it came time for the care-aides' jobs to be privatized the vocal group of care-aides began to share their experiences at the care home with the local community through local newspapers. When the SSWs read the articles in the newspaper they took action to counter what they perceived to be misinformation. Catherine describes this process.

Sure enough, when it came their (care aides) turn it started all over again (crying). Basically I felt for them… I felt just as bad for them. We tried to help them (p13fg1pt5). When it was closer for the care aides to be contracted out, god forbid it was all about them loosing jobs all of a sudden! They went to the media. They were on paper you name it. They wrote a couple of nasty articles in the paper. Off course that was little too much to handle. So, we turned around and went to the editor. We told the other side of the story which went into the papers. It was very truthful of what the process was and what chances we were given before this all

happened. You guys weren't just told that you lost your job but we were dealing with this over a year. When it hit the papers they were even madder and they were even angrier that we even dared to have a voice. But I tell you, I felt so good and most of us who were working here felt good doing it (p13fg1pt5).

Joanne remembers the hostility she faced from some of the care-aides as a result of the article the SSWs submitted to the local newspaper.

I was cornered because of the article in the paper. They came and they slapped it (the newspaper article) and said how could you say all this garbage and say that you are happy (p14fg1pt4).

The privatization process appears to have done two things. First, it alienated the SSWs from several groups, including the government, who described them as "toilet bowl cleaners"; the union, which excluded the SSWs from meetings; the care-aides who did not support the decertification process; and the care home, which privatized their jobs. The SSWs were isolated with very little support. Second, the alienation from these groups necessitated the SSWs to come together and support each other and develop a collective voice. Writing to the local newspapers to counter what they perceived as misinformation from the care-aides is an example of the SSWs coming together. Further, to cope with the backlash from the care-aides they needed to remain united to support each other.

After Privatization and Involvement in the Care Planning Process

In this section, I have presented the data thematically because although the various interventions could be described in a chronological fashion, the participants did not describe them that way. It is evident from the transcripts that

participants described their experiences as a process that was dynamic, evolving

and developing, not as discreet and disconnected interventions.

The interventions enabled the SSWs to participate in the care planning

process. Several participants spoke of the freedom they felt, the appreciation of

the educational opportunities that opened up for them, enabling them to be more

resident-focused and to provide the best care possible in a home-like setting.

The SSWs wanted to learn new ways of doing their work and desired to

renegotiate their identities. Catherine explains,

> I felt so much freedom… we were able to create and express new ways of doing things. Our leader [myself, the researcher] brought us wonderful opportunities… a new way of deciding what our reason or purpose was to be a support worker. I of course bought right into it because… in the past… there were no opportunities to use any knowledge or skills you may have to offer. We spent half of our day with the residents. With proper education and training, we can learn more on what to observe and what is helpful to know to be able to offer better plan for the care of the residents (p5iipt5).

The SSWs also wished to shift from task orientation to people orientation, which

Catherine summarizes as,

> we all wanted to be more focused, so we sat together and came up with an aim statement "people focused" to make the home as open and home-like as we were able to. We wanted to provide the best care by being innovative and hopefully offer the best quality of life that we could for the residents (p3iipt5).

Joanne found that being resident-focused occurred even during meal breaks.

> I often find during our lunch or coffee breaks we are not talking about our personal lives but we are talking about work, about what to do, for example have your noticed so and so is acting this way. It seems to be a lot of that now (p26fg1pt4).

Catherine shared how positive the experience has been for her, and many of her

co-workers agreed.

The changes that I have experienced personally have been life changing. When I look at where we are today and where we were before contracting out as far as the service delivery goes, there isn't any comparison. (p6-7iipt5).

These are examples of developing new workplace norms, which is one of the 'leadership substitutes' described by Sergiovanni (1992). The SSWs wanted to be resident focused, to be a part of the care planning process, and to contribute to giving the residents the best possible quality of life at the care home. These are the same desires the SSWs expressed in their Aim Statement. As a result, these desires can also be seen as the reduction of what Sergiovanni (1992) describes as 'goal displacement,' where the means become the end. The SSWs were beginning to focus more on their self-developed 'AS' as the end instead of their tasks as ends. Finally, the internal motivation that is present in these comments also suggest the SSWs' work was becoming more intrinsically motivating, which is another leadership substitute described by Sergiovanni (1992).

Interaction with Individuals and Knowledge Development

Understanding and Working with Residents

The dementia care training program appeared to have made a significant impact on the SSWs' ability to understand the residents' health conditions, and report health-related observations to the care team; they found the ongoing education exciting. Judith shared her experience, which was similar to many other participants prior to and after receiving dementia care training:

When I first began working at the care home, I was new to the health care field. I had always had an interest in the medical field, and without higher education, working here, even in housekeeping intrigued me. The first few

months of work, were a bit confusing. There didn't seem to be a whole lot of respect for the support services department. There seemed to be an invisible border between the care staff and the support staff. We had our jobs, and they had theirs. I remember one time early on, that I had mentioned to a care aid in the special care unit that one of the residents was moaning and seemed to be in some kind of pain. She frowned at me and just said, 'oh really?' and walked off in the other direction. I felt embarrassed and that perhaps I had overstepped my boundaries. After the first few months of work, I wasn't sure if I would find the job satisfying, or if I would enjoy it for very long. It was hard to work around some of the care staff who looked down on you or talked or laughed when you turned your back. I felt that many times. As the months went on we began to learn, through dementia training, and our mini in-services and weekly meetings, more about the elderly and the diseases that often inflict them. The more I learned, the more I began to take notice. Learning about dementia and the stages of Alzheimer's really opened my eyes and helped me understand what some residents were going through. I could see the progression of their disease, and how important it was to share the knowledge of what I observed. Now, I don't think I would want to work at anything else. I've grown to love what I do, and everyday is a learning experience. (p6iipt6)

Catherine also shared a similar experience.

Our dementia training for the first time[2] around was incredible to me. There were so many behaviors that I had observed, but didn't understand why it happened. With ongoing education in dementia care now over time so many of the staff have become very confident in their ability to speak confidently on the different stages of dementia and can share their findings at shift reports (p5iipt5).

Joanne explained how it is not just about staff giving to the residents but also the

residents giving back to the staff, which allowed for relationship development

with the residents.

The residents give me back a lot… because some of the things that they say, so they are giving back to me. I am not only giving to them. A resident this morning… I go up and held his hand and I just love him. He looks at me and holds my hand and says how are you today? I said I am fine and I said you are such a sweet man. He looked at me and says you

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[2] As I reflected and described in the previous chapter, the SSWs initially did not accept my interventions and actually resisted participation. However, the SSWs do not mention this in either the focus group or individual interviews.

are such a sweet talker… I just held his hand like that. It was just so cute and he had such a big smile on his face… I just gave him one back and those are stories to remember. (p27-28fg2pt4).

Judith described how allowing relationships with the residents motivated her.

When I first started to work at the care home there were boundaries on your relationships with the residents in just how you felt about them. You aren't supposed to get attached because these people are going to get sick, and they are going to die, and they are going to be gone. So you don't allow yourself to become close to them. Now through all this process, I think what kind of motivates me is that I do allow myself to get close to them, I allow myself to love them, and it's hard when they pass away, but I understand and I respect the fact that it's all part of our being here (p12fg2pt6).

Many of the participants said the most motivating part of their job was making the residents happy and seeing them smile, since they viewed the residents as part of their extended family. Monika described her interaction with the residents at the beginning and end of her shift.

I even noticed that when I leave at night, I say good night or say something funny like don't party too late. They smile and wave goodbye and when I come in the morning they say hello and big smile on their faces. They get to know you and it's almost like you're a family member coming by because for lot of them we are their family as they don't really have anybody. Others have family member who visits on a regular basis but they know we are here five days out of seven (p27fg2pt9).

The development of relationships with the residents is a key component of the SSWs' participation in the care planning process. As they got to know the residents the more they were able to notice health-related and other changes during their day-to-day activities. Further, the development of relationships allowed the SSWs to develop a sense of attachment to the residents and increased their sense of obligation to ensure the residents' needs were being met.

Understanding and Working with Co-workers

In addition to better understanding the residents, many participants spoke about the importance of the interventions in understanding their co-workers. Catherine explained that,

> One of my biggest areas of development I have found is really understanding people's style of leadership. We have all got different styles to teach people and learn in different ways. So I am a mediator, which means I want to make sure everything works. I don't act quickly, I don't jump on things. I sometimes need overnight to think about it. Other people react very quickly. They are directors…but I can laugh about it and I can laugh with them to say you need to take a step back. You are acting too quickly…Maybe the thought hasn't processed and you haven't thought it through clearly. So everybody has a style including yourself and you need to figure out and understand what their style is and appreciate the pros and cons in all styles and I am totally there… So anyway I have come so far in confidence just because learning that people behave for certain reasons. I think back… oh that's why she did that without thinking it through. It all makes sense to me now because people react differently depending on what their styles of leadership are. I can pick out what they are like and why they might behave or think the way they do. All of that has been really rewarding. It's been very helpful because you can pretty well go out there in your own personal life at home and sees how and why people are the way they are (p 22-23iipt5).

Further, she spoke about how training in conflict management improved relationships.

> All staffs have had in-service on an ongoing basis as to how to appropriately deal with conflict and how to resolve it. I can truly see the confidence they have gained and how they actually handled conflict with other staff members. Staff from other departments knows that if they are going to pass rumors around or begin to cause problems about a support worker, they will be approached and asked certain questions regarding the situation. We find that there is very little conflict among staff as there will be accountability on things that may or may not have been said (p8iipt5).

Several other participants spoke about how understanding their co-workers'

learning styles and becoming better listeners has helped them improve their

relationships.

Catherine spoke of the change in respect the staff had for each other and

themselves based on her observation of sick time use and WCB claims.

> When I look at the past history of sick leave or WCB abuse I just can't believe what we have today. The team is definitely there for each other. There is very little sick leave and WCB doesn't exist. That to me shows how much staff cares for each other. There is a real connection towards each other (p23fgpt5).

She also perceived cohesiveness among the team as a result of their way

of handling gossip, misleading, or inaccurate information, which most times was

spread to create unnecessary problems between departments or staff members.

> We need to stand up for ourselves. We are trained enough now to deal with it. We will approach somebody to say I understand that you were upset with something I have said. What is it and we call back and make that person accountable. Most times it wasn't something that was said. It was somebody that was out to cause a problem. But it is very minimal now here. Its very minimal two years later because staff know that if they are going to be nasty they are going to be held accountable and called on it… you are not going to get away with passing rumors… you are going to be accountable for what you have said (p 19iipt5).

Several participants mentioned their relationships with nursing and care-

aide staff had significantly improved. Most of the care-aides who strongly

opposed the decertification process either did not apply for work with the private

company or were not hired. This facilitated the re-building of relationships

between the SSWs and the care-aides. The SSWs stated there was more

respect and commonality between the two groups and Susan explained that it

"opened doors and through that there is connection… conversations developed,

relationships developed, friendships developed as well" (p23iipt2). Another

opportunity Catherine described as helping to build relationships with co-workers

was being involved in committee work at the care home.

> Being on the committee has made me way more confident here. We are
> all just people trying to do the best for the residents and that's been really
> helpful. In the past you just were not asked to sit on a committee. It was
> no. It was all either care aides or higher or when they were desperate they
> would take anybody. But now there is a huge improvement in relationship
> building (p10-11fg2pt5).

The relationship development with other workers at the care home was an

example of the leadership substitute 'collegiality' as described by Sergiovanni

(1992). The SSWs developed skills to better understand themselves and other

workers, and used effective conflict management skills to maintain positive

relationships. The improving relationships also contributed to the decreasing

sense of isolation among the SSWs and facilitated the SSWs' participation in the

care planning process.

Understanding and Working with Families

Developing relationships with families of the residents was important. In

these relationships the SSWs were able to discuss with the families their roles in

the care of the residents, which Catherine explained:

> We talk to them (residents' family) about room concerns, room safety,
> laundry issues, and dietary concerns. The administrator gets our staff
> involved now. We are the spokespersons now with the residents' family.
> We are very comfortable to sit down with them at the table and say you
> know you don't need to worry. There is a lot of effort that goes into all of
> their concerns… If it is something managers can't handle they will right
> away turn you (family members) over to the staff. Most times they (family
> members) are very content of what they hear and very comfortable. So
> that process is really changed. We are all definitely part of the whole plan

of the residents' well being and the care home. Now we are more acknowledged for it (p 14-15iipt5).

Relationship development with family members and the care home management's involvement of the SSWs in helping to resolve family concerns contributed to correcting the misrecognition of the SSWs and facilitated the SSWs' participation in the care planning process.

Kanungo's (1979, 1981, 1982, 1983) work on the motivational approach to diminishing alienation explains some of the SSWs experiences. The SSWs identified their workplace needs, including their desire to be "more people" focused, to be recognized and respected for their efforts, and to be happy. These needs of the SSWs were being met through new ways they were doing their work. The new ways of doing their work facilitated the development of relationships with residents, co-workers and residents' families. These strong relationships are examples of Starratt's (1996) work on connectedness and Noddings (1993) work on ethic-of-care. The increased understanding and relationship development by the SSWs created an opportunity for the SSWs to participate in the care planning process. Developing the necessary skills to get to know the residents, developing resident health-related knowledge, having the skills to manage conflict, being involved with committee work at the care home, and being part of the problem solving process when families raised concerns served as remedies for misrecognition as described by Fraser (1997, 1998, 2000) and an opportunity to develop new workplace identities. As a result, the level of alienation diminished as the SSWs were able to meet their salient

workplace needs of participating, influencing and being recognized for their efforts at the care home.

Use and Development of Knowledge

    Using Knowledge Generated at Work Outside of Work.

    Joanne talked about how her learning at work helped her better understand her mother's behaviors at the end of her life and how the learning enabled her to be a resource to elderly individuals in her condominium complex.

> Quite often I hear that when a resident is getting ready to pass away or wants to pass away they give up. Here (at the care home) one thing they do is they push their meals away. They just don't want to eat and it's their way of saying let me go. They know that they will shut down and go. When my mom was passing away, I thought she was still doing really well and doing ok. I would visit her and I noticed that her [meal] trays were not touched or barely touched and the nurse would say we tried to make her eat. Mom would say no, no and she'll push it away and she started to get weaker and weaker. Then I started to clue in that she wants to go because she would say things I don't want to be here much longer. She wasn't eating and sure enough she passed away. She didn't eat but I was unable to recognize. I mean I was in denial… when I look back thinking that she was pushing her meals away just like they do here when they are saying that's enough. So you get to recognize things outside what you see here. So you take that knowledge out. (p29-30fg2pt4).

> [Also] I live in a condo for 55 years and over. My aunt's there and she is 95 years old and by far we are the youngest ones there the other ones are probably 80 plus. I find the knowledge that I have gained here; I have helped some of the elderly. I have been able to give them information and tell them where to go and what to do. They have asked me, are you a nurse or do you work in a hospital?. No, actually I work in a care home and I am actually a housekeeper. Well, how do you know that. I said well, I see it everyday and I am learning about things and this is what I think could be the problem. So they start to search out for their doctors and start asking questions. We do take it out of here. (p34fg2pt4).

    A few other participants described similar stories where they were perceived to be a nurse or other health care professional. Gale shared an example of helping her family members understand Alzheimer's dementia.

> With my grandmother getting Alzheimer's… when she was coming to visit
> and she didn't know how to pack her bag and she would leave the oven
> on and things like this. I was telling my mom… the doctor can check her
> meds and they can see what levels she is at and help her out through that
> scary train ride. I know that one of my grandmothers' biggest fears is
> Alzheimer's. There is a way they could help her out. I don't think that my
> family even thought about different levels of Alzheimer's. There are
> different stages where they can help them out and make their life a little
> easier. (p30fg2pt1)

These were examples of transferring and applying knowledge the SSWs

developed at their workplace. This was an opportunity for these workers to

participate in discussions they previously would not have. This participation

developed a shift in the SSWs' identity towards being healthcare workers as they

saw themselves as a source of health information.

Contributing Knowledge to the Residents' Care.

In healthcare, the process of systematically documenting health-related

observations is referred to as charting. Each entry is dated, signed and the

action to be taken, or that was taken, is also recorded. The SSWs were asked to

record their resident-related information and observations in the Kardex System.

Each resident had their own file labeled with their name, room number and

doctor's name. These files were stored in a Kardex. The SSWs found the

process of charting residents' health-related observations led to the care aides

improving their resident-related observations and reporting. Catherine explained,

> I couldn't get enough of the charting. I saw how the data was used at
> resident care conferences and how we are gaining the recognition we
> deserve from our efforts of truly wanting to care. Knowledge is definitely
> power (p 5iipt5). The care staff, I have noticed seem a lot more interested
> in care planning now as well, as they know that we are able to do it. If we
> see as much as we do and document it and it goes up to the care

planning process it is going to look a bit funny if we see all what we do and care [staff] doesn't. They need to be more on the ball. Like if we can see it, why haven't they made any observation? So now they are under pressure to provide better information (p11iipt5).

Charting also made the SSWs more attentive to resident needs. Joanne

explained,

I enjoy being involved in the care planning of the residents. I wasn't involved in the resident care plan before and what I did really didn't matter. What did I know? I am just a housekeeper. Our responsibilities are making sure that resident's needs are priority. The care plan is now allowing us to be more attentive to their problems. This allow us to investigate and bring it to the other staff so that we together can find out what their problems are and address the issues for them (p1-2iipt4).

The SSWs also thought action was taken quicker once they had charted and

reported.

Charting is crucial in our involvement with the resident care planning. It really helps us communicate with each other regarding the residents… our residents have much more complicated health concerns than what we had been used to in the past. Their needs and concerns change very quickly as their health declines. The Kardex is where we chart and share our observations of those changes. New observations are taken into the shift change reports, and shared with the care staff and the RNs. I like that we can be involved in the residents' care planning process (p5-6iipt6).

Gale explained that charting made the information more important and moved

the care home one step closer to resolving the problem.

Well, I think it impacts because when we are writing it down it does make it more important in a sense that I have taken the time to write it down and somebody takes the time to check into what I am writing down to communicate further. It brings everything another step closer to dealing with the situation or solving a problem (p15iipt1).

Susan explained that charting also served as a resource, communication and

learning tool.

You don't always remember all the details about it (management of health conditions) but, I remember so and so was going through exact same thing and it's so handy to… refer back to your old notes. Then you can refer back to how you dealt with the situation and other staff members dealt with the situation…. You could see what was happening on your days off. You could read them and then it would explain sometimes certain behaviors and things. I became more knowledgeable on medical terminology… you could relate more [to the nurses notes] when you are doing charting. I have started paying attention to the residents when they act differently… if I now notice something unusual, it would be in the back of my mind to pay more attention to that resident… was it that one time thing or did it continue to the next meal… have they acted like this before. (p15iipt2).

Finally, Joanne spoke of how a chronological method of charting helped her learn more about the residents, detect changes more easily, and have the change investigated by the nurses.

I find that by charting when you take the residents' page and look back at it, you can see the changes…I have noticed that I have seen blood today and yesterday, so maybe this is a 'one of'. Has somebody else seen this before? So I will look back on the Kardex and see if one of the other girls has charted on it, and if they did we get together and talk about it. If they say I have seen it too, so let's go further on this because this is not a 'one of'. Let's go to an RN and let them to check to see what's happening. When we do our RCTCs, we check to see whether the hearing or the vision has worsened or not. Somebody can be hard of hearing and we say well, yeah they are getting worse. Let's look back and see what we charted last time on this resident. Oh, we put that their hearing was no problem but how come now we have to speak louder, what is happening here? They used to be able to see us coming down the hall. How was their vision? Well, they are banging into the railing; they are holding the railings for guidance while they are going along. Well a few months ago they weren't. Just watching them and coming to a conclusion that there is a change and talking over with other staff, putting all of what we are finding together and then presenting it allows others to see what's happening with them (p6iipt4).

Many SSWs recalled being nervous when they first began to chart resident information. Their anxiety mainly related to using wrong words or poor grammar.

Charting was something I was really afraid to do. I like to chart exactly what I see or hear. I guess we really shouldn't do that because there is a

way of putting it down that is proper… you know this is brought up in front of families when they have their meetings, so we have to be careful how we word all things. I try to word it better and I have trouble finding polite way to word all these (p5iipt4).

The charting of resident-related information was part the process of 'knowledge storage' as described in the knowledge management literature. This stored knowledge was retrieved by various workers and used in the care planning process. By sharing their unique resident-related information in written format to be incorporated into a care plan, the SSWs' sense of powerlessness, meaninglessness and self-estrangement variants of alienation were significantly reduced. The fact that SSWs' knowledge was being retrieved by other groups demonstrates its uniqueness, otherwise there would be no need for it to be retrieved.

In the charting resident-related information, the SSWs were engaged in the process of 'reification,' which Wenger (2005) described as making a "thingness" out of an experience. Wenger (2005) argued that the meaning of work is created in the interaction of participation and reification. The SSWs no longer saw their work as meaningless; they saw themselves as workers who were involved in problem solving to improve the care received by residents. They did this through ongoing learning, communication, attentiveness to the residents, and investigation of concerns when raised. Further, they took on the role of leaders as they influenced the practice of care-aides by creating pressure for the care-aides to know at least as much, if not more than, the SSWs in the care planning process. Additionally, they had a voice in the care planning process and the care team investigated concerns they raised. This demonstrated a significant

reduction in the SSWs' sense of powerlessness. The SSWs' identities were also shifting to that of healthcare workers and important contributors to the care planning process because other workers recognized and used the important resident-related information reported by the SSWs. Reductions in the sense of meaningless, powerlessness, and self-estrangement, and the shifting of SSWs' identities towards those of health care workers reduced the overall sense of alienation among them.

Continuous Learning

Attending Onsite In-services

The SSWs were willing to attend in-services on their own time because they believed they could apply what they learned both at work and in their personal lives. Joanne explained,

> I try to attend as many as I can… I [tell] my husband 'by the way I'll be little late as we are having a workshop'… [previously] I didn't care to go because everything you learnt, it didn't mean anything. You took your time to go and learn but for what. But now we go and we learn and we walk away from this place and when we come back tomorrow we have gained more knowledge. We have gained something else and we can use many of these tools in our everyday lives. It's exciting, yeah!" (p11-12iipt4).

This was an example of Tronto's (1993) 'care about' phase in the caring process. The SSWs' learning about the health conditions of the residents enabled them to 'care about,' a phase that is associated with caring by more powerful individuals. As a result, the SSWs' sense of powerlessness further declined and their status at the care home was elevated as they continued to participate in the ongoing education process. As the SSWs developed more knowledge regarding the health conditions of the residents and were able to

contribute in helping manage those conditions by participating in the care planning process, the identities of the SSWs shifted towards becoming healthcare workers.

<div align="center">Attending Nursing Report at Shift Change</div>

The administrator of the care home was a former nurse and occasionally involved herself in the care planning process. She approached me one particular day regarding a resident's nutritional care plan. To respond to her question, I brought her back to the dietary office to review the notes the SSWs had documented in the Kardex. She was not previously aware of the extent to which the SSWs were charting and she was positively surprised. She looked at the SSWs' notes for this particular resident and glanced at notes for other residents and told me that this was very important and useful information that we were collecting and storing. She wanted to know what we did with it. I explained to her that we use it for admission, quarterly and annual nutrition care plan reviews. She asked me if I could share this information with the nursing staff more often and more regularly as it would help them in their care planning. Knowing how enormous a task this would be for me in view of my already heavy workload, I decided to send two SSW representatives to the nursing report at shift change once a week to share the information being stored in our Kardex System. Over time, more SSWs were encouraged to attend the nursing report at shift change and the representatives now attended on a daily basis. I knew the care team would not immediately accept the SSWs attending their reports at shift change. Anticipating resistance, I instructed the SSWs to avoid drawing attention to

themselves, to listen for the first little while to learn how to report, and to develop

their level of comfort in doing so, and to share what they knew in a short and

concise way. I also reviewed topics such as leadership, conflict management,

and working with difficult co-workers to help the SSWs integrate themselves into

the reporting process at shift change.

When asked about the experience of attending nursing report at shift

change the participants said that it was initially a difficult and challenging

process, but they were able to legitimize their involvement over time and came to

feel like they were part of the team. Catherine explained her experience as

follows:

> When we attended the shift report, I was really nervous to go because you
> knew what they were going to feel. Like who are you to step in on our
> territory. So we were very careful, we just basically always smiled and
> tried to kill them with kindness because how can you not like people like
> that. But we also just listened. We didn't offer a lot. When we started
> going we just listened and showed the respect we had for their comments.
> We didn't start throwing out things we knew. We just eased our way into it
> and then after a while it probably took about 4-6 months they accepted us.
> Now, when you came, they (nurses and care aides) are excited. It did not
> happen over night. None of this did. It's been a long process but if you do
> it smartly and it's all about your approach then you will be accepted (p
> 12iipt5).

Susan had a similar experience and saw the value in attending the nursing report

at shift change.

> First I thought wow! You know, these people have so much more medical
> experiences and training. It was little bit frightening and intimidating at first
> but as time went on it became a joint effort and we were actually well
> respected. (p5 ii-pt2). I think we are more able to discuss our concerns
> about residents from different perspectives. When the doors opened to
> communicate you can hear what other people are observing from their
> perspective. It brings the whole picture together and it makes the care
> plan a little bit clear… you don't feel like you are on the outside anymore.

You feel like you are part of the group that's what motivates me (p13 fg2pt2)

Gale talked about how she took a more active role in becoming part of the care planning process, despite the animosity from the care-team, because she felt it was the right thing to do.

When I first went, I felt the animosity of the care team… when we started going into shift reports and at first I was shunned upon because yeah, it was something new and people are adverse to change in lot of ways but I pushed through it. I pushed past it because I was interested in making a difference in their life (residents). I think that brings the person, your personality, into what you are doing and you are pushing forth and digging where you feel is necessary and what you are seeing, like your points of view, I think are important… everyone's point of view everyone is looking at different angle and you know and really make the care 360 degree instead of very one dimensional (p4iipt1).

Catherine shared an example of significant contribution by one of the housekeepers at the nursing report at shift change. This particular contribution prevented unnecessary medical procedures and saved the housekeepers from having to intensify their disinfecting procedures for no reason.

One of the residents had a huge load of diarrhea. So they were all thinking ok we have got an [infectious] outbreak and what should we do. She (support worker) was able to contribute because she was in housekeeping and knew that he (resident) had eaten an entire box of chocolates the day before. So that was the cause. They may not have known that and they may have started treating it and being all afraid that the facility was in for a big problem (infectious outbreak). So that was a great contribution (p 22 FG2pt5).

Participating in the care planning process was not an easy task for the SSWs when they first started. The SSWs had to develop a great deal of courage to take action in accordance with their beliefs about what was in the best interest of residents. This was particularly the case when the SSWs began to attend the nursing report at shift change to share their resident-related observations directly

with the nurses and care-aides. At first, the care-aides and nurses made the

SSWs' participation in the nursing report at shift change as challenging as they

could through behaviors such as ignoring them, and rolling their eyes.

> I can tell you that in the beginning when we first started doing it was
> mentally exhausting. It was not pleasant. If you can imagine sitting there
> and having everybody stare at you and then stare at each other and roll
> their eyes (p21 FG2pt5).

The SSWs endured and the nurses and care-aides eventually recognized

the important contributions being made by the SSWs. The SSWs' commitment

and their regular participation solidified their membership as part of the care

team, contributing to the shift in identities towards healthcare workers.

The participation in the nursing report at shift change also helped remedy

'misrecognition,' a concept described by Fraser (1997, 1998, 2000). By attending

the nursing report at shift change, the SSWs were able to showcase their

resident-related knowledge. As their skills were recognized, the SSWs appeared

motivated for additional learning opportunities, which further enhanced their

skills. Increase opportunities for skill development through flexible scheduling,

education opportunities, and opening other practices for SSWs' participation

might be perceived as helping to remedy what Fraser (1997, 1998, 2000) terms

'maldistribution', and this also enhanced the SSWs' participatory parity and a

contributed toward a shift in their identities. Attending nursing report at shift

change was an opportunity for peripheral participation through immersion, a

theoretical concept introduced by Wenger (2002). The SSWs were able to learn

about the nursing community of practice and engage in it. This opened up

additional learning opportunities and opportunities for relationship development.

The combination of being recognized for their knowledge, being seen as equals,

and developing relationships created a trusting workplace where nurses felt

comfortable approaching SSWs and asking them for resident-related information

and making them part of the care planning process.

All of the above resulted in a shift of the position the SSWs now occupied

at the care home, as expressed by Gale and Catherine.

> I think people come to me with questions which they might not have
> before, like nurses will talk to me about somebody losing weight where
> previously they might have gone directly to the dietitian and she wouldn't
> even consider us but they do come to us with a lot more questions. They
> take us seriously and they take our advice and work with it. I think it
> brought respect (p11iipt1).

> I have more to offer than just food on the plate you know and drink in their
> hand. I think other people have started to see as well, which in turn makes
> you want to be more resourceful to others and be more communicative of
> everybody's needs… Before I used to say I am a cook. Now I say I work
> with the nutrition of the elderly. We make a lot of choices, and care plans
> for them (p4iipt1).

> I am now always called by management to talk to resident families to
> explain how situations work and why something may have happened. In
> the past so many people were involved with the family member other than
> the staff that actually knew how to rectify the problem. My confidence on
> the floor and handling situations has increased significantly (p6iipt5).

Here Gale and Catherine described the change in their position at the

care home through words such as being resourceful, being respected and being

involved in problem-solving. The nurses and management perceived the SSWs

as important resources of information for improving services at the care home.

This is a significant positive shift in the workplace identities of the SSWs. The

SSWs are also actively managing their new workplace identities. Gale's

comment that "I used to say I'm a cook. Now I say I work with the nutrition of the

elderly" is an example of reframing, refocusing and recalibrating the tasks that

the worker considers most important to their work, concepts introduced by

Ashforth and Kreiner (1999). Gale created an opportunity to describe her role at

the care home from her own perspective, challenging preconceived notions of a

cook's role at a care home. By doing this she participated in creating and

managing a workplace identity with which she would be happy.

Learning from Observations

Catherine talked about how everyone had something to offer and

something to learn to improve healthcare services.

> Everybody has something to offer no matter what they are doing. There is always something to learn. Knowledge I believe is power... You are always learning. It doesn't have to be in health care but you are always experiencing something that you can share. I mean if you have children, you loved your children you can do the same thing with other people's family members. You can do a lot of dementia care and special care. These 90 year old adults have reversed back to childhood. They are in essence babies again. With proper training you know what to watch for, anybody can do that if they are given the opportunity. It's incredible and I really believe in this when I say that. You know health care needs to go more along these lines of teaching people those skills because the more people in health care that can provide that, no matter what level, it is going to be better care. People are going to be happier (p16iipt5).

Several participants shared how their resident-related observations helped

improve the care delivered to the residents. Joanne gives an example of a

resident who had undiagnosed diabetes.

> There was a resident in the special care unit… he urinated on the floor and it was sticky. Every time I washed it, it would dry but still had a sticky content to it. I charted it, told the staff and kept telling them because it kept happening and when they did the testing on him they found that he was diabetic (p2fg2pt4).

Several participants spoke of changes they noticed among residents and the possible reasons for those changes. They then alerted other members of the care team who monitored those individuals more closely. Susan, Gale and Judith shared their experiences of observing residents in the dining room.

> Mrs H is a small eater so it's very unusual for her to ask for more…larger appetite means she is usually coming down with something and it's usually an UTI (p2fg2pt2). Mr R is another one, when he is not communicative or he won't talk and if he does talk he is looking up somewhere and that's a sign of a seizure coming (p3fg2pt1). Another example that we find frequently is with Mr. B. His bed will be wet in the morning when he gets up. Usually 9 times out of 10, it would indicate that he has had a seizure during the night. We will let the care staff or nurse know about it, and they will try to keep an eye on him and see that he doesn't have multiple seizures (p3fg2pt6).

Joanne talked about what motivated her and her co-workers to share their observations with the care team to ensure the residents got the best care.

> I think what motivates us is because we want best for them. When we communicate with the nurses and care staff, it is investigated to why things are wrong and why they are not feeling good and it gets taken care of and so that they can start getting proper medication and whatever care they need to feel better. Moreover, for the safety of residents it motivates us because we don't want to see them fall because if they fall then are going to get hurt, they are going to break their hip, they are going to the hospital and then they usually go down hill from there. So this motivates us to keep them safe and comfortable (p5-6fg2pt4).

These were examples of how the SSWs saw their contributions made significant differences in the care the residents received. This not only made the SSWs feel good but also helped them see their work as meaningful; and because the concerns SSWs raised were taken seriously and properly investigated in a timely manner, the SSWs' sense of powerlessness declined. Further, these were examples of what Tronto (1993) described as the process of 'taking care of' because the SSWs' role was to report information and the nurses

and care-aides were responsible for 'care-giving' process. Since according to

Tronto, 'taking care of' was associated with more powerful individuals, this also

contributed to reducing the sense of powerlessness among the SSWs and

elevating their status at the care home.

Learning about and Influencing the Practice of Others

The SSWs influenced the practices of the care-aides by pressuring them

to improve reporting of resident-related information to the nurses. The SSWs

also influenced the nurses' practice of providing medications to the residents.

The dispensing of the medications to the residents required the nurse to match

each medication to the medical administration record (MAR) and then deliver the

medications to the resident and watch them swallow the medications. The

medications cannot be left with the residents as it increases the risk of either the

resident not taking their medications or giving their medications to other

residents. Susan explained her observations in this regard.

> When I first came, I remember they (nurses) were putting all those pills on
> the table for each person. I was completely amazed. Would you leave all
> these pills on the table in a place where there are Alzheimer's residents?
> Of course us saying stuff like housekeepers always finds pills on the floor
> when they are sweeping and me even saying something to the nurses like
> why would you do that like you don't know if that person would sit there or
> not. They could be taking somebody else's heart medicine. I think all
> those changes have been for the good (p 27fg2pt2).

The housekeepers and dietary staff found lots of unconsumed

medications in the residents' rooms or dining room. When they found the

medication they would immediately notify a nurse where the medication was

found. The housekeeping and dietary staff became concerned about the number

of unconsumed medications they were finding as it meant that the residents were

not getting those medications. Dissatisfied by the nurses response of a 'thank you' and no other action, the SSWs approached me in frustration about their concern for the residents' health and the amount of time it took for them to find and report to a nurse, who at the end took no visible action. As a result, I developed a system to report medications found on the floor or Dixie cups of medications on tables. The system was a simple one that included taping the found medication on to a form and describing the location and time the medication was found. These forms were collected over the day and the next morning they were submitted to the Director of Care (DOC). This saved a significant amount of time for the housekeepers and the dietary staff as they no longer had to find a nurse and report the found medication, which they were doing several times during the day. The volume of medications being found and the DOC's ability to track which nurse was on shift led the nurses to change their practice. Nurses no longer left medications on the tables and ensured the residents consumed the medications before they left them. Afterwards, the housekeepers or dietary staff rarely found medications on the floor and if a nurse accidentally dropped a medication and could not find it, she would report the incident to the SSWs that she has dropped a medication.

Learning about and Proposing Treatments

Several participants spoke of natural supplements they used at home and took the initiative to introduce them to the facility. Susan described how the SSWs played a key role in the development of the acidophilus protocol.

> Most of our residents have suppressed immune systems or compromised immune systems and when they go on antibiotic therapy they all tend to

get diarrhea and dehydrate. One thing that we (SSWs) had all discussed amongst ourselves… at home most of us take acidophilus or take the yogurt with the acidophilus on regular basis or for sure when we are on antibiotic… [this discussion started a research project] and then came the [acidophilus] protocol. We are now noticing that their recovery time was shorter and they were bouncing back and remaining healthier and longer in between infections as well. It just ensured a little bit quality of life for them, less discomfort. (p6-7fg2pt2).

Joanne spoke of the use of melatonin as a sleep aide.

We try to figure out why some residents don't sleep at night and are wandering. In the day time they are agitated, they are hitting because they didn't get a good night sleep. So lot of the times us girls take it over and above and try to find out things on our own… one of things was Melatonin. It's a natural thing that your body produces and if you don't sleep you could be deficient. I came across a book and read the book and then brought it to a co-worker to read the book and how if you give that to them it can give them a good night sleep. We brought up to our supervisor and we brought it up to the administrator and then DOC and they said that is an awesome idea. All they need is to get a doctor on board… It is something that's actually been looked at. I understand a doctor has been approached to see if he is on board and give it an experimental trial. Well, that all came from us. So I mean if that would work that would be awesome. Give them a good night sleep and rested. We have done lot of stuff like investigating things and finding out information and then given it to our supervisor and see what they say and they don't go for right away we try again (p32-33fg2pt4).

Influencing the practice of HCWs and proposing treatments were examples of the increased power the SSWs now had at the care home. They had the knowledge and confidence to set standards that were difficult for the care staff to reject, instead they had to comply. This increasing influence reduced the powerlessness variant of alienation for the SSWs.

SSWs' Positive Changes in Self-Perception

Respect and Self-Esteem

Catherine described how their efforts in the care planning process did not go unnoticed.

I had witnessed a registered nurse say to another nurse she was training 'If the support worker gives you any information, you need to take it very seriously. They know what they are talking about'. I felt so proud and all I could do was smile (p6iipt5).

Several participants talked about how their efforts led to other staff members viewing them as resources. As previously mentioned, Gale shared how she now had nursing staff coming to her and asking questions related to residents diets and or their weight, questions that would previously have been directed to the dietitian. Catherine explained how care home management often involved her in resolving concerns raised by family members regarding housekeeping and laundry. Catherine also observed an increased level of recognition and appreciation for the SSWs' involvement in the care home.

My personal experience of watching many of my co-workers grow within themselves over time has been in itself wonderful. I have staff from all departments telling me how much they appreciate the teams' kindness and helpfulness towards the residents all the time. I get feedback all the time to say we are different and that is a huge change. I can only say that I know we are appreciated because we get so many compliments. I believe the staff goes the mile because they now have a real feeling of self-worth. They feel much appreciated and want to stay at that level. Nobody wants to go back (p7-8iipt5).

Catherine talked about how the process of being involved in the care planning process changed the power and status of the SSWs.

What I think about daily now is how far we have come as recognized staff in the building, and how much the roles have reversed between the care aides and support workers. We are finally looked upon as being equally valued and more. We are looked upon now as definitely able to provide valuable feedback that could be involved in the care plan for the residents. The comments I have heard from care staff and the registered nurses are that we should start to attend every shift report now as they do learn from us (p1iipt5).

Joanne went on to say,

> They (care aides and nurses) look to us for information and they now
> sometimes come to us for information and they sometimes come to us
> with questions like "have you noticed this or that", which is awesome! I
> think that other co-workers have lot of respect for what we do and what
> we observe. When they come to ask for answers they respect what we
> have to say. They know that they can trust us and sometimes we do have
> stupid questions, I mean we are not nurses or care aides and we haven't
> been trained by the way they have. When you go through so many years
> for not being part of their team really and now that we are its really neat
> that they can come to us and we can go to them. We are all together for
> one purpose and the purpose is for the residents. Knowing that we have
> something to say and something to offer is a good feeling (p7iipt4).

Gale provided a specific example when a nurse came to her to discuss a

resident's diet.

> A nurse came with a requisition, concerned about somebody not eating
> well. She came and was talking of a specific resident and we talked on the
> same level. I didn't consider myself better than her I wasn't talking down
> to her because it was about food and she wasn't talking down to me
> because she is a nurse. We were one-on-one trying to solve the problem.
> It was good that we both accepting each other in a position and respecting
> each others position and being able to talk about it. I didn't feel inferior
> when she was talking to me. She left me with knowing that what I said at
> the end would be what it is. (p15fg2pt1)

Judith also shared her view on the change of status for the SSWs

> It's taken several years, to get where we are. For the support services
> workers to really become ARC [Allied Resident Care] workers. The daily
> contributions we make to the care planning process are invaluable. Our
> input has become accepted and expected. A great change from just a few
> years ago. The training we've received has given us confidence to share
> our concerns and observations. The care staff and RN's now rely on our
> observations and take them very seriously. They often ask for our
> opinions and are willing to share new information with us. We have
> become very credible assets to the care team. Over the past few years,
> we've noticed a big change in the residents that come to [the care home].
> They are in poorer health. Some are in the end stages of their lives and
> well advanced in their diseases. They often come, in similar condition to
> those we used to send out to the extended care at the hospital. With the
> complex care they require, it only stands to reason that the care team
> needs all the support that is available to them, and we are a big part of

that support. (p11iipt6) [She goes further on to say,] it almost seems that in the past year or so, the roles and responsibilities that our department has with the residents' care planning process has become equal to that of the Care Staff. We aren't looked at as just housekeepers, but as an ever present connection to the residents. We are the eyes and ears on the floor, and the knowledge that we've gained through our training and experiences have made our presence in the care planning a much accepted and respected position. The staff trusts our knowledge and observations. Rarely does a concern we have about a resident go unchecked or not investigated immediately. (p25iipt6)

This was a significant change from, not long ago, when the SSWs used to be told "resident-related information was confidential and cannot be shared with them" (p17fg2pt6).

Confidence

Many participants spoke about the confidence they gained from participating in the care planning for the residents, Joanne summed it up:

I had no confidence before. I would second guess myself and I was afraid to ask questions. I was afraid to have my own opinions, own judgment and asking a stupid question… When I go to them now I have confidence and know I am going to be met with respect and that they trust me. I don't have to second guess. I just go and so I feel very confident now (p35fg2pt4).

Developing confidence made Monika more assertive.

Confidence makes you more assertive and makes you more sure of what you feel or say. It gives you the knowledge and it makes you a little braver about going out and suggesting things to people. Whether you are right or wrong at least your ideas and input are heard (p35fg2pt9).

Gale explained that confidence allows individuals to take "a lead, not always be the follower… I think it teaches you to just not sit on the foreground and wait for somebody else to make your decision or not be part of the decision process" (p35fg2pt1).

The SSWs' participation in the care planning process enabled them to establish themselves as a source of resident-related information and they were recognized for their contributions. This was another example of the correction of misrecognition the SSWs previously suffered. The correction of misrecognition made possible the SSWs' participatory parity, resulting in the elevation of their status in the care home. Further, the use of the title 'Allied Resident Care" worker or ARC worker was an example of identity management. It enabled the SSWs to construct new and positive workplace identities by reframing, refocusing and recalibrating their roles and responsibilities at the care home.

Further, the significant change in the SSWs' level of respect and self-esteem were examples of the reduction of the self-estrangement variant of alienation. The SSWs developed a positive outlook on who they were and how much they contributed to the care planning process. The SSWs were able to express their unique abilities, potentialities and personalities contributing to the reduction of alienation as described by Blauner (1964).

Improved Quality of Worklife

Job Satisfaction

The opportunities to learn and become apart of the care planning process significantly improved the SSWs satisfaction with their job. They were able to make important contributions, be recognized for their contributions and efforts, and serve as a resource to other staff members.

> You know to clean toilets… isn't the most rewarding job but it's the other that goes along [with the job] that makes us want to come everyday. The

laughter, the humor and the recognition and the ability for us to say well, you know I don't think that works. [We] are definitely offering suggestions. [We] often have better suggestions and [we] are able to offer without feeling threatened or anybody else feeling threatened anymore. I think it has made everyone's lives in here much better (p15iipt5). It only benefits the residents at the end for sure (p11fg2pt5). This job, believe me would not be motivating in the same way if you just came in and you did your toilets because I found before we changed over I was border line wondering what I would try next because for me it was boring. How could you come in and do the rooms everyday. It wasn't stimulating at all. But now you are able to do something… you are using your organ (brain). It didn't happen overnight, it did take us a while, we eased into it with the care staff. This whole little thing has worked out. I think it has made our job way more motivating and special to come to work (p23fg1pt5).

Jennifer compared housekeeping in other institutions to her job as a

housekeeper at the care home.

I have had some experience being in with a patient in a hospital. So I know that the SSWs don't have a voice and they don't have an identity. They kind of sneak into your room, do their work quietly and sneak back out again. So that was my perception of what support services workers were at that point. Now coming into this place here and working here and knowing that what we do and what we say can make a difference in someone's life… When they have RCTC meetings with the doctors and the nurses… all of that information that we provide for them can make a difference with someone's care plan (p6iipt8).

The new job titles led many of the participants to describe their jobs to individuals

outside of their work environment and feel proud doing it.

When you are away from here you can elaborate on your job little more and explain the type of things you do and I think people are fascinated that you are not just cooking for them and cleaning after them and it is so much more than that. I do think people are quite interested and all of us can be proud of it (p24fg1pt1).

Judith described the satisfaction she got from her job because it feeds her

passion for knowledge.

Throughout the process of developing into an ARC worker I've been able to feed my passion for knowledge. I've improved my communication skills and in turn have become a better listener, better educator and leader.

With every new resident comes a new set of concerns. Their health, their mobility, their moods and possible dementia, and even their furnishings in their room are all things that I don't take for granted anymore. All of these things are important to my learning about them, and being able to make their lives here at the care home as comfortable and content as possible. I have often been anxious to get home at the end of my day, to jump onto the computer and research an unfamiliar illness or condition and see if there is anything we as SSWs can do to make life better for that particular resident (p30iipt6).

These new opportunities helped fulfill Catherine's dream of being a nurse.

My dream out of school was to be a nurse. I wanted to look after people. I realize now with this new opportunity that we were given to change our lives in here has been what I have been looking for all along. I didn't need to be a nurse to do that. I needed to have a different way of looking at things and that we could be around health care and provide the same feeling of caring which is exactly where I am now. I don't want to be a nurse; I don't want to do the poking. I just want to be looking after… you know the caring part. Be part of the process. Be able to take on the important information and pass it on. I don't need to be a nurse to do that I just need to be able to be around it and learn it (p25-26iipt5).

The significant shift in the level of satisfaction derived by the SSWs from their work can be explained by Kanungo's (1979, 1981, 1982, 1983) motivational approach to reducing alienation. The SSWs identified their salient workplace needs, which included: laughter, humor, recognition, feeling safe, desire for stimulating work, making a difference in someone's life, being proud of their work, fulfilling their passions and realizing their dreams. Then the SSWs were able to modify their jobs to have their salient needs met at work, which contributed to increased levels of satisfaction and the reduction of alienation. Finally, they could manage their new identity using their new job titles.

Recruiting and Training

Catherine spoke about the importance of recruitment and orientation of

new staff and maintenance of low staff turnover in sustaining the new roles of the

SSWs.

> In health care you have to have certain attributes, patience, respect, passion attitude are some. You need to be here looking after people because you genuinely want to be here. So it's not about toilet scrubbing and cleaning sinks etc, just about anybody can pull that off but it's definitely to be people focused and caring. I want to make those last days of their (residents) lives the best we can. They all feel the same and it starts back at the hiring process, the constant mentoring and sharing our belief of being people focused (p 9iipt5). What I have noticed in the last 5 years is that people… are content. There is no [job] movement. They finally are happy perhaps because where they are now… they found something that they are looking for…I know there has been a couple that have never stayed [in one job] before for 5 years…they are feeling important (p.27iipt5).

Gale spoke of her frustration related to the higher turnover in the care-aide

department. She spoke of how new employees were not aware of the SSWs'

different role in this care home compared to traditional roles of SSWs. The SSWs

had to train these new care-aides to think differently.

> I know when they (care-aides) get new people coming in it is almost like we end up having to train that person on a type of thought.... Caring for someone doesn't mean that you have to be a care aide…. I just find with the turn over of care staff frustrating as you are used to working this way and then when a new person comes in its like stick in the wheel and you just got to push through it and… hopefully they will come on board (p30fg1pt1).

Wages

Catherine showed some concern over the lower wages and higher

expectations, but then minimized the importance of higher wages and stated that

a motivating and exciting work-life is more important.

I am not there with the wages yet, I do believe that we deserve more[3]. I know it's not all about that I know that (p23fgpt5). If you don't provide a happier, more motivating and exciting work-life… it doesn't matter if you were making $ 18.50 an hour… they were unhappy. I mean if I look at the wage that way because even if you were now at $ 20 an hour, unless you are… more than just swinging a mop, it's hard, it's not motivating and it can be boring… The staff in the past were always very very unhappy because it really did not matter about the wage… there was always something that they were complaining about chronically because they were bored (p28fg1pt5).

Developing a Training Course for SSWs

Many participants concluded that the process of being involved in care planning has elevated the status of support work and has significantly improved the care residents receive. They hope to see the process formalized and implemented at other care homes.

People can be taught... Let's teach these certain areas on what to watch for, little bit of dementia care, be part of the care process… give them a certificate, not just a cleaning certificate that we used to have to get. I feel like some sort of two week program… before you even walk into the facility. I think that's what they need to learn because it would help health care in the future. It really would help because you have got more people involved that can do the care and I think it would be a win-win all around to be honest I really do (p28-29iipt5).

Joanne summarized her view of her job now, a sentiment that was echoed by many of the participants.

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[3] The SSWs were making between $17.89 and $21.12 an hour prior to contracting out, depending on their position. The SSWs started at $11.00 an hour when they were first contracted out in 2003. Over the last 5 years, I have been able to negotiate wage increases and the wages in 2008 were $14.45 an hour or an equivalent of 31% wage increase over 5 years. I have also been able to negotiate an additional 3 hours of paid work combined for both dietary and housekeeping departments for the paperwork and meeting times that are involved to be part of the care planning process. My argument for the wage increases and additional hours was that the SSWs are a vital part of the care team and the care planning process and ought to be compensated accordingly. The care aides, for whom I am not responsible, under their contractor started at $15.00 an hour and are currently making $17.85 and hour or an equivalent of 18% wage increase. Because I have been able to negotiate a significantly higher percentage of wage increase there has been a narrowing of the wage gap between the SSWs and the care aides.

The work that I do now is lot different from what I used to do… We are resident focused. They are part of our family and that's how I take them. Before they were people but now they are my mothers and grandmothers. I take interest in their everyday life, everyday care. It is not a job anymore whereas before a lot of them were duties and now it is for them and for their personal lives. I try to make their life better during their last days and that's what it is. All the pain that they are going through, all their sufferings from their past that even if you spend that couple of minutes with them it makes their day. Lots of time they forget why they were crying. Being involved in the care planning… makes a big difference… It makes me feel proud and honored to do that. I am happy to do that and show that compassion and to know that I am supported for doing that. My family knows what is happening here because sometimes I can't be quiet about it. I go home and basically brag about it. I brag in the community that we have the best facility where we care and we are encouraged to care. I wasn't like that before. I am excited to come to work. I am excited to come to work because what's going to be new today, what am I going to do today[4]? (p3-4iipt4).

The recommendation by the SSWs to open up the opportunity to be involved in the care planning process for SSWs in other facilities is a testament to the positive experience of the SSWs. The suggestion to involve other SSWs in the care planning process was motivated by the desire to improve the working conditions of SSWs, and to improve the entire healthcare system. Ironically, not too long ago the SSWs were described as "hospitality" workers, "toilet bowl cleaner", "non-essential" workers and "an economic drain on the healthcare system," and now the SSWs were suggesting that involving them in the care planning process could improve the entire healthcare system. This demonstrated

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[4] It is important to note the data tend to present a positive picture overall, despite the explicit question, "what have been your biggest losses?" asked in the individual interviews. Some reasons for this positive response might include: after the first focus group interview, the SSWs were able to reflect and compare the challenging times they went through to their current situations and realize the significant improvements. Another reason could be the third-party facilitator did not probe the participants for negative experiences in order to avoid the negative emotions that had emerged during the first focus group interview. Finally, the participants who had negative experiences may have decided not to share their negative experiences due to the overwhelming positive comments from their co-workers, or perhaps individuals with negative experiences choose not to participate in the study.

the significant development of self-confidence and self-esteem among the SSWs and their belief they were making significant contributions to the overall healthcare system. This was ultimate evidence of the shift in the SSWs' perception of their elevated position within the care home and strong evidence of reduced alienation.

Chapter Summary

This chapter demonstrated how the SSWs reduced their sense of alienation and developed new identities as healthcare workers. The first step towards alienation reduction for the SSWs was the development of relationships, a notion that is supported by Starratt (2003) when he speaks of connectedness, by Noddings (1993) when she speaks of caring relationships, and by Sergiovanni (1992) when he speaks of collegiality. In this study the SSWs began to understand and develop relationships with residents, co-workers and families of the residents. The development of relationships began to reduce the isolation component of alienation, thus contributing to the reduction of workplace alienation. The second step towards diminishing alienation was for the SSWs to identify their salient workplace needs and work with me to modify their workplace to meet those needs, processes described by Kunango (1979, 1981, 1982, 1983) and Dickson (1981). The third step was generation and use of resident-related knowledge, which established the SSWs as a resource of resident-related knowledge. The process of creating time and space for knowledge generation, and opportunities for continuous learning can be seen as remedies for maldistribution described by Fraser (1997, 1998, 2000). Further, as the SSWs

were recognized for their resident-related knowledge, the misrecognition that the

SSWs previously suffered was minimized. The combination of correcting both

maldistribution and misrecognition created opportunities for the SSWs to develop

participatory parity. The documentation of the SSWs' resident-related information

allowed the SSWs to develop new meanings of their work through what Wenger

(2005) described as the interplay between reification and participation. This

helped reduce the meaninglessness variant of alienation. The development of

new meaning of their work was also shifting the identities of the SSWs to

healthcare workers. Further, the notion of participatory parity was particularly

useful in the SSWs participation in the nursing report at shift change, which

made possible the SSWs' legitimate peripheral participation through immersion,

as described by Wenger (2005). Through peripheral participation, the fourth step,

the SSWs were further able to negotiate their identities based on the work they

actually did at the care home, including their duties outside their core daily

duties. They were able to manage their new workplace identities through

reframing, refocusing and recalibrating, as described by Ashforth and Kreiner

(1999).

As the SSWs relationships developed, their meanings of work shifted,

their resident-related knowledge increased, their identities began to shift, and

they began to take leadership roles such as participating in committee work,

proposing treatment, being involved in solving problems and influencing the

practice of other workers including the nurses. Also, the type of caring the SSWs

were involved in was 'caring about' and 'taking care of' both phases of care that

Tronto (1993) associated with more powerful individuals. The combination of

these steps decreased the powerlessness variant for the SSWs. Finally, as the

SSWs began to recognize their influence within, and their positive contributions

to, the care planning process, their positive self-perceptions and confidence

levels increased. This decreased the self-estrangement variant of alienation

among the SSWs. The SSWs demonstrated how pleased they were with their

experiences when they suggested that SSWs in other care homes be given

similar opportunities. They further claimed this would not only improve the

working conditions of the SSWs but the healthcare system in general.

In the next chapter, I will discuss the importance of the journey the SSWs

and I have experienced, as well as implications for practice and future research.

CHAPTER 6 – DISCUSSION AND IMPLICATIONS

In this study, I described and analyzed my experiences as a leader and the SSWs' experiences with privatization in a seniors' care home. Our early experiences were those of alienation, but after a number of interventions the SSWs became more involved in the care planning process, which brought significant positive shifts in their attitude and their workplace identity at the care home. The SSWs came to be viewed by themselves and other workers in the care home as healthcare workers and important members of the care team. The SSWs' involvement also brought significant positive shifts in my attitude, engagement and identity at the care home. I went from being a powerless manager to an influential leader-educator. To understand these shifts, I examined two sources of data. One source of data was my own reflection on my practice and the second set of data was group and individual interviews with the SSWs. I used a conceptual framework developed by integrating bodies of literature chiefly related to caring, moral leadership, alienation and identity development to understand my experiences and experiences of the SSWs. In this concluding chapter, I return to the research questions and then discuss the implications of this study for future research and for practice. The following research questions were posed:

1. What were the SSWs experiences of the healthcare reforms and the subsequent privatization of their jobs at the care home?

2. What was their experience of going through the various interventions employed by me to involve them in the care planning process? What

were their views of the subsequent change in their engagement with

the residents' care planning process? How did this impact the SSWs

engagement at the care home?

3. How did the engagement in the various interventions and subsequent

involvement in the care planning process impact the SSWs'

relationships with their coworkers, the meaning and purpose of their

roles and responsibilities, and overall workplace identity?

4. What impacts did the SSWs' engagement in the care planning process

have on me in relation to my engagement, my leadership role and my

identity at the care home?

The findings of this study reveal that the SSWs experienced the

healthcare reforms and the subsequent privatization of their jobs at the care

home as highly alienating. The SSWs described their sense of alienation from

the care home management and their own union since both groups told them not

to participate in tasks they were not considered qualified to perform. Further,

other workera and residents' families rarely recognized the contributions the

SSWs made at the care home. Finally, the SSWs were alienated from tasks they

performed, which were repetitive, fragmented and required little or no skill. The

sense of workplace alienation experienced by the SSWs increased during

privatization of their jobs and the subsequent significant wage and benefit

reductions.

In this study, I expected the SSWs to speak about the specific

interventions I used, such as the Aim Statement (AS), Desired Practices (DP),

Talk-Time (TT), To Care is To Know (TCTK) and the Documentation System

(DS) as they responded to the interview questions to share their experiences. I

was surprised that they did not perceive the interventions as discreet events.

Instead, they talked about the interventions as a coherent whole. They did not

mention any specific intervention as more important than any other.

However, my own observations reveal that the AS and DP had a profound

effect on the SSWs. Prior to the development of the AS and DP, the SSWs

appeared to be more alienated by my efforts to get them to report their

observations of the residents. They complained that such work was not part of

their job descriptions and they accused me of getting them to do work for which I

was responsible. The process of developing the AS allowed the SSWs to

uncover their salient foundational needs at work and the purpose of their work,

and the DP helped the SSWs achieve their purpose. The combination of the AS

and DP significantly influenced the SSWs participation in subsequent

interventions.

The development of the AS and the DP is an example of how one might

operationalize the motivational approach to diminish workplace alienation

(Kanungo, 1979, 1981, 1982, 1983). Kanungo argues the first step in diminishing

workplace alienation is for workers to clearly identify their salient workplace

needs. In the case of the SSWs, the AS captured the SSWs salient workplace

needs for a sense of belonging and contribution and a desire for continuous

learning. The second step described by Kanungo is the need to make changes

to the work design to allow staff to meet their salient workplace needs. In this

case of the SSWs the other interventions of TT, TCTK and DS contributed to modifying the SSWs' work design by changing schedules, routines and procedures.

An important thing to note is the SSWs developed a sense of their own community as SSWs before they engaged with other existing communities at the care home. Prior to the interventions, the SSWs were fragmented according to their work (laundry, housekeeping and dietary) and had little interaction with each other. The interventions as a whole brought the SSWs together to develop a sense of community across the department.

This study suggests that the SSWs' meaning and purpose of work and development of workplace identity occurred first in the SSWs' own community of practice through reducing both goal displacement and trained incapacity as defined by Sergiovanni (1992); these changes were needed before they could begin to develop relationships with co-workers from other communities and develop identities as care workers. The interventions as a whole, and the AS and DP in particular, reduced the goal displacement and trained incapacity by allowing the SSWs to conceive of their roles and purpose of work in broader terms compared with their existing task-related job titles. Their interactions with the nurses and the care-aides and their involvement in the care planning process shifted their identities to those of care workers. The SSWs legitimized their interactions and involvement in the care planning process by possessing and sharing important resident-related knowledge. These findings make a contribution to Wenger's (2005) work on communities of practice by suggesting

that it may be important for individuals such as SSWs, who do not have a real sense of their own community, to form a community among themselves first, as an important step in moving toward peripheral participation.

The SSWs involvement in the care planning process in this study broadens our understanding of the concept of 'care' as articulated in healthcare. In the healthcare literature, care is typically assumed to be limited to the domain of those workers who are directly engaged in medical or personal care tasks (such as bathing, dressing, feeding, and administering medications), however, this study suggests that it would be beneficial to think of care as more broadly enacted among care home workers. Caring is a human phenomena and SSWs can and do provide care and contribute to the care planning process.

This study demonstrates that the SSWs' participation in the management of resident-related knowledge through creating, storing, having their knowledge retrieved, transferred and applied was important in the development of their workplace identity. This suggests that management of knowledge of a particular phenomenon at work, such as the SSWs managing resident-related knowledge, has an impact on the development of workplace identity.

As new workplace identities begin to take shape, these identities have to be socially negotiated as described by Wenger (2005) and may need to be reframed, refocused and recalibrated as described by Ashforth and Kreiner (1999) on an ongoing basis to sustain them. One way this process may be facilitated, I speculate, is through renaming jobs and departments that more closely reflect the purpose of the employees' work and their emerging identities.

In the case of the SSWs, their job titles were changed to Allied Resident Care (ARC) worker and the department name was changed to ARC Department.

This study also makes important connections between the knowledge management literature and Fraser's ideas of participatory parity and workplace alienation. The process of knowledge management contributes to the reduction of misrecognition and maldistribution for the purpose of diminishing workplace alienation. Subsequent to privatization, the SSWs lacked participatory parity, as described by Fraser (1997, 1998, 2000), due to maldistribution of resources and misrecognition as workers. The SSWs' participation in the management of resident-related knowledge served as an important factor in reducing misrecognition. The SSWs were recognized for their contributions to the care planning process. As care aides and nurses saw the importance of SSWs' contributions at shift changes and at care conferences, they began to value the SSWs more. These findings contribute to Fraser's work on participatory parity by suggesting the important role the knowledge management process can play in reducing misrecognition and maldistribution. In turn, the recognition of the SSWs facilitated the management of knowledge across the organization. These findings suggest there may be a reciprocal relationship between recognition of marginalized workers and knowledge management.

My reflexive stance in this study revealed that the SSWs' engagement in the care planning process encouraged me to take a caring and moral approach to leadership as described by Noddings (1993), Starratt (1996), Fenstermacher (1990) and Sergiovanni (1992). This approach facilitated my transition from a

transactional leader to a moral educational leader, which shifted how I worked with the SSWs and cared for the residents. This study supports Kanungo's work that when managers have moral imperatives underpinning their decisions and not just the practical considerations of the bottom line, the workplace becomes more engaging and less alienating. This study contributes to Kanungo's theories by suggesting that not only do the workers, such as SSWs, benefit from a moral approach by leaders but leaders, like myself, also benefit by having our own salient workplace needs met. As a result, the benefits of moral leadership are mutual. Further, the findings of this study suggest that taking a moral leadership approach can reduce the gap between management and workers creating a more egalitarian workplace.

<div align="center">Implications for Future Research</div>

In this study, the SSWs experienced a steep learning curve. Their practices continue to change as they learn. They are excited to learn about the various health concerns of the residents and they are even doing their own research (such as looking for healthcare information on the Internet) to determine if there is anything they can do personally to manage the health concerns of the residents. A follow up study might be conducted to examine the nature and quality of information the SSWs retrieve and whether media literacy education might improve the quality of SSWs' contributions to care planning.

Additional studies related to SSWs are needed at other care homes to examine similar research questions in other settings. Further, in this study, only the views of the SSWs were explored in relation to the various interventions and

their subsequent being involvement in the care planning process. A follow-up study or similar studies in other settings would be useful to explore the views of other groups in the care home, including nurses, care-aides, and management.

It might also be interesting to examine the data of this study or other similar cases of privatization from a different conceptual framework. For example, using Bourdieu, potential research questions might include: What is the relationship of cultural and social capital to economic capital for entry-level workers such as the SSWs? Can entry-level workers, such as the SSWs convert social and cultural capital into significant economic capital? Is social and cultural capital fair compensation for reduced economic capital?

This study unequivocally demonstrates that SSWs can be educated to make significant contributions to the care planning process through various educational interventions. More importantly, this study reveals that when workers located lower in the workplace hierarchy, learn and are able to participate in the tasks of workers above them or at least become familiar with the tasks of the workers immediately above them, they can positively influence the practice of those workers and catalyze continuing development. More research is required to examine 'ground up' approaches to employee and organizational development, such as occurred in the care home in this study. Ethical imperatives need to be at the centre of this type of research and practice.

Implications for Practice in General

Developing the sense of moral purpose among workers in social service jobs is an important first step when dramatic workplace changes are required.

Moral purpose guides the direction of the organization and its workers. In social service sectors in particular, leaders might want to work with their staffs to develop moral purpose in their work and then strive for congruence between decisions and practices and the moral purpose.

Second, the coherence of interventions is important. The SSWs did not talk about or identify any specific intervention as having more impact than others; they appeared to have experienced the interventions as a coherent whole. This suggests that the coherence of interventions may be important so the workers do not experience the interventions as fragmented exercises.

Third, it is evident from this study that leaders need to ethically and respectfully create enabling opportunities that maximize potential abilities and capabilities of individuals they lead. I, like the government, the SSWs' union and other staff and management at the care home had initially dismissed the SSWs as overpaid and under-skilled hospitality-type workers who had no significant role to play in the care of the residents. This study demonstrates that this was certainly not true. It is morally wrong and non-productive to treat employees as deficient. Instead, SSWs should be viewed as capable of contributing beyond their job titles particularly when given appropriate educational opportunities.

Fourth, managers could be encouraged to enroll in some type of sustained leadership program that emphasizes educational and moral leadership. In this study, many of my interventions resulted from a series of coincidences that occurred which called me to react. However, even in my reactive state, I was able to develop effective solutions to the challenges that

were emerging. I credit much of my ability to do so to the various theories I was exposed to while in a doctoral program, particularly theories of moral leadership.

Fifth, when services are privatized and the same individuals who were laid off are hired back to do the same or similar work at lower wages, it can lead to a demoralized workplace contributing to significant alienation. The ethics of privatization need to be questioned due to the detrimental impact it has on the economic welfare of employees. Having acknowledged this, the study demonstrates that despite significant reduction in wages and benefits, opportunities to engage in meaningful work can significantly reduce demoralization and alienation and increase job satisfaction. Sustainability might be dependent on how the care home decides to spend the savings from privatization to benefit the staff and residents. Ideally, care homes might find alternative ways of generating efficiencies to pay for improved resident care and services.

Implications for My Own Practice

The journey of writing this dissertation has been profound for me, providing significant insights to how I can improve my practice. I have learned how to conceptualize workplace challenges, how to conceptualize my role within those challenges and how to sustain my leadership development through continuous integration of theory and practice.

At the beginning of the journey, I did not situate the care home within the broader context of healthcare privatization and, as a result, I did not critically reflect on the process and its impacts. I was a passive recipient of information

from media, government, or unions. I have learned that it is important to consider situations in the workplace within the broader social, political and economic context. This helps one understand the structural dimensions that have a bearing on everyday lived experience and can possibly lead to ways to effectively respond.

I have also learned that I need to conceptualize more broadly my role as a Registered Dietitian. I am a healthcare provider and my role to provide care and support goes beyond the domain of nutrition. Part of my earlier lack of satisfaction with my job related to the fact that I viewed my role narrowly, limited to residents' nutrition. By setting-up the mechanisms by which the SSWs share with me their resident-related knowledge, I was able to provide care for residents beyond nutrition. I am now involved in the process of helping diagnose, treat and monitor conditions such as depression, chronic pain management, progression of Alzheimer's dementia and chronic conditions such as diabetes, thyroid disease and cardiovascular diseases among others. I also now have increased interaction with residents, staff and health care professionals.

Another learning that has been important to me relates to Kanungo's (1979, 1981, 1982, 1983) ideas of the importance of defining and developing one's salient workplace needs and then modifying work practices to attempt to fulfill those identified needs. I now know my workplace needs include being resourceful, growing, excited and connected to people at work, and I understand my work design may need to be modified on an ongoing basis so I am able to meet these needs. Finally, as a leader, I also have an obligation to help other

workers define and develop their salient workplace needs and modify their work, where possible, to support them in fulfilling their needs. Modifications can help SSWs attain job promotions, onsite education, and support for formal education opportunities. It may even be appropriate to support a SSW's decision to search for more challenging work elsewhere.

I have learned the SSWs' involvement in the care planning process was more than just sharing their knowledge with me or other members of the care team. The care home became a more humanized community through the development of positive relationships. I can continue to promote the development of positive relationships and opportunities for interaction among the SSWs and between SSWs and other workers at the care home. I can continue to engage in learning more about the medical conditions affecting the residents and continue to contribute to the education of the SSWs.

<div align="center">Conclusion</div>

This study demonstrates that educational initiatives can facilitate the transition of workers who feel alienated, who have low status and minimal influence toward becoming a team with a strong sense of belonging and influence. Marginalized workers in a care home are quite capable of becoming insiders and important contributors to the care planning process. The study demonstrates how a leader can make the transition from alienated manager with little influence to an engaged, moral, educational leader who makes a difference in the lives of both residents and staff.

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APPENDICES

Appendix A: Recruitment Flyer

Participants for Research Study

I am looking for Support Service Workers to participate in a research study for the partial fulfillment of my Doctor of Education degree from UBC.

The purpose of this study is to explore the experiences of Support Service Workers during the contracting out process and their views about participating in various activities that led to a greater involvement with the care planning process for the residents. These activities include: creating a vision statement, receiving dementia training, attending nursing report at shift change, charting in the Kardex and NCP, attending weekly staff and RCTC meetings, attending mini-inservices, and spending 15 to 20 minutes interacting with the residents on a daily basis.

You are eligible to participate in the study if your employment at the care home began prior to October 2003.

If you are interested in participating, a box beside the communication book contains a consent form, which explains the details of the study and your rights and responsibilities as a participant. To minimize any pressure or obligation to participate in the study, I will not be involved in any of the interview processes. The interviews will be organized and carried out by a third party person. This will also minimize any fear to withhold information as your identity will protected as I will not have any information that would identify who said what.

Also attached to the consent form is a sheet with the questions that will be discussed at the focus group meeting. The questions are provided to allow you an opportunity to think about your experiences before the focus group meeting, but you do not have to prepare written answers.

If after carefully reading the consent form and the focus group meeting questions you remain interested in participating contact the third party participant at XXX-XXX-XXXX. Take a signed copy of the consent form sealed in the envelope with you when you go for the focus group interview.

The third party person will contact you to let you know the date of the focus group meeting. The time of the meeting will be roughly between 6:00 pm to 7:30 pm.

If you have any questions please see me and I will be happy to answer them.

Bobby Nijjar, MSc RD

Appendix B: Certificate of Approval

CERTIFICATE OF APPROVAL - MINIMAL RISK

PRINCIPAL INVESTIGATOR: Wendy L. Poole	INSTITUTION / DEPARTMENT: UBC/Education/Educational Studies	UBC BREB NUMBER: H07-02492

INSTITUTION(S) WHERE RESEARCH WILL BE CARRIED OUT:	
Institution	Site
N/A	N/A

Other locations where the research will be conducted:
This research study will be conducted with the eligible staff of ███████████ ., a private company providing contract support services at ████████ ████████ - a long-term care facility for elderly individuals.

CO-INVESTIGATOR(S):

Muninder Bobby Nijjar

SPONSORING AGENCIES:

N/A

PROJECT TITLE:
Knowledge Management, Moral Leadership and Identity: A Critical Examination of Support Service Workers' Workplace Experiences and Learning in the Context of Healthcare Reform.

CERTIFICATE EXPIRY DATE: January 3, 2009

DOCUMENTS INCLUDED IN THIS APPROVAL:	DATE APPROVED: January 3, 2008	
Document Name	Version	Date
Protocol:		
Research Proposal	N/A	December 10, 2007
Consent Forms:		
Consent Form	N/A	January 2, 2008
Advertisements:		
Recruitment Flyer	N/A	December 10, 2007
Questionnaire, Questionnaire Cover Letter, Tests:		
Individual Interview Questions	N/A	December 10, 2007
Focus Group Questions	N/A	October 5, 2007
Other Documents:		
Agency Approval Letter	N/A	October 5, 2007

The application for ethical review and the document(s) listed above have been reviewed and the procedures were found to be acceptable on ethical grounds for research involving human subjects.

Approval is issued on behalf of the Behavioural Research Ethics Board and signed electronically by one of the following:

Dr. M. Judith Lynam, Chair
Dr. Jim Rupert, Associate Chair
Dr. Laurie Ford, Associate Chair

Appendix C: Consent Form

Consent Form

Title of the Study

Knowledge Management, Moral Leadership and Identity: A Critical Examination of Support Service Workers Workplace Experiences and Learning in the Context of Healthcare Reform.

Research Investigators

Principal Investigator/Faculty Advisor
Dr. Wendy Poole, BA, B.Ed, M.Ed, PhD
Associate Professor
Faculty of Education, Department of Educational Studies
University of British Columbia
604-822-5462

Co-Investigator/Student
Bobby Nijjar, BSc, MSc, RD

I understand this study is being conducted for the partial fulfillment of the requirements for the degree of Doctor of Education.

Purpose of the Study
I understand the purpose of this study is to explore my experiences as an Allied Resident Care Worker during the contracting out process and my views about participating in various activities that led to a greater involvement with the care planning process for the residents. These activities included creating a vision statement, receiving dementia training, attending nursing report at shift change, charting in the Kardex and NCP, attending weekly staff and RCTC meetings, attending mini-inservices, and spending 15 to 20 minutes interacting with the residents on a daily basis.

Method of the Study
I understand I will be involved in a 90-minute focus group interview, followed by a 60-minute individual interview on a later day for a total of 2.5 hours of time commitment. I also understand there will be an optional second 90-minute focus group meeting after the individual interviews that I can choose to attend or not attend. All these sessions will occur in the boardroom at Pleasant View Care Home, they will be conducted by a third-party facilitator, and will be audio taped and transcribed by the facilitator.

Identity
I understand that I am not permitted to talk to others (including Bobby Nijjar) about who participated in this study. I also understand that my name will not be recorded and nor will it appear in the transcripts or in the final report; pseudonyms or 'fake' names will be used. My specific job title or references to specific work tasks that I alone perform will also not appear in the transcripts or in the final report. I also understand the facilitator will forward the audio tapes from the interviews and the consent forms directly to the principal investigator, Dr. Wendy Poole, who will store them at UBC. The co-investigator (Bobby Nijjar) will not have access to the tapes or consent forms. The transcripts will be protected by storing them in a locked cabinet and the copies on the computer will be protected by a password.

Voluntary Participation
I understand that my participation in this graduate thesis study is completely voluntary. There is no pressure or obligation for me to participate. I may refuse to participate or withdraw from the study at any time with no negative consequences whatsoever.

I understand that if I have any questions or desire further information with respect to this study, I may contact the research supervisor, Dr. Wendy Poole, Associate Professor at 604-822-5462 or wendy.poole@ubc.ca.

Rights of the Participants
If you have any concerns about your treatment or rights as a research subject, you may contact the Research Subject Information Line in the UBC Office of Research Services at 604-822-8598 or if long distance e-mail to RSIL@ors.ubc.ca.

I have received a copy of this consent form for my records.

I consent to participate in this study.

_____   _____
      _____
         Signature   Printed Name   Date

Appendix D: Focus Group Questionnaire

Focus Group Questions

There have been several changes at the care home in the past few years including the major decision to contract out Support Services in May 2003 followed by Care Aides/Rec Aides in September 2003.

During this time there were several activities some of you may remember, including: meetings with the Administrators starting in Sept 2002 related to the major financial crisis the care home was facing, laying-off the part-time evening housekeeping staff, reduced staffing on weekends and holidays, reduced staffing for vacation and sick relief.

During this time Support Service Workers and Care Aides/Rec Aides voted down a collective agreement that would reduce their wages and unsuccessful efforts were made to decertify from the union to prevent contracting out.

Finally in March 2003 all the Support Service Workers were laid-off and had to re-apply for jobs with the private company, WestCana, who was awarded the contract. Some of you applied with WestCana from the community and worked along side with Care Aides/Rec Aides who were still making union wages/benefits until they were contracted out 5 months later in September 2003. At that point many of you again witnessed Care Aides/Rec Aides being laid-off and having to re-apply for their jobs and the challenges that arose from that.

In addition to all these changes, the care levels were significantly increased. Only very frail and elderly individuals were eligible for admission into the care home. This dramatically increased the workload of the support service workers by increasing the amount of laundry, number of completes, complexity of meals, diet textures and specials. Critical think how you felt during these times.

1. Can you tell me what this process was like for you?
2. What were you feeling and thinking during this time? Now?
3. How did this affect your worklife including:
    a. your sense of who you are;
    b. your relationships with your co-workers;
    c. your commitment to your workplace and;
    d. the meaning of your work?

After contracting out, we made several changes, including making support service workers more involved in the residents' care planning process. We worked on creating a goal to provide the best qualify of care and the best quality of life for the residents in a home-like setting, we received dementia training, we attended nursing report at shift change, we charted in the Kardex and NCP, we attended weekly staff and RCTC meetings, we attended mini-inservices, and we

spent 15 to 20 minutes interacting with the residents on a daily basis. Critical think how you felt during these times.

4. Can you tell me what this process was like for you?
5. What were you feeling and thinking during this time? Now?
6. How did this affect your worklife including:
    a. your sense of who you are;
    b. your relationships with your co-workers;
    c. your commitment to your workplace and;
    d. the meaning of your work?

Appendix E: Individual Interview Questions

Interview Questions

1. What do you think of your new job title of Allied Resident Care (ARC) Worker? How would you describe the work roles and responsibilities of the ARC workers? How have they changed since contracting out and being more involved in the care planning process?

2. What was your personal experience of contracting out and being more involved in the care planning process? You might remember a particular moment or part of a day that captures these changes. What were you feeling and thinking at the beginning of these changes? Now?

3. What kinds of changes have you experienced particularly in relation to your sense of who you are? Do your family/co-workers see you differently? Do people see you and the work you do?

4. How did the process of charting and being involved in the care planning process impact the information you know about the residents? What do you think of your new role of providing information about residents to the nurses, dietitian and other healthcare workers? How do you share your resident-related information with others? What do you feel and think about this?

5. How has your new role and responsibilities affected: (a) your relationships with your co-workers, including the nurses, dietitian, the care aides, recreation aides, (b) the meaning you make of your work (c) how you think other groups in the care facility perceive your role (d) your ability to do your work?

6. What knowledge including: clinical, leadership and communication have you gained from being involved in the care planning process? How has this learning affected you?

7. What have been your biggest gains since these changes began? Your biggest losses?

8. What are your dreams? What do you want your future to be like? How have your workplace experiences affected your dreams?

9. Are there things you would like to add or say that you have not had a chance to talk about in the group meeting or in this interview?

10. Additional questions maybe asked to clarify or expand on ideas.

Appendix F: Data Analysis (Themes and Categories)

Summary of themes emerging during data analysis

32 Themes	Consolidation of themes into 8 Categories	Phases of the privatization process
1. Lack of recognition		Prior to the privatization process
2. Lack of encourage to participate outside of core duties	1. Lack of Respect	
3. Inferior workers		
4. Repetitive work		
5. Meaningless work		
6. Taking a leadership role	2. Experience of the SSWs during the privatization of their jobs and those of the care-aides	During the privatization process
7. Communication		
8. Verbal/Mental abuse		
9. Frustration		
10. Strategy		
11. Educate and kill with kindness		
12. Division between workers		
13. Isolation		
14. Fear		
15. Reporting to media making isolation and fear more intense		
16. Relationship development	3. Interaction with people	After privatization process
17. Caring		
18. Recognized		
19. Trusted		
20. Sharing Knowledge	4. Use and development of knowledge	
21. Positive impact on care of residents		
22. Making a difference		
23. Being a resource		
24. Participation outside of core duties	5. Continuous Learning	
25. Increased awareness		
26. Learning		
27. Self growth	6. Positive self-perception	
28. Self improvement		
29. Equality		
30. More than a job	7. Improved Quality of Work Life	
31. Proud of job		
32. Professionalization		