

DECOMMISSIONING CITIZENSHIP:
THE ORGANIZATION OF LONG-TERM RESIDENTIAL CARE

by

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ABSTRACT

Long-term residential care (LTRC) is a complex sociopolitical milieu where people from diverse backgrounds come to live and work together. In recent years health care restructuring has resulted in the closure of facilities; healthcare policy has narrowed the population that accesses LTRC so that only those who are the most medically and socially complex are admitted; and there has been a transformation of the workforce, a workforce that is mainly comprised of Women of Colour and is among the lowest paid in health care. The purpose of this study was to critically examine the organization of care in LTRC within this context.

The theoretical perspective guiding the study was informed by postcolonialism, postcolonial feminism, intersectionalities, and Foucaudian epistemology. The method of inquiry for the study was critical ethnography, which allowed for critical analysis of ‘taken for granted’ assumptions in the organization of care.

Over a period of ten months, I was immersed in two LTRC facilities in the Lower Mainland of British Columbia. Field work consisted of approximately 218 hours of participant observation. I conducted 51 interviews with administrators, family members, residents, and staff. I reviewed relevant provincial policies and facility-based policies and procedures. I also collected quantitative data related to resident transitions in the health care system (for example, admissions, discharges, and hospital admissions), and staffing levels.

Findings from this study were discussed in three key themes. First, a systematic decommissioning of citizenship occurred for residents and staff in this setting. Second, the impact of health care restructuring over the past decade had important consequences

for relationships between residents, family, and staff. Third, relational care took place in ‘stolen’ moments that occurred despite heavy workloads. All of these themes were underscored by intra-gender oppression, relations of power, and influenced by discourses of ageism and corporatism, which ultimately played out in day to day interactions between those who live and work there. Recommendations from this study included: addressing the entrenched hierarchies in nursing, further examination of the public-private funding model in LTRC, and the introduction of an independent ombudsperson to ensure consistent, high quality care across the LTRC sector.

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DEDICATION

This work is dedicated to my husband Dean and my daughter Ellanore
for their understanding and support
regardless of how many rewrites and contemplative moments were needed.

Just when the caterpillar thought the world was over it turned into a butterfly.

Unknown

CHAPTER 1: INTRODUCTION

Background and Significance of the Study

Long-term residential care (LTRC)¹ continues to be a central component of healthcare services for Canada's aging population. While deinstitutionalization has occurred for other populations in British Columbia, with questionable results, models of institutionalized residential care are expanding for older adults. Multiple issues are impacting upon LTRC, notably multifaceted demographic factors and healthcare restructuring, with inevitable interfaces between the needs of the population and the capacity of the healthcare system to provide the care that is needed.

The first demographic factor is that of Canada's aging population. While 13 percent of Canadians (for a total of 4.2 million people) were 65 years and older in 2005, it is projected that by 2036, 25 percent of Canadians will be in this age group. Within the aging population, the fastest growing group are aged 85 years and older - those most likely to require placement in LTRC (Ministry of Health Services [MHS], 2004; Statistics Canada, 2006a). In 2003/04, 9 percent of adults aged 66 to 84 years and 37 percent of those aged 85 years and older lived in an institution (Statistics Canada, 2006b).

A second demographic factor is the increasing ethnic diversity of the aging population. In 2005, one million, or 19 percent of immigrants were 65 years or older (Statistics Canada, 2006a). Within this group of older immigrants, almost one-quarter are

¹ For the purposes of this study, I use the term long-term residential care to refer to those "care services [that] provide a safe, protective, supportive environment and assistance with activities of daily living for clients [termed residents in this study] who cannot remain at home due to their need for medication supervision, 24-hour surveillance, assisted meal service, professional nursing care and/or supervision. Clients may have moderate to heavy care needs which can no longer be safely or consistently delivered in the community. They may suffer from a chronic disease, from a disability that reduces their independence and, generally, can not be adequately cared for in their homes" (Hollander, 2002), p.60). Other terms often used to refer to these institutions include long-term care facilities, nursing homes, homes for the aged, and old-age homes.

Persons of Colour² (Statistics Canada, 2006a). The majority of older immigrants live in two metropolitan areas of Canada: Toronto and Vancouver. Among seniors who arrived between 1991 and 2001 in Vancouver, 60 percent could not speak either official language (Statistics Canada). Immigrants, especially those who are more recent immigrants, those who are Persons of Colour, and those who experience a language barrier, are confronted with additional challenges as they age in Canada, including isolation, risk of lower quality of life, and increased difficulty accessing health services (Brotman, 2004; Lai, 2004; Moriarty & Butt, 2004; National Advisory Council on Aging [NACA], 2005).

A third demographic factor is the ethnocultural diversity of the LTRC workforce. With shortages of nurses and workers in general, Canada has entered a global market to find people to work and many end up in LTRC. British Columbia employs 39.5 percent of the Internationally Educated Nurses (IEN) in Canada, the highest proportion of any of the provinces. The main source country of Internationally Educated Nurses (IEN) is the Philippines (26 percent of IEN) (Canadian Institute for Health Information [CIHI], 2006). These numbers do not include the nurses who come to Canada and spend time working as nannies, home support workers, or healthcare workers in LTRC while they work towards gaining licensure.

These demographic trends are occurring alongside health care reform and restructuring. As part of provincial health care restructuring, between 2001 and 2005, 2,529 residential care beds were permanently closed in British Columbia (Cohen, Murphy, Nutland, & Ostry, 2005) even while it has been estimated that nationally, the

² Throughout this study, I use the term Person or Persons of Colour to acknowledge that individuals who are not White are not “an automatic unitary category based on geographic location or racial identity in opposition to white, but...[share] a common post-colonial struggle based on their differential through intersecting histories of slavery, colonialism, imperialism, racism and genocide in capitalism” (Carty, 1991, p.12).

demand for this service will rise from 184,000 beds in 1996 to over 565,000 in 2031 (Pitters, 2002). In British Columbia during this time, there has been an increase in Assisted Living (AL) beds³, which provide a less clinically-oriented option for residential care. However, the population of older adults that access LTRC are increasingly frail and medically compromised, requiring an even higher level of clinical care, often on the border of needing acute care services of the hospital (Chan & Kenny, 2001; National Advisory Council on Aging, 1999). Policy changes made after 2001 have contributed to the development of this clinically challenging resident population. These policy changes include the move to a needs-based system of access to LTRC, referred to as the First Available Bed (FAB) (MOH, 2008). As well, there was the introduction of complex care, which ensures that priority placement in LTRC is given to those who have the greatest medical need and who cannot have their care needs met in the community or other supportive living environments such as AL.

These changes influencing the makeup of the resident population have occurred at the same time that clinical nursing expertise at the point of care is declining. Often, elders in LTRC are being cared for mainly by unlicensed health care workers (HCWs) who have limited specialized knowledge related to the care of older adults and who receive minimal supervision from health care professionals (HCPs), such as Registered Nurses (RNs) (Anderson et al., 2005; Conant, 2004). As well, Licensed Practice Nurses (LPNs), who have less clinical preparation than RNs, are replacing RNs as the source of licensed nursing staff in LTRC (CIHI, 2004a).

³ Assisted Living provides housing and a range of services, including personal assistance (such as assisting with dressing, monitoring medications), hospitality services (such as meal service, housekeeping, laundry), and 24-hour staffing (staff are typically Licensed Practical Nurses or Health Care Workers, not Registered Nurses). (Retrieved February 25, 2008, from www.health.gov.bc.ca/assisted/what_is_al.html.)

These issues – demographic shifts and healthcare restructuring – set the stage for the sociopolitical milieu of care delivery in LTRC. This milieu, illustrated in the day to day life of LTRC, provides the backdrop to interactions where people from various sociopolitical locations come to live and work together. Often, a large proportion of residents, RNs, and administrators represent the dominant culture: Eurocentric and White (Li, 2000), while the majority of HCWs are immigrants and Persons of Colour. HCWs are often working in low paying positions that do not necessarily utilize their education or expertise from their countries of origin (Berdes & Eckert, 2001; Foner, 1994a). Another, smaller group is the immigrant resident; this group may be under-diagnosed for cognitive impairment at the time of admission, have fewer financial resources, and be more dependent on family members for assistance with decision-making than the larger resident population (Huang et al., 2003).

Historically, relations among these groups are structured into a strict hierarchical system, which formally and informally shapes the way that care is organized (Jervis, 2002). This hierarchy is structured with a small group of administrators at the top, followed by RNs, with HCWs at the bottom. In addition to those who live and work in LTRC, there are the informal caregivers (often family members) who interface with formal care providers, a process that entails negotiation and sharing of resident care tasks (Caron, Griffith, & Arcand, 2005; Keating, Fast, Dosman, & Eales, 2001; Ward-Griffin, Bol, Hay, & Dashnay, 2003). The sociopolitical milieu is also underscored by a biomedical, institutional context (Kayser-Jones, 2003) that has not been responsive to the increasingly complex relations among those who live and work in LTRC (Berdes &

Eckert, 2001; Schirm, Albanese, Garland, Gipson, & Blackmon, 2000), a situation which is, ultimately, evident in how care is organized.

Research Problem

There are multiple issues influencing the organization of care in LTRC. While the demand for LTRC rises with the increase in adults aged 85 years and older -- those most likely to require placement in a residential care facility (Statistics Canada, 2006b) -- with health care restructuring there has been a concomitant decrease of LTRC beds and a shift towards less clinically oriented residential options such as AL.

The population that does access LTRC increasingly requires complex care, but is cared for primarily by unlicensed HCWs who have limited specialized knowledge related to care of older adults, and by LPNs who are less professionally prepared to care for the needs of this population, and who receive minimal supervision from RNs and input from physicians (Anderson, et al., 2005; Chan & Kenny, 2001; Conant, 2004; Kayser-Jones, 2003). With less specialized knowledge at the point of care, residents are at risk for being underdiagnosed for acute health crises and at increased risk of requiring hospitalization once the problem is identified (Conant; Kayser-Jones), thus creating greater demand for acute care services.

Against this backdrop of multifaceted demographic factors and healthcare restructuring, is the sociopolitical milieu of LTRC, which shapes the environment for day to day care delivery. LTRC is a gendered environment, the majority of residents and workers are women (Steckenrider, 2000). In 2003/04, 71 percent of residents were women and 53 percent of these female residents were aged 84 years or older (Statistics Canada, 2006). Many of the residents have low retirement incomes, while HCWs are

among the lowest paid in healthcare and have little opportunity for advancement (Cohen et al., 2005; (Berdes & Eckert, 2001; Foner, 1994a).

As well, HCWs who have immigrated to Canada may have been professionals (both health care professions and others) in their countries of origin, but now find themselves underemployed (Alboim, Finnie, & Meng, 2005; Reitz, 2005) and therefore work in these low paying, low status positions. Older adults living in LTRC who are not from the dominant culture, may experience language barriers, a sense of isolation, and be at greater risk of not having changes in their health status diagnosed appropriately (Huang et al., 2003; MacLean & Bonar, 1995; Mold, Fitzpatrick, & Roberts, 2005). The sociopolitical milieu, then, has many facets and reflects the complex intersections of age, gender, class, and race.

Thus, while demand for LTRC services grows with the aging population, the availability of these services and the level of specialized knowledge among those providing care, is shrinking. Moreover, with less clinical expertise at the point of care⁴ for a resident population that increasingly has acute medical care needs, there may be increased demand on the acute care sector where the necessary diagnostic resources and technological supports are available. Further, the organization⁵ of care in LTRC occurs within a complex sociopolitical milieu, which to date has received little attention when examining how individuals and groups from diverse backgrounds come together to live and work in this setting.

⁴ 'Point of care' refers to hands-on nursing care or care that involves face-to-face interactions between care provider and the recipient of care.

⁵ For the purposes of this study the 'organization' of care refers to the system in which multiple groups come together to provide resident care in LTRC. Similar to skill mix, a term used to refer to the organization of paid caregivers, in this study 'organization' also encompasses informal caregivers, who often are one of the 'groups' who have a role in the provision of resident care.

The aim of this study, therefore, is to improve care for elders living in LTRC by:

i) gaining a greater understanding of how care is organized in LTRC within a complex sociopolitical milieu, and ii) considering the potential consequences of how care is organized in LTRC for the larger health care system.

Significance and Implications

Multifaceted demographic factors, restructuring of the healthcare system, and a complex sociopolitical milieu, intersect to impact on the organization of care for elders living in LTRC. The resulting paradox following years of healthcare restructuring to make LTRC more efficient and cost-effective is that while only those in greatest need can access the service, the entire system of care delivery relies heavily on the least expensive care providers who have limited specialized knowledge to care for this population.

Potential issues arising from this situation include: increased demand for acute care services as changes in residents' health status may only be detected once they have become seriously compromised, thereby requiring transfer to hospital; increased reliance on informal and private pay services to supplement care. This study, which is underpinned by a theoretical perspective informed by postcolonialism, feminist postcolonialism, intersectionality theory, and Foucauldian epistemology, brings a critical analysis to the intersecting issues that are impacting upon the organization of care in LTRC. Implications from this study will be relevant to policy makers and health care decision makers in order to ensure that changes to LTRC take these multifaceted issues into account. There are also implications for the profession of nursing, particularly related to our professional responsibility for the delivery of safe and effective care for

elders living in LTRC and, by extension, our role in providing leadership within this clinical setting for those engaged in resident care.

Purpose and Objectives of the Study

The purpose of the study is to critically examine the organization of care in long-term residential care within the larger health care system and a broader sociopolitical milieu. The specific *objectives* associated with this purpose are:

Objective 1: To examine the everyday encounters between residents living in long-term residential care and those involved in providing their day-to-day care;

Objective 2: To examine staff members' perceptions of how different roles contribute to the organization of resident care;

Objective 3: To examine social relations in the complex, institutional context of long-term residential care;

Objective 4: To examine how acute care services are utilized by residents of LTRC;

Objective 5: To examine the organization of care for residents living in LTRC within a broader sociopolitical milieu, and specifically within the context of the health care system in British Columbia.

Overview of the Dissertation

This dissertation is written in nine chapters. Chapter 1 provides the background to the study, explains the significance, and provides the purpose and objectives that guide the study. In Chapter 2, I review the relevant literature. The chapter is divided into four main sections. The first section locates this research in the field of gerontology. The second section explores in greater detail the multifaceted demographic factors that are impacting upon LTRC. The third section situates LTRC within the larger health care

system. The last section of the literature review includes research related to the organization of care within the institutional setting. Chapter 3 presents the theoretical perspective for the study. This research is guided by a theoretical perspective informed by postcolonialism, feminist postcolonialism, intersectionalities, and Foucauldian epistemology. The chapter concludes with a synthesis of the literature review and theoretical perspective, which lead to the research questions. Chapter 4 explains the method of inquiry - critical ethnography - and the research methods for this study. The dissertation then transitions into the findings. This section begins with an introduction to the study findings and provides greater description of the study sites in which the ethnographic work was conducted. Chapter 5 presents the findings about what it is like to live in LTRC through the residents' voices. Chapter 6 presents findings related to the informal systems that operate within the institutional setting, in particular those related to how work is organized among the various groups that coexist in this setting. Chapter 7 presents the findings related to LTRC as part of the larger health care system, as well as the impact of health policies on care. In Chapter 8, I discuss the study findings in three key themes that emerged as being most salient to understanding the organization of care in LTRC. The final chapter, Chapter 9 includes a summary of the study, conclusions, and recommendations.

CHAPTER 2:

REVIEW OF THE SELECTED LITERATURE

This review of the selected literature provides a background to the multifaceted issues that impact upon, and ultimately shape, the organization of care for elders in LTRC. The study is situated within the field of gerontology, which is concerned with the study of aging and aging-related issues. The growth of gerontology is related to population aging, a demographic phenomenon occurring in the Western world. Population aging is occurring because of a number of converging factors, including: declining fertility rates, the aging Baby Boom cohort, and increasing life expectancy (Statistics Canada, 2006b). Along with population aging is another demographic factor, ethnocultural diversity, and both of these factors are impacting upon the makeup of the resident and workforce populations in LTRC. At the same time that these populations are evolving, healthcare restructuring is changing the shape of how care is organized in LTRC. The influence of restructuring is multifaceted and extends from the philosophical values underpinning how and where care is provided to more pragmatic areas such as access to care. All of these broader issues then have consequences for how care is organized within the institution of LTRC, at the operational and at the personal level. Underscoring these issues are discourses of ageism, racism, the gendered nature of LTRC, and the influence of neoliberalism in healthcare delivery. In this review of selected literature, I bring together these issues to illustrate the complexities of how care is organized in LTRC and the need to address the gap in knowledge that exists around their intersections.

I begin this literature review with a description of the sources of literature. The body of the literature review is then divided into four sections. In Section I, I locate the study within the larger field of inquiry of gerontology and review critical perspectives in gerontology such as critical and feminist gerontology. This section also includes an introduction to the discourse of ageism and its influence on perceptions of age and aging. I conclude Section I with a discussion of health disparities and aging. Section II focuses on the multifaceted demographic issues that impact upon the organization of care in LTRC. Specifically, this section begins with a review of demographics related to Canada's aging population and elders living in LTRC. The other demographic factor I examine in this section is Canada's ethnocultural diversity. This area includes a brief historical background on Canada's multicultural and immigration policies. I also review literature related to ethnocultural diversity and aging, and ethnocultural diversity and the workforce. In Section III, I situate LTRC within the larger healthcare system and describe recent healthcare reform and restructuring in LTRC in British Columbia. In the final section, Section IV, I review literature related to the organization of care within the institutional setting. I conclude this chapter by summarizing the literature review and identifying where the current study will contribute further understandings of the organization of care in long-term residential care.

Sources of Literature

A number of sources were drawn upon for this literature review. I used mainly four search engines for academic literature: Ageline, CINAHL, Sociological Abstracts, and PubMed. I focused on the time period 1995 to 2007 and also included some ethnographies that are considered 'classic' in our understanding of LTRC. A variety of

terms were used to capture literature. For example, for the setting, I searched ‘nursing homes’, ‘long-term care facilities’, ‘residential care’, ‘skilled nursing facility’. To access literature about staff, in particular HCWs, I also used a number of terms, including, ‘Resident Care Attendant’, ‘Care Aide’, ‘Nurses Aide’, and ‘Nursing Assistant’. Various combinations of these terms were applied to the literature. For each section of this literature review, there were more specific terms, such as ‘job satisfaction’, ‘skill mix’, ‘health care restructuring’, ‘power’, however, this is not an exhaustive list. To collect academic literature that I did not find during database searches, I also read through reference lists of articles that I retrieved to find additional, relevant articles, and hand searched more recent editions of journals that had not yet been added to the data bases.

Once articles were retrieved, I reviewed them. Each paper was read thoroughly, assessing it for scientific quality and scholarship, according to the standards for the type of study. I then pooled papers that were similar in substantive area and examined them for similarities and common themes. Once this step was completed, I synthesized the findings across studies to provide the state of knowledge in that area. Where there were contradictions between papers, I identified a potential gap in knowledge that could be further examined in this study.

In addition to academic literature searches, I used Statistics Canada and the Canadian Institute of Health Information (CIHI) websites to search for statistical information related to the aging population and the LTRC workforce. I also searched the federal and provincial government websites and local health authority websites for literature related to demographic changes and LTRC. I drew on organizations, such as

the National Advisory Council on Aging (NACA) and Research on Immigration and Integration in the Metropolis (RIIM) for publications on issues of interest in this study.

Literature used in this review is mainly drawn from Canada, the United States, the United Kingdom, and Australia, where similar models of residential care exist. A recent review of geriatric and gerontology literature found that over half of the academic publications available in this field are produced by the United States, followed by the United Kingdom. While Canadian literature has a respectable presence, it accounted for only 6.7 percent of the publications overall (Navarro & Lynd, 2005). Limitations of this review of the literature, therefore, are the heavy reliance on publications from the United States and Western European perspectives, and the exclusive use of publications available in English.

Section I:

Locating the Research in the Current Field of Study of Gerontology

This research study is situated within the field of study of aging known as gerontology. In this section, I provide a brief background to this area of study and broad area of inquiry, social gerontology, in which the research is located. I then discuss critical perspectives in gerontology, including feminist gerontology. Next, I introduce the discourse of ageism, which influences many of the areas explored in further sections of this literature review. The final component of this section is about health disparities and aging. This area discusses important differences between older adults, grounded in differences of race, gender, and geographical location.

Gerontology: The Study of Aging

The impending demographic shifts and demand for services specific to the aging population have encouraged the development of the field of gerontology, or the study of aging. Research about aging was conducted throughout the 20th century and gerontology continues to develop as a distinct discipline in academia. This multidisciplinary field has many facets, including a concentration on the biological changes of aging and a more sociological perspective on aging (Wade, 2001).

The current study fits with the area of inquiry known as social gerontology (McPherson, 1990). Theory development in social gerontology has focused on aging at the individual level and at the societal level, often referred to as ‘micro’ and ‘macro’ level theories. This theorizing about aging has focused on a few main areas: the aged, aging as a process, and age as a dimension of social structures (Chappell, Gee, McDonald, & Stones, 2003). While it is beyond the scope of this literature review to explain all of the theories of aging, for this study I draw loosely on the social and differential models of aging. In essence, these perspectives stress the individualized nature of the aging process, which is biological, psychological, and social in nature. It is influenced by the social, political, and economic contexts in which the individual lives and has lived. Older adults as a population, therefore, are not viewed as a homogenous group (Ulysse, 1997).

Critical Perspectives in Gerontological Research

In addition to attention to the social aspects of gerontology, the current study is further situated within critical gerontology, a theoretical perspective that has developed in response to the traditional, biomedically-driven view of older adults as passive and dependent (Baars et al., 2006; Gubrium, 1993; Kontos, 1998). This perspective

“provokes and challenges assumption, and...is grounded in a commitment not just to understand the social construction of aging, but to change it.” (Minkler, 1999 p.1). In its early development, this approach to research focused on centralizing the voices of older adults in dialogue about aging and the aged. The aim was to make visible the diversity, agency, and creativity that exists in aging by bringing those voices that have previously been silenced to the fore (Gubrium, 1993; Kontos, 1998). Yet this particular approach to critical gerontology has been critiqued for continuing to ignore the role of the social context in aging, in particular the dynamic interactions between the individual and their physical and social surroundings (Kontos). Out of this critique has grown a more political aspect of critical gerontology, one that views ‘problems’ of aging as structural – that is, political, economic, and social. In combining these two paths of critical gerontology, it is possible to critically examine issues of aging from the individual’s perspective while also being cognizant of the structural forces at play.

Feminist gerontology has also grown out of a need to critically examine issues of aging from women’s perspectives. Scholars advocating for feminist gerontology have critiqued gerontological theories as being based on the experiences of white, middle-class, heterosexual men and then being generalized to women and members of cultural minorities. They have also been critical of feminist research which has often ignored issues of aging and objectified older women as burdens of care for younger, working women (Ginn & Arber, 1995). A feminist gerontological perspective, therefore, validates the experiences of older women and values their experiences by centralizing their voices in research (Calasanti, 1993; Garner, 1999; Ray, 1999). More recently, scholars drawing on this perspective have begun to examine a gendered analysis of aging (Calasanti,

2004). I used this perspective to inform my Masters thesis about ever-single older women's perceptions of their health and health care needs as they experienced increasing age and frailty (Baumbusch, 2000). Although critical gerontology and feminist gerontology have provided an important focus on aging and the voices of the aged, further critical analysis of age as an axis of oppression is needed to address inequities in health care for older adults, in particular older women.

Discourse of Ageism

In keeping with the need to further examine the role of aging in Western society is an examination of the discourse⁶ of ageism in Western culture. Butler (1975) was the first to define ageism as the systematic stereotyping of, and discrimination against, people simply because of their age. This system of social exclusion of anything related to aging or caring for the aged has been connected with exclusion of older adults from participation in the 'normal' social world. This exclusion has been cited as beginning with mandatory retirement and continuing as chronological age becomes enmeshed with notions of clinical needs, physical and cognitive decline, and dependence (Simms, 2004). Images of older adults in the media often re-inscribe these views for the general public and for healthcare providers (Wade, 2001). Ageism interplays with discourses that typify these images, in particular the idea that older adults create an intolerable pressure for publicly funded programs, such as health care, possibly making them unavailable for more deserving, younger, contributing members of society. Several scholars from the

⁶ Foucault defines the role of discourse as providing "a set of possible statements about a given area, and organizes and gives structure to the manner in which a particular topic, object, process is to be talked about" (Kress, 1985). Cheek (2000) extends this definition by stating "thus, a discourse consists of a set of common assumptions which, although they may be so taken for granted as to be invisible, provide the basis for conscious knowledge" (p.23). In this sense, discourses help to frame how knowledge is produced and, therefore, what is included and excluded from the way we construct reality. At any time, certain discourses may be more dominant than others, thereby marginalizing certain knowledges (Cheek, 2000).

United States have pointed out that these discourses are used to support rationing of health services for older adults (Kane & Kane, 2005; Stallard, Decker, & Sellers, 2002). They also help to underpin the establishment of ‘separate’ programs, agencies, and services for older adults, which often serve to reaffirm their position as ‘outsider’ or undeserving of regular treatment or service (Wade, 2001).

Health Disparities and Aging

Ageism is a discourse that contributes to health disparities in general for older adults as a group (described in the previous section), however, within the aging population, there are also inequities that contribute to intra-group disparities. Health disparities have been linked to race, ethnicity, and socioeconomic position (Bierman & Clancy, 2001), yet very little is written about health disparities among older adults. Women over the age of 65 years are more likely than men over the age of 65 years to have chronic health conditions although life expectancy is higher for women (Statistics Canada, 2006a). Older women also have lower incomes compared to men (Statistics Canada). Members of the First Nations in Canada tend to experience health disparities across the lifespan, which extend into old age. The life expectancy of members of the First Nations continues to trail the general population, with only 4 percent of Aboriginals over the age of 65 years compared to 13 percent of non-Aboriginals in 2001 (Statistics Canada). Place of residents also shapes health, as older adults living in rural areas have difficulty accessing services (NACA, 1999). Older immigrants, particularly those with a language barrier, experience difficulty accessing health services (Brotman, 2003). With regards to the LTRC population, gender and socioeconomic status contribute to the likelihood that an individual will use this service (Statistics Canada).

Section Summary

Gerontology as a field of study has been proliferating over the past few decades. An important aspect of this growth is the development of critical and feminist perspectives that situate aging within broader social, economic, and political contexts. These contexts are influenced by discourses of ageism, which persist despite the growing number of older adults in our society. Within the population of older adults, there are health disparities that function along axes of gender, race, geographical location, among others. Further critical analysis of the issues raised in this section would enrich our understanding of how discourses of ageism intersect with the aging experience in Western culture, contributing to disparities among older adults. This study will provide further understanding of how these issues operate within the LTRC setting, particularly in the Canadian context, fitting with the research priorities set by the Institute of Aging in the Canadian Institutes of Health Research, specifically for research related to health services and policy relating to older people (Institute on Aging, 2002).

Section II:

Multifaceted Demographic Factors Impacting on the Organization of Care

In this section I introduce the multifaceted demographic factors that are impacting the organization of care in LTRC. I begin by describing Canada's aging population and provide specific descriptions of elders living in LTRC. I then examine a second demographic factor, Canada's ethnocultural diversity. I provide a brief historical backdrop of Canada's multicultural and immigration policies to explain the changing makeup of Canada's immigrant population. Against this background, I describe the population of older immigrants, in particular those who live in LTRC. I conclude by

considering how the current demand for nurses is contributing to the make-up of the workforce in LTRC.

The Aging Population

Canada's aging population is often cited in relation to its implications for various aspects of society, with the ability of the healthcare system to meet the needs of this population being one of the main areas of debate. Population aging, as this phenomenon is often called, has developed as a result of increased life expectancy, improved health care, the aging of the 'baby boom' generation, and decreased fertility rates (MOH, 2004; Statistics Canada, 2006a). In 1998, 12 percent of Canadians were 65 years and older, This increased to 13 percent by 2005, and it is projected that by 2036, 25 percent of Canadians will be in this age group. Within this population, the fastest growing group are those aged 85 years and older- those most likely to require placement in a residential care facility (Statistics Canada, 2006a). While population aging varies among the provinces, British Columbia is experiencing a similar demographic shift as the national average. In British Columbia adults aged 65 years and older account for 13 percent of the population and by 2031 will account for 24 percent of the province's population. Moreover, British Columbia's population is increasing in those in the oldest age range, those aged 80 years and older. Between 1991 and 2001 there was a 54 percent increase in the number of adults aged 80 years and older, again this reflects the highest growth of this group of older adults among all provinces (MOH, 2004).

Older Adults Living in Long-term Residential Care

In 2004/05, 3.4 percent of those aged 65-74, 7 percent of those aged 75 – 79; and 16 percent of those aged 80 years and older lived in LTRC in Canada (Statistics Canada,

2006b). In 2001, in British Columbia, 29 percent of women and 17 percent of men aged 85 years and older lived in LTRC (MOH, 2004). The majority (85 percent) of residents in LTRC are over the age of 75 years and have complex, chronic health issues (Tully & Mohl, 1995) including Alzheimer Disease or other dementia and urinary incontinence (Trottier et al., 2000). Today, only the most frail and complex adults are admitted to LTRC, “individuals who on average require a higher, more intensive level of care than earlier clients” (NACA, 1999, p.44). In addition to having complex, chronic health problems, there are other issues that make certain older adults more likely to live in residential care. A ‘typical’ resident in Canada is over the age of 80 years, female, single, and has primary school education or less, and has a lower income than her/his counterparts who remain living in their homes (Trottier et al.).

Despite limited demographic information about the makeup of the LTRC population in Canada, it has been estimated that 75-80 percent of residents are female (Havens, 2002). This group represents 38 percent of all women over the age of 85 years and 10 percent of women between 75 and 84 years (Pitters, 2002). Women often outlive their spouses, for whom they provided care in the home. As a consequence, as women experience increasing frailty and chronic health conditions as they age, they become more likely to move into a residential care setting (MacLean & Klein, 2002). The majority of female residents have incomes at or below \$25,000 (Cohen et al., 2005). The population accessing LTRC, then, are female, older, with complex health issues, who tend to be from lower socioeconomic class than their counterparts who remain in the community. With the aging population and lack of other healthcare options (as discussed

in Section III), it is anticipated that the demand for LTRC will grow (Tully & Mohl, 1995).

Ethnocultural Diversity and LTRC

Along with the aging population, ethnocultural diversity is impacting on the organization of care in LTRC. Ethnocultural diversity affects residential care for older adults mainly in two ways: first, more residents who have non-European backgrounds are moving into residential care (Huang et al., 2003); and second, studies in the United States have indicated that large numbers of health care workers (HCWs) in LTRC are immigrants and Women of Colour (Berdes & Eckert, 2001; Foner, 1994a). This shifting makeup of the resident and worker groups has occurred partially as a result of the introduction of a model of multiculturalism and the evolution of Canada's immigration policies over the past several decades. In the following paragraphs, I review multiculturalism, immigration policy, and their implications for those who live and work in LTRC.

Multiculturalism and Immigration Policy in Canada

In 1971, the federal government introduced a national policy of Multiculturalism, with the dual underlying values of preservation of cultural identity and equality among all citizens, and the Canadian Multiculturalism Act was passed in 1988 (Government of Canada, 1988). The idea of multiculturalism as a descriptor of Canada's population was first articulated in the Royal Commission on Bilingualism and Biculturalism in the 1960s, in which everyone not of English or French descent was referred to as a "third force" thereby making up a cultural mosaic. At that time, the majority of immigrants living in Canada were of European descent (Li, 2000). In 1967, immigration policy underwent

tremendous change, eliminating criteria based on racial or national identity, and adopting a point system, which accorded potential immigrants points based on their education and occupational skills regardless of their country of origin. It was after this change in policy that there was a shift from predominantly European immigrants to a greater proportion of Persons of Colour settling in Canada (Li, 2000). The point system was revised again in 1997 in an attempt to connect potential immigrants' educational backgrounds with labour market needs in Canada (Alboim et al., 2005).

Over time, multiculturalism and immigration policy have become increasingly critiqued by Canadian scholars for their focus on preserving cultural identities rather than promoting, and enforcing, social equality (Li, 2000). Scholars have also critiqued ways in which multiculturalism supports the dominant culture and marginalizes other groups by ignoring the systemic racism that exists in Canada (Henry, Tator, Mattis, & Rees, 2000). As a consequence, there have been mounting issues of racial tension among Canadians that have gone unaddressed by the federal government (Li, 2000). One way in which systemic racism plays out is in the socioeconomic disadvantage that persists among immigrants. Scholars have noted that immigrants who are Persons of Colour are at distinct economic disadvantage in the labour market, with lower incomes than their White counterparts (Li, 2000; Picot, Hou, & Coulombe, 2007) and are often underemployed (Reitz, 2005). For instance, new immigrants begin with an earnings disadvantage of about 30 percent, with little improvement over the first five years of residency in Canada (Alboim et al., 2005). This situation is more pronounced for immigrants who are Persons of Colour than for those who are White (Reitz).

The discourse of multiculturalism has also been critiqued for causing shortcomings in the delivery of equitable health care to older adults in the community and in LTRC. Brotman (2003) posits that the overemphasis on multiculturalism in aging research has contributed to an avoidance of issues such as racism as experienced by older adults. In her study with older women from various ethnic backgrounds, Brotman found that language was a major barrier to receiving appropriate care. Issues around interpretation underscored assumptions that were made with regards to certain communities being 'deserving' or 'undeserving' of care. Health care providers acted as gatekeepers to interpreters and, therefore, some women in the study did not feel that their health care needs were met as they had no ability to communicate them to their care providers. There were also issues around race and racism that were connected to notions of culture and embedded within institutional practices concerning older women from ethnic minorities. The relative invisibility of racism supported these practices thereby perpetuating issues around access to services. In sum, multiculturalism began with the dual underlying values of preserving cultural identity and equality among all citizens. Several scholars have explicated how, over time, multiculturalism and immigration policy have become increasingly focused on preserving cultural identities rather than on promoting and enforcing social equality. It is these barriers of systemic racism and systemic inequalities, which neither the ongoing discourse of multiculturalism nor legislation have addressed, that continue to contribute to inequities and disparities in health and health care among some groups.

Aging, Immigrant Population and LTRC

Currently, British Columbia receives 35-38,000 immigrants every year, most of whom come from non-European countries (Statistics Canada, 2003). For example, between 1991 and 2001 the majority of immigrants who settled in the Lower Mainland of British Columbia were from China, Hong Kong, Taiwan, and India (Statistics Canada, 2003). Immigrant groups in Canada are experiencing the aging population phenomenon (Lai, 2004). In 2005, one million, or 19 percent of immigrants were 65 years or older. Within this group of older immigrants, almost one-quarter, or 23 percent are Persons of Colour (Statistics Canada 2006a). Many older immigrants are recent immigrants with 15 percent having arrived in Canada between 1981 and 1996 and 6 percent having immigrated in the last 10 years (NACA, 2005).

As immigrants to Canada age, they are accessing health care services, including LTRC. Several scholars have demonstrated that older immigrants, in particular those who experience a language barrier, experience challenges in accessing health care services. The lack of interpreter services may prevent older immigrants from accessing services, the inability to communicate may also contribute to underdiagnosing health problems, and, in LTRC, older immigrants may experience an overall sense of isolation and loss of culture (Brotman, 2004; Huang et al., 2003; MacLean & Bonar, 1995; Mold et al., 2005). Residents live in an environment that was developed for the dominant/White/Western European culture, and consequently, many experience difficulties related to loss of family, loss of culture (including their ability to communicate in their own language) and loss of community, culminating in an overall sense of isolation (MacLean & Bonar, 1995). A literature review about older immigrants in LTRC found that residents may

experience greater barriers to accessing LTRC; there needs to be an acknowledgement of ethnic diversity in LTRC in relation to religious beliefs and practices; and there are issues around language and communication, pointing to the need to make interpreter services available so that elders can express their needs (Mold et al., 2005).

Importing Care: Ethnocultural Diversity among LTRC Staff

Another significant demographic factor impacting upon the organization of care in LTRC is the increasing ethnocultural diversity of the workforce. The globalization of the nursing workforce and exploitation of nurses from poor countries by first world nations is well documented, particularly issues of racism, isolation, and low pay (Brush & Vasupuram, 2006; DiCicco-Bloom, 2004; Hawthorne, 2001; Kingma, 2001; Ogilvie, Mill, Astle, Fanning, & Opare, 2007; Ross, Polsky, & Sochalski, 2005; Turriffin, Hagey, Guruge, Collins, & Mitchell, 2002; Xu, 2007). British Columbia has the highest concentration of Internationally Educated Nurses (IEN) among the provinces with the majority of IEN coming from the Philippines (CIHI, 2005).

Unlike RNs, the ethnocultural and immigration backgrounds of unregulated HCW are not well documented. Some scholars (Priester & Reinardy, 2003) in the U.S. have actually suggested targeting immigrants for HCW positions in LTRC. They stress that, while ‘New Americans’ will have to adopt cultural and language norms in order to successfully integrate into the workforce in LTRC, they are ideally-suited to working in this sector because “these workers have exhibited a greater willingness to work in jobs that many U.S. nationals have been reluctant to take because of low wages, difficult working conditions, and other perceived drawbacks” (p.9).

There are also several examples of ways in which nurses of Colour are steered into working in LTRC. For example, the Ontario Human Rights Commission found that, at one hospital, nurses of Colour were directed towards working in LTRC, while White nurses were given their choice of specialty area of practice (Hagey et al., 2001). Das Gupta (1996) has written about a similar systemic racism that exists in Canadian nursing. She has described the stratification of power in nursing according to race as illustrated by the predominance of White nurses in positions of power, such as managers, with women of Colour relegated to positions as staff nurses. Within this structure, White nurses act as key players in a system of surveillance of the staff nurses, excessively monitoring and more frequently disciplining nurses of Colour. Thus, a class structure of nursing is established, with a hierarchy of White managers, White RNs, and RNs and HCWs of Colour.

Similar to Das Gupta's (1996) analysis of the hierarchy of nursing, LTRC has a clearly hierarchical structure based on race, class, gender, and age. In an ethnographic study in LTRC conducted in the United Kingdom, Jervis (2002) described the power dynamics as a 'chain of command' with a small number of staff, usually White, at the top, and a large number of staff, predominantly Persons of Colour and immigrant groups, at the bottom. She describes the 'top staff's' perception of HCWs as irresponsible, uncommitted, and transient, resulting in a focus on discipline and staying in control. HCWs were well aware of the class-based system of their workplace and the insidious racism that pervaded this system that placed them in subservient positions requiring a high degree of surveillance. A result of this situation were disguised, low-profile acts of resistance on the part of HCWs and, ultimately, resignation. In a similar study conducted

in the United States (Schirm et al., 2000), HCWs also expressed recognition of the racialized structure of care provision in LTRC, reporting that this contributed to feelings of disrespect and demoralization.

Some of the hierarchy described by Jervis (2002) is rooted in the history of LTRC facilities. Many facilities were built by European immigrant societies or religious organizations, and the residents were, and remain, largely a White population of European heritage. The staff providing direction at these facilities – administrators and nurses – are also primarily White, while the HCWs are mainly non-European immigrants (Berdes & Eckert, 2001; Foner, 1994a). Racism in LTRC has received some attention in the literature, particularly racism towards HCWs. A U.S. study reported that 73 percent of HCWs experienced racism in the workplace – 56 percent from residents, 23 percent from family members of residents, and 40 percent from fellow staff (Berdes & Eckert, 2001). Another study with 337 HCWs working in nursing homes in New York found that higher levels of perceived racial/ethnic bias were associated with higher levels of demoralization and job burnout (Ramirez, Teresi, Holmes, & Fairchild, 1998). In both of these studies, HCWs who were immigrants reported higher levels of racism in the workplace than staff who were Persons of Colour (such as African-Americans) but were not immigrants (Berdes & Eckert, 2001; Ramirez et al., 1998).

Berdes and Eckert (2001) described a form of racism that is largely discounted by HCWs. HCWs may not interpret behaviours as racist because they come from residents diagnosed with dementia, who they deem not responsible for their behaviours. Even so, some staff admitted that racism was worse in the work environment than in the outside

world. These findings have implications for care delivery and the quality of care that is possible in this work environment.

Section Summary

Multifaceted demographic factors influence the organization of care in LTRC. As Canada's population ages, there may be greater demand for LTRC services, particularly by women and those with low incomes who cannot purchase care in the community. In addition to population aging, there is also growing ethnocultural diversity among those who live and work in LTRC, a situation shaped by Canada's immigration policies. Despite multicultural policies, the cultural roots of LTRC in Western European practices can create an isolating atmosphere for residents who are immigrants, particularly those who do not speak or understand English. For staff, there are issues of systematic racism that create hierarchies within the nursing profession that force many nurses of Colour to work in LTRC even if that is not their preferred area of practice. Within LTRC these hierarchies are quite overt, and may result in a system of power relations, resistance, and struggle among care providers.

Section III:

Situating LTRC within the Larger Healthcare System in Canada

In this section of the literature review, I situate the organization of care in LTRC within the larger health care system. Much of the literature included in this section reflects current health care policy and is not research-based. I begin with LTRC's role in the Canadian healthcare system. I then move on to health care reform and restructuring, which has changed the landscape of healthcare over the past couple of decades in Canada. Next, I review recent restructuring changes specific to LTRC in British

Columbia and consider the implications of these changes for LTRC residents, staff, and the larger health care system. I conclude the chapter by critically considering how converging discourses that influence the care of residents interface with the health care restructuring reviewed in this chapter.

Long-term Residential Care in Canada's Health Care System

Canada is internationally-renowned for its universal health care system. Public funding of health care in Canada began in 1957 through the Hospital Insurance and Diagnostic Services Act, followed by the Medical Care Act in 1966. Since its inception, the federal government has set national standards and provided funding in a shared model with the provincial governments, while the provinces were responsible for actually administering health care services (for a full description of the evolution of funding for Canada's health care system and the impact on long-term residential care, see Alexander, 2002). Only two main areas are covered by the Canada Health Act – physician services and hospital-based care. Other sources of care, including LTRC, community home care, pharmaceutical costs and dental care, lie outside of the universal system, often requiring shared or sole responsibility for payment with the patient (Hirdes, 2001).

Federal health policy and funding, therefore, are not inclusive of LTRC and this sector has evolved differently in each province (Alexander, 2002; Hirdes, 2001; Shapiro, 2000). As of 2004/05, there were 1,952 LTRC facilities for older adults across Canada, serving 189,325 residents, and generating about \$10 billion in annual revenue (Statistics Canada, 2006b). Across the country, there is a mix of private and public facilities and variations in the requirement for co-payments by residents of these facilities (Hirdes, 2001). There are no national standards for assessing LTRC needs and services, and little

is known about the resident population across Canada, or about the way this service is being delivered (Hirdes, 2001; Shapiro, 2000). Although the Canada Health Act includes the main values associated with the health care system - access, portability, public administration, comprehensive coverage, and universality, aspects of health care delivery that are not funded through the universal insurance, such as LTRC, continue to evolve differently in each province and may not reflect these core values (Hirdes, 2001)

Reform and Restructuring of the Canadian Health Care System

Long-term residential care has often been a site of health care restructuring. In the 1970s, as demand for hospital services grew, provincial governments turned their attention to LTRC to provide a less costly alternative to hospital care by providing ongoing, residential care for people who were unable to live at home (Alexander, 2002; Shapiro, 2000). Then, in the 1990s when reform and restructuring of the hospital-based component of the system accelerated, health-care decision makers once again looked to LTRC as one potential area that could absorb some of the consequences of changes being made in acute care (Chan & Kenny, 2001).

Restructuring has been an integral and ongoing aspect of health care delivery in Canada since the early 1990s (Decter, 1997; Shamian & Lightstone, 1997). While the rationale for restructuring has been linked to ‘patient-focused care’, the outcome of this process often involves cuts to services and staffing in the form of regionalization and amalgamation of services (Aiken & Fagin, 1997). Because provinces are responsible for the delivery of health services in Canada, restructuring has taken different forms across the country. In British Columbia, as in some other provinces, regionalization was one of the first steps in this process. Regionalization leads to the elimination of local hospital

boards and, often, to decentralization of services and amalgamation of roles, and to the consolidation of hospital services and closure of some hospitals (Decter, 1997). British Columbia has also focused on the continuum of care model, which ideally involves creating a comprehensive, seamless system of services across hospitals and community, thereby making it more effective and efficient than a system that relies mainly on hospital-based care (Decter, 1997). A challenge of this approach is that funding has not always been associated with the shift in focus from hospital to community. For LTRC, this means that while more complex residents are being admitted, resources may not be made available to support the increasing care needs of this population (Chan & Kenny, 2001; Hirdes, 2001).

Restructuring of Long-term Residential Care for Elders in British Columbia (2001-2005)

In British Columbia between 2001 and 2005, there was an acceleration of restructuring activities impacting upon LTRC. These changes include: the closure of LTRC beds, a shift to a needs-based waitlist through the First Available Bed policy (FAB), and legislation that allowed contracting out of resident care services along with wage rollbacks for unionized HCWs. In the following paragraphs, I describe each of these areas of restructuring.

The first area of restructuring was the closure of LTRC beds. Since 2001, 2,529 LTRC beds have been permanently closed in British Columbia. These beds include the closure of 26 government-funded facilities (Cohen et al., 2005). A further reduction of

559 residential care beds in Vancouver Coastal Health⁷ is planned between 2004 and 2009 (VCH, 2005). Yet, it has been estimated that the number of beds required in LTRC in Canada could rise from 184,000 in 1996 to over 565,000 in 2031 (Pitters, 2002).

To address the gap between the available beds and the demand for LTRC, there has been a growth in residential options that are less clinically-focused, such as Assisted Living (AL). In British Columbia, between 2001 and 2005, 1,065 subsidized AL units were built (Cohen et al., 2005). Assisted Living, however, should not be viewed as a direct replacement for LTRC beds. Rather a shift to this type of housing for older adults represents a philosophical shift away from the provision of 24-hour nursing care, as with LTRC, to a more independent style of housing which requires residents to ‘purchase’ care options, such as bathing and medication management, which are normally provided in LTRC. Yet, ultimately, when a resident’s care needs exceed the services provided in AL, difficult decisions must be made about how and when to move the individual into LTRC, a dilemma confronting many AL facilities (Munroe & Guihan, 2005).

The development of the AL sector has also been accompanied by a marked increase in corporate involvement in this area. Previously, health authorities mainly contracted beds from non-profit LTRC facilities, but there has been a shift to corporate ownership and for-profit developments in AL and contracting of private, for-profit LTRC beds. Consequently, private pay institutions are replacing the non-profit LTRC beds that have been closed (Cohen et al., 2005).

It has been estimated that, on average, it costs \$44,000 to \$67,000 per year to live in a private pay AL facility in British Columbia. While this fee covers basic room and

⁷ Vancouver Coastal Health is one of five health authorities in British Columbia and is responsible for health services for the population in the coastal mountain communities, Vancouver, North Vancouver, West Vancouver, and Richmond.

board, there are often additional charges for services such as assistance with bathing and medication management. The costs associated with AL, therefore, put it out of reach for many older adults who may need to pay extra fees for ongoing personal care support, or these individuals need to waitlist for a government-subsidized AL facility. For example, three-quarters of the largest subpopulation of users of long-term care services, such as home support, in the community - unattached women over the age of 70 years - had incomes at or below \$25,000 in 2000 (Cohen et al., 2005). Little is known about how this shift is affecting the population in need of LTRC, for instance, are those with assets and high retirement incomes choosing AL, and if so, is this having an impact on the pressure for LTRC beds? Thus far though, there has not been substantial evidence that AL is relieving the need for LTRC beds.

The loss of LTRC beds and the lack of financially-accessible alternatives have potential consequences for the larger health care system, in particular, the acute care sector. As the number of LTRC beds shrink, those waiting for placement often spend a prolonged period of time in the hospital. These patients are categorized as Alternative Level of Care (ALC) to indicate that they do not require acute care services yet cannot be safely discharged home even with community supports. In 2001/02, ALC patients accounted for 14.8 percent of all inpatient days in acute care (MOH, 2004). It is estimated that an acute care bed costs four to seven times the amount of a LTRC bed (Government of British Columbia, 2000). As patients wait to be transferred, they may lose functional abilities and become more dependent on care providers, therefore, increasing their care requirements once they do go to LTRC.

A second area of restructuring occurred in April 2002, when the Ministry of Health Services moved from a chronological waitlist for LTRC placement to a needs-based waitlist resulting in only those with the most complex care needs being placed in LTRC (MOH, 2002). This policy, called the First Available Bed (FAB) policy, essentially means that only the sickest and most clinically complex people can access placement in LTRC. This change in how potential residents access this service in British Columbia has had an impact on the resident population, which has become increasingly medically-complex. While it is important that those most in need of this shrinking resource are prioritized, it could be anticipated that, without greater resources to care for them, the lifespan of newly admitted residents is shorter than under the previous system. While this may be viewed as an efficiency by having greater turnover of residents, little is known about the impact of this situation on staff. For instance, it is not known whether staff are able to manage a higher rate of admission (if, in fact, higher rates are the case) or whether staff are adequately prepared to provide a greater degree of end-of-life care. As well, little is known about the impact on the resident and their family if the resident is moved into the first available bed rather than a facility of choice.

A third area of reform is related to legislation and policies that have made it easier and more economically attractive to replace RNs with LPNs and HCWs in LTRC. Policy level support for the deprofessionalization of care for elders living in LTRC reflects the perspective that this area of health care falls under a social model of care as opposed to a medical model. In essence, the social model removes LTRC from the realm of health care, instead focusing on how it meets the social needs of older adults as a residence. This approach “fails to address the professional healthcare needs of the acutely sick and

complex extreme old person and makes evident new gaps in the provision of age care services” (Angus & Nay, 2003 p.131). This model contradicts the biomedically-driven atmosphere that permeates the site of care even when, at a policy level, positioning LTRC in this way allows for a less costly workforce (Angus & Nay).

In 2002, the BC government introduced Bill 29, the Health and Social Services Delivery Improvement Act⁸, as legislation that allowed facilities to contract out for direct care services provided by LPNs and HCWs. This legislation had a large impact in LTRC where most HCWs are employed. In addition to creating this less expensive alternative to unionized staff, at the same time, the government applied a 15 percent wage cut to the union that represented most LPNs and HCWs in the province (HEU Contract, 2002-2005). As a consequence of these actions, many employers opted to contract out direct care services, thereby gaining significant savings. As this has been a recent change in the LTRC workforce, little is known about its impact on staff cohesion. For example, RNs were traditionally ‘team leaders’, however, with the introduction of contracted HCWs, there is now an added layer of management between RNs and HCWs. While it could be anticipated that these changes have contributed to a fragmentation of care, this question requires further investigation. Overall, the acceleration of restructuring in LTRC has left many gaps in our understanding of how care is organized, as the traditional models of waitlisting and staff employment have changed radically over the past few years. Equally important is the lack of knowledge about the consequences of these changes on the organization of resident care and utilization of services from the larger health care system, in particular acute care, by elders living in LTRC.

⁸ On June 8, 2007, this Bill was, in part, struck down by the Supreme Court of Canada as being illegal. The ramifications of this decision are still unknown.

These restructuring changes in LTRC have had particular impact on the mainly female workforce in this component of the healthcare system. Historically, working in this setting was associated with low pay, low status, and job insecurity (Schell, 1993). It is estimated that 97 percent of paid caregivers are women. While HCWs have received notoriously low pay in the United States (Steckenrider, 2000), with contracting out for these services and changes to collective agreements, pay scales for this group have dropped significantly in British Columbia in the past few years. This is particularly evident in LTRC, “since the general notion is that anyone can provide care to the elderly, many elder care occupations require low levels of skill and consequently compensation is not high” (Steckenrider, 2000 p.461). For example, one U.S. study found that HCWs working in hospital earned a median of \$12,000 compared to \$9000 in a nursing home (Crown, Ahlburg, & MacAdam, 1995). Because contractors are not regulated in BC, there is no reporting of the wages paid to HCW although anecdotal reports range from \$9-\$15/hr as compared to about \$20/hr for unionized staff. Additionally, contracted HCW do not have the same job security, medical benefits, or vacation benefits as their unionized counterparts. The work of HCWs is characterized by low occupational status, low pay, limited benefits, little opportunity for advancement, and poor job stability (Berdes & Eckert, 2001).

Interface between Demographic Shifts and Health Care Restructuring

The historical and continuing exclusion of services for older adults, such as LTRC, from the Canada Health Act and recent restructuring of this component of the health care system in British Columbia intertwine with several discourses, such as ageism, rationing of care, and entitlement to care, all of which permeate our health care

system. In health care, there are dominant discourses around issues of entitlement and how care should be rationed among the population. Recently, Canadians have been bombarded with media coverage on health care shortages and waiting times, further ingraining these discourses into the public consciousness. When these discourses intersect with ageism, a public sense that older adults should be less entitled to health care services as their younger counterpart is fostered, and that those working with older adults are less deserving of pay and job security similar to those working in acute care settings.

Fears that an aging population will monopolize health care services have long been debated in the academic literature (Barer, Evans, & Hertzman, 1995; Barer, Hertzman, Miller, & Pascali, 1992; Binstock, 1993; Callahan, 1991). A common solution is that services should be rationed according to age, thereby denying older adults access to various services. This idea has been greeted with much protest by scholars stating that there is an inherent social obligation to provide appropriate care to older adults (Stallard et al., 2002). In Canada, these fears of the aged monopolizing care have led to a number of studies focusing on various issues, including: the availability of physicians (Black, Roos, Havens, & McWilliam, 1995; Watson, Reid, Roos, & Heppner, 2005), pharmaceutical costs (Grootendorst, O'Brien, & Anderson, 1997; Maclure & Potashnik, 1997), and hospital utilization (Barer et al., 1995). Consistently, these studies have found that the demands of the aging population will not overwhelm the health care system and yet 'apocalyptic' predictions persist (Evans, McGrail, Morgan, Barer, & Hertzman, 2001).

Alongside the discourse of shortages of health care service, are the economics of health care delivery. By positing older adults as an economic drain on the health care system, the door opens to further shifting care from this population away from the mainstream (Angus & Nay, 2003). Already we have seen the shift away from professional care in LTRC, a shift that is becoming more common in acute care medical wards with a high ratio of older adults as a component of restructuring (Aiken et al., 2002; Shamian & Lightstone, 1997). Thus, we are seeing a (de)evolution of care and services for older adults despite the growing size and needs of this population.

In a similar way, there are discourses affecting how immigrants and members of visible minorities, especially those patients with limited or no English, are viewed with regards to health service utilization, particularly around entitlement to care. There is often an undercurrent in health services that those with limited or no English *should* have these language skills and, therefore, HCP often act as gatekeepers to interpreter services. Reimer Kirkham (2003) found this sentiment in her research, articulated as “‘Why don’t they learn English? This is Canada’” (p.768). By associating knowledge of English with being a ‘true’ Canadian and, therefore, being entitled to public health care along with a range of other services, HCP re-inscribe this discourse in everyday practice (Reimer Kirkham, 2003). Brotman (2004) reported a similar experience in her research in which older female immigrants reported that HCPs did not offer to provide interpreter services, thereby essentially denying health care services.

Older immigrants are confronted by a combination of these discourses about older adults and immigrants. They are constructed as heavy burdens on Canada’s public health care system, people who endanger the ‘sustainability’ of the system, spawning studies to

‘prove’ that they are not overutilizing services (Wu & Schimmele, 2005). Older immigrants, in particular, those who moved to Canada later in life, are perceived as a group undeserving of health services as they have not ‘contributed’ to the system by living and working in Canada during their ‘productive’ years. A recent newspaper editorial reported “New Canadians with easily transferable work experience can expect to make a fairly smooth transition to a good job without becoming a charge on the public purse. But the trauma and dislocation associated with refugees and elderly newcomers present a quite different charge on the public purse” (Editorial, 2005 p.A12). The only letter printed in response to this editorial stated “Our medical system cannot give proper care to citizens who have lived here all their life. We cannot look after any more elderly immigrants coming to Canada with all kinds of medical problems” (Letter, 2005 p.A21). As these discourses interplay with ongoing reform and restructuring, it is possible that there will continue to be further reductions in services and a continued acceptance of certain actions that exclude various groups from health care services. As Kayser-Jones (2003) demonstrated, elders living in LTRC often go undiagnosed for acute health issues, pointing to the need to continue to critically examine how multiple discourses of ageism scarcity, economics, and entitlement intersect to influence the organization of health care for older adults.

Section Summary

LTRC has long had a role in supporting the larger health care system. At times, policymakers and health care decision makers have restructured aspects of LTRC to relieve pressure on the acute care system. Yet, despite this historical role, recent changes in British Columbia have seen a significant decline in the number of LTRC beds and a

concomitant shift towards a system of housing that places greater responsibility on older adults to manage their needs as they experience increasing age and frailty. Moreover, restructuring has had a tremendous affect on the LTRC resident population and the workforce. Despite these changes, much of what is known about the actual consequences is anecdotal and has not been examined in a systematic way. An undercurrent to these changes are discourses that influence how care for the aging population and the immigrant population in particular, is constructed and help determine what is deemed socially acceptable despite our claim to a public health care system for all.

Section IV: The Organization of Care within the Institutional Setting

In this Section, I review the literature related to how care is organized for older adults in the institutional setting of LTRC. I begin with a brief overview of the ethnographies that have been conducted in this setting. Numerous ethnographies have painted detailed portraits of various facets of LTRC, and, therefore, I focus on those that are most pertinent to this study. Following this, I review literature related to caregiving, specifically the relationship between the informal/unpaid caregiving network and the formal/paid network. Finally, I focus on literature related specifically to how care is organized in LTRC, beginning with a review of the development of gerontological nursing as a specialty area of practice and knowledge in nursing and concluding the section with research related to workforce issues such as skill mix, roles and responsibilities, and job satisfaction.

Ethnographies in LTRC: Painting a Picture of Life and Work in LTRC

While LTRC provides a much needed service for elders, experiences of those living and working in residential care are often portrayed as less than optimal. Living in

residential care has been compared to a ‘double burial’ in which institutionalized elders experience a social death upon admission to LTRC, and are consequently isolated from the world of the living (Stafford, 2003). Kontos (1998) has described “home” as a place that affords independence and is space controlled by the individual, where they can pursue personal interests and is essential to self-identity. From the ethnographies that have been conducted in LTRC, it could be argued that there are few aspects of home in residential care. Residents have a limited amount of space, which is often furnished with institutional beds and dressers to facilitate care, they are expected to eat in common areas with little choice about the kind of food that is prepared by staff, and they are often medicalized and pathologized by staff rather than being viewed as individuals.

In this study, I have framed LTRC closer to the institutional model described by Stafford (2003) rather than the home model described by Kontos (1998). The use of institutional in the current study, therefore, is intentional in describing the residential space and the people who live there. Placing older adults in institutions is largely a Western approach to dealing with the needs of older adults who require ongoing care (Montigny, 1994). As asserted by Savishinsky (1991), we live in a society that institutionalizes the dependent, not just because of illness but also for social reasons. He states, “we are, in a medical, social, and political sense, an institutional society” (p.238) with a history of creating spaces outside of the common social space for those deemed marginal – the insane, criminals, orphans, alcoholics, indigents, infected, intellectually disabled, and, of course, frail elders. Foucault also provided insight into the heavy reliance on surveillance and discipline as methods for controlling those in institutional settings (Foucault, 1977). Over time, there have been evolutions and revolutions within

the marginalized space of the institution, with some of these groups becoming 'de-institutionalized', while others continue to be excluded from the broader society (Savishinsky, 1991). Within the current study, the institutionalized elder is the object of marginalization, yet research has illustrated how attitudes towards those living in the institution of residential care extend to those working there.

Beginning with Gubrium (1975) and his work at 'Murray Manor', ethnographies have illustrated the complex dynamics that occur when people from disparate sociopolitical locations come to live and work together in the same space. Many of these ethnographies have been conducted in the United States although aspects of daily life in LTCH in the United States do reflect those in Canadian facilities to a certain degree. Often, these studies provide a powerful portrayal of lives that are heavily structured within a biomedical setting despite their claim on being 'homes'. Stafford (2003) describes this transition: "When you enter the nursing home as a patient, you experience a loss of self, of personhood. Your walking becomes "ambulation". Your food becomes "diet". Your eccentricities become your "behaviors". Your life becomes your "record"" (p.12).

Because of the institutional structures that lead to this loss of self in the resident, as described by Stafford (2003), there is often a struggle for control over various aspects of daily life between residents and staff. One area that is often used to exert power over and to stage a resistance is food. An ethnography at an 84 bed skilled nursing facility in New York, (Savishinsky, 1991, 2003) focused on control over food as a key site of struggle between residents and staff. For the residents, food was seen to represent sociability, pleasure, anger, control, and responsibility, as well as important aspects of

identity. On the other hand, staff tended to medicalize food and, at times, diagnoses (such as ‘failure to thrive’) were connected with food. Residents would intentionally refuse to eat as a means of having some measure of control over their body.

Beyond medicalizing food, it has also been noted that staff tend to pathologize residents (Paterniti, 2003). In an ethnography conducted at a private, for-profit, long-term care facility in the United States, this tendency to pathologize residents was seen in concert with the propensity of staff to view residents as a one-dimensional, homogenous group. Labels used to refer to residents included ‘morning showers’ (in reference to their weekly bath time), ‘feeders’, ‘bed-bound’, and ‘wanderers’. Residents struggled to maintain a sense of identity, despite being perceived as time-consuming and troublesome by staff. Efforts to maintain identity took the form of telling stories repeatedly, calling out to staff, and engaging staff in predictable conversations. These efforts were often quashed by staff through avoidance or ignoring residents and persisting with care.

Issues of power and resistance occur between staff members as well. Foner (1994a; 1994b) conducted an ethnography examining the working conditions of HCWs in a 200 bed nursing home in New York. She described the group of aides that she observed as a mix of women from Jamaican, Puerto Rican, Black American, and other backgrounds. The aides were primarily Black and Hispanic, while the RNs and administrators were White. Foner (1994a) discussed how institutional requirements, such as getting assignments done on time, led to a “rationalization of affective care” (p.73). This caused conflict for some aides, who felt that providing affective care was the ultimate expectation of their role. While aides were often perceived as ‘monsters’ or ‘angels’, rewards, in the form of pay and recognition, were tied to being efficient rather

comment would appear to be just as relevant in LTRC as the resident population becomes more complex, and should push towards a more critical examination of how care is organized in this setting.

With the current skill mix there is an expectation that RNs will delegate portions of their role to other staff. Areas, such as medication administrations, have been delegated to LPNs include medication administration (Rheume, 2003). With regards to HCWs, RNs have delegated almost all work related to personal care activities. Currently, RNs mainly do managerial paperwork with limited personal contact with residents (R. Anderson et al., 2005). In British Columbia, between 1998-2001, the amount of time LTRC staff spent in providing direct nursing care to residents varied greatly among those engaged in nursing practice. In government-funded, not-for-profit, multilevel care facilities, RNs spent an average of 0.86 hours/day in direct-care, LPNs spent 0.11 hours, and HCWs spent 2.46 hours (McGregor et al., 2005). Other studies have estimated that HCWs provide between 80 percent and 90 percent of care to residents (Pennigton, Scott, & Magilvy, 2003). The disparity between the time spent with residents in direct nursing care between RNs and HCWs highlights the shift concentrating certain aspects of resident care, particularly “bed and body care” with unregulated staff (Foner, 1994a). This raises concerns, though, about the ability of nurses to adequately assess residents when they are dependent on HCWs, who have limited clinical knowledge, to alert them to changes in residents’ conditions. Herein lies one of the paradoxes of this system of skill mix: while the complexity and acuity of residents rises, the care providers with the least amount of clinical knowledge are almost the sole providers of direct resident care. RNs are reliant upon the reporting of HCWs to monitor changes in resident health status. Consequently,

problems may not be identified quickly enough to avoid transfer to acute care (Conant, 2004; Perry et al., 2003).

Despite the diverse skill mix in LTRC, ambiguity remains around the roles and responsibilities of the various groups who contribute to resident care, that is RNs, LPNs, and HCWs (Canadian Nurses Association, 2003; Tully & Mohl, 1995). For RNs part of the ambiguity may be related to role differences across clinical settings. For instance, it has been noted that some of the clinical procedures performed by RNs in acute care are not done by RNs in LTRC (Angus & Nay, 2003). A review of the literature in the United Kingdom on the role of the support worker (HCW) in nursing homes suggested a number of additional sources for the ambiguity. For example, delegated tasks can vary from site to site depending on the organization's protocols and even then the RN may choose to do a task that is usually delegated to a HCW. Some of the tasks that are delegated to HCWs include: administration of medications, ear syringing, and catheterization. In addition to task delegation, other sources of role ambiguity include: role confusion, significant overlap of duties, and reliance by RNs on staff providing direct resident care for information on resident status (Baldwin, Roberts, Fitzpatrick, While, & Cowan, 2003; Tully & Mohl, 1995).

Role ambiguity can also come about from the lack of clear, standardized role definitions. In a qualitative study with RNs and HCWs in the United Kingdom, researchers found that, while RNs tend to view their role as all-embracing, HCWs defined their role by what they were not allowed to do. Despite the large amount of resident care that RNs have delegated to HCWs, some still reported difficulty with this situation. They expressed concern about the lack of educational preparation for HCWs

and, therefore, their inability to recognize subtle changes in resident status, which, consequently, they would not be able to report these to the RN. In some instances, this caused the RN to continue to provide personal care for certain residents, even though this task should be delegated to HCWs. Interestingly, despite their difficulties with delegation, RNs and HCWs in this study agreed that there need to be more HCW staff, not necessarily more RNs (Perry et al., 2003).

This ambiguity around roles often results in an atmosphere of tension and conflict between RNs, LPNs, and HCWs (Coffey, 2004; Rheume, 2003). The result of this diverse skill mix is that it has been difficult to maintain control over task boundaries and agreeing to which tasks can be delegated to other groups (Rheume). As a consequence of the shifting responsibilities, RNs have expressed concern that they will be replaced by less qualified staff, particularly in the LTRC sector (Rheume), a concern that has already become a reality. The ultimate result of this role ambiguity may be lower job satisfaction and greater staff turnover (Baldwin et al., 2003). Scholars have suggested, therefore, that there needs to be greater understanding of how these roles are delineated, which should lead to greater consistency across sites (Masterson, 2004).

Job satisfaction among LTRC staff can impact upon the quality and effectiveness of care delivery, as low satisfaction can lead to staff turnover in this setting (McGilton & Pringle, 1999). An Australian study, which compared job satisfaction between staff in nursing homes and hostels for older adults, found lower job satisfaction among the nursing home staff. Job satisfaction was influenced by workload, team spirit, and professional support. For nursing home staff, workload was related to an inability to attend training and education sessions, which could paradoxically help staff perform their

work more effectively. In nursing homes, it was also noted that a higher rate of casual and part time staff made it difficult to develop the sense of team spirit needed to enhance personal job satisfaction, increased workload for regular staff, and had a negative influence on quality of care (Chou, Boldy, & Lee, 2002).

Job satisfaction also varies among those working in LTRC. In a Canadian study of job satisfaction among front-line managers, RNs, and RPNs (comparable to LPNs) in LTRC, the authors found a positive relationship between job-related empowerment and organizational commitment among managers and RNs. However, this relationship was not as strong for RPNs, possibly related to their limited opportunities for promotion within the organization. In terms of levels of job-related empowerment and organizational commitment, there were no significant differences between RNs and RPNs. The authors queried whether this was related to the similarity of roles of RNs and RPNs in this setting (Beaulieu, Shamian, Donner, & Pringle, 1997). In a study of staff of rural nursing homes in Saskatchewan, researchers examined job satisfaction among RNs, HCWs, and activity workers. Because many of the staff had been displaced from acute care to long-term care due to hospital closures (52 community hospitals were closed in the 5 years preceding the study), staff felt they had not received adequate training to work with the growing number of residents who were cognitively impaired. Staff also expressed concern that staffing levels had not been adjusted to reflect the increasing care needs of the resident population. For instance, on average, HCWs had 10 residents on their assignments, and often there was only one RN and one activity worker on duty for up to 36 residents. The rigid routine of the residents' day also contributed to job strain and lower job satisfaction as HCWs were not always able to complete their care

assignments, for example, in time to have all their residents ready for breakfast. HCWs' jobs were characterized by high demands and low control. Activity workers, while having greater control over their work, felt responsible for meeting the psychosocial needs of all the residents, a monumental task for one person. Various issues, then, contributed to workload demands on staff with lower job satisfaction as the end result (Morgan, Semchuk, Stewart, & D'Arcy, 2002).

In sum the organization of resident care in LTRC is illustrated by a continuing dilution of nursing care across a diverse skill mix, which includes regulated and unregulated care providers. The reliance on additional groups to provide resident care is grounded historically in the development of gerontological nursing and will likely continue given the demands on the nursing profession, which itself is experiencing an international shortage. Within the skill mix in LTRC, staff have a wide variation in educational preparation and clinical knowledge. This is compounded in the delivery of nursing care by poor delineation of roles at the point of care. The organization of nursing care in LTRC is often portrayed as creating an atmosphere of tension, largely due to role ambiguity and concern by RNs that they will be replaced by less qualified staff. Moreover, at a time when the complexity of resident care needs is increasing, the continued reliance on LPNs and HCWs to provide the majority of direct resident care may mean that RNs are not aware of changes in residents' conditions until transfer to acute care is necessary with resultant impacts on the resident and the larger health care system.

Section Summary

This section has provided a broad illustration of some of the issues that are impacting upon the organization of care for elders in LTRC. There have been many ethnographies conducted that have provided a rich portrayal of living and working in this setting. Yet this portrayal is largely based on research conducted in the United States and, therefore, the dynamics of the Canadian system are not necessarily reflected. Negotiating care between the informal caregiving network and the formal network is another area of consideration. With the changing resident population making greater demands upon the workforce, the family's role in the organization of care may be changing. Finally, previous research about the workforce in LTRC has generated many more questions about the nature of the roles of various groups in the skill mix and, ultimately, how these groups can come together to provide quality care for elders living in LTRC.

Summary of the Review of Selected Literature

This has been a broad ranging review of the literature related to the organization of care for elders living in LTRC. Importantly, this literature review illustrates the complexities of intersecting issues that underscore the organization of care in LTRC at this point in time. In Section I, the study was located within the expanding field of inquiry of gerontology, which includes critical issues of aging such as the discourse of ageism and health disparities among the aging population. Section II examined the multifaceted demographic factors impacting upon LTRC, in particular the aging of Canada's population and the growing ethnocultural diversity among those who live and work in LTRC. Section III described the impact of reform and restructuring of the

healthcare system on LTRC and, consequently, the larger healthcare system. I also examined the converging discourses that underscore the health care system to consider how they influence the organization of care for older adults. Section IV reviewed knowledge related to living and working in the institutional environment of LTRC. Ultimately, the organization of care for elders living in LTRC abounds with complexities and contradictions. Although many of the issues involved in this process have been examined in isolation as demonstrated by this review of the literature, key to gaining greater understanding is the critical examination of the convergence and intersections of these multiple discourses and issues.

CHAPTER 3:

THEORETICAL PERSPECTIVE

In this chapter I introduce the theoretical perspective for this study. I am drawing on a number of perspectives to create the theoretical scaffolding for the research. I begin with postcolonialism, including some of the key theorists in this area in the 20th Century. Then, I draw upon postcolonial feminism, which introduces an emphasis on gender. Next, I discuss the emerging area of intersectionalities. Lastly, I use Foucauldian notions of discourse, knowledge/power, and subjugated knowledges. I follow this discussion of each theoretical area with a summary to examine how they contribute to the aims of this study. Then, I synthesize the theoretical perspective with the review of literature presented in Chapter 2 in order to consider how this study will help to extend our understanding of the organization of care in LTRC. This chapter concludes with the research questions that guide the study.

Postcolonialism

Postcolonialism grew out of political acts of resistance. Although there are multiple approaches to postcolonialism, central to this area of scholarship is the engagement in critical analysis of the experience of colonialism and the historical construction of race and culture (Anderson et al., 2003). Postcolonialism is an act of resistance decentring our colonial legacies by interrogating Western hegemony and its silencing of non-Western voices and knowledges (Gandhi, 1998). In this section, I focus on the political roots of postcolonialism and introduce writers and theorists whose perspectives fit well with the overarching aims of this study. Although there is no single, cohesive history of postcolonialism, as the issues raised and interrogated are done so

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through time and place, I move through the writers and theorists who have influenced this study in a chronological manner to illustrate the movement of ideas in this perspective.

A critical starting point in the development of postcolonialism was the actions and writings of anticolonialists. Franz Fanon (1963) was among a group of vocal anticolonialists challenging repressive colonial rule. He proposed a radical style of total resistance, suggesting that rejection of European hegemony was a necessary part of overthrowing colonial rule and moving on towards a stage of decolonization and African nationalism (Desai & Nair, 2005; Gandhi, 1998). As Bhabha (1994) suggests, Fanon was also aware of the importance of “retrieving their repressed histories” (p.9) for people who had been subordinated and colonized. Important work, therefore, for the political aims of postcolonialism is reclaiming of self.

From this beginning in political resistance, writers began to produce texts that articulated the effects of colonialism. One of the first major texts to do this was Said’s Orientalism (1978). This book clearly illustrated the West’s systematic approach to dominate, restructure, and have authority over the Orient. Said introduced the concept of Other - a way of dehumanizing those from outside (Other) of the dominant culture while reassuring the dominator (Occident) of their superiority, thereby constructing a dichotomy through essentialization.

In the work, Can the Subaltern Speak? Spivak (1988) continues the postcolonial dialogue of colonizer/colonized by challenging traditional notions of how the ‘subaltern’/Other have been represented. She poses a series of questions about how the subaltern has been positioned and the consequences of this for representation and representability. Spivak illustrates how certain groups have been constructed or silenced

through the academic process. By articulating the position of the subaltern, Spivak brings focus to the systematic, historical determination of relationships of dominance and subordination (Gandhi, 1998). Both Said and Spivak's writing, among many others not mentioned here, address common threads of domination, power, and marginalization.

By writing about the homogenization and essentialization of groups, postcolonial theorists have also challenged the view of culture as a fixed and static state. Homi Bhabha (1990) introduced the idea of the 'Third Space', a place of cultural hybridity where two forms of culture come together, resulting in the creation of new positions. Bhabha posits that culture is something negotiated, and that shifts occur as part of the colonizing process and that "the spaces in which culture is constructed are not neutral, but have been fraught with relations of power, subjugation and domination between the colonizer and the colonized" (Anderson, 2002, p.14). He states:

This third space displaces the histories that constitute it, and sets up new structures of authority, new political initiatives... The importance of hybridity is that it bears traces of those feelings and practices which inform it, just like a translation, so that hybridity puts together the traces of certain other meanings or discourses... The process of culture hybridity gives rise to something different, something new and unrecognizable, a new area of negotiation of meaning and representation. (Bhabha, 1990 p.211)

Bhabha, then, offers a different view of culture as an entity that is fluid and dynamic, rather than fixed and exists within the global and transnational nature of postcolonial relations.

From this perspective on culture, I move into another area in postcolonial theorizing about race. Postcolonial theorists such as Stuart Hall (1994) and Paul Gilroy (2000) have critiqued the notion of race as a fixed element of identity. Rather than viewing 'race' and 'culture' as fixed constructs, which are often subsumed into the same neutral category, postcolonialism frames them as socially constructed, through the sociopolitical processes of colonialism and imperialism. As Anderson (2002, p.13) discusses, postcolonial activity allows for the disruption of "ahistorical, generalizing, essentializing, culturalist and racializing discourses" (Anderson, 2002, p.13) which have relegated people to very narrow categories according to race. 'Race' then becomes seen as socially produced and 'culture' as fluid and dynamic (Anderson, 2002; Anderson et al., 2003). Racialization moves away from biologically/socially/politically defined concepts of race and culture and instead "refers to a political and ideological process by which particular populations are identified by direct or indirect reference to their real or imagined phenotypical characteristics in such a way as to suggest that the population can only be understood as supposedly biological entity" (Cashmore as cited in Ahmad, 1993 p.18). Simply put, "racialization involves a process of investing skin colour with meaning, such that 'black' and 'white' come to function, not as descriptions of skin colour, but as racial identities" (Ahmed, 2002). Importantly for healthcare research, the process of racialization has implications for how people receive, or are restricted from, health care services, and how relationships are constructed in the clinical setting (Anderson, 1998; Anderson et al., 2003).

There have been critiques of the limits of postcolonialism. Some scholars have questioned whether postcolonialism can be equally applied in different societies, for

instance between Canada and Australia and Africa and Asia (Gandhi, 1998; Hall, 1996). However, postcolonialism is not geographically or historically bound to certain places or times, rather it is a universalizing process (Anderson, 2002). Also, although postcolonialism brings to the fore issues of history and politics, race and class, it does not include a focus on gendered analysis (Gandhi). The following section discusses approaches to postcolonial feminism, which address this limitation.

Postcolonial Feminism

Postcolonial feminism has emerged with two main aims. The first aim was to racialize mainstream feminist theory. The second aim was to insert feminism into postcolonial theorizing (Lewis & Mills, 2003). This section focuses on the second aim of postcolonial feminism.

In describing the place of women in a postcolonial context, Quayson (2000) writes about “the conundrum of attaining citizenship whilst becoming alienated subjects” (p.103). Mohanty (2002; 2003; 2006) further examines the role of women in the postcolonial context. She points out that a simple gendered analysis ignores the historically situatedness of women’s existence and assumes a universal unity among women. It also ignores the histories of racism and imperialism that are woven with Western feminisms. She gives the example of the lack of analysis of immigration and nationality by Western feminists. Spivak has been another vocal writer on the relative ignorance of White women to the situations of women in non-Western countries (Lewis & Mills, 2003). Mohanty suggests that within a postcolonial feminist context, we must be attentive to neocolonial discourses, exploitative structures, and the role of globalization in shaping the sociohistorical contexts of women’s lives.

Postcolonial feminism has been taken up by a few nursing scholars. Anderson and colleagues (2003) describe this approach as a critical, gendered analysis that provides a framework for analysis that combines the broader sociopolitical context with voices from the margins. This approach, therefore, could be taken up to examine a broad variety of issues in healthcare. Salas (2005) has critiqued nursing theory development from a postcolonial feminist perspective. Similar to the critiques brought forward by Mohanty and Spivak, Salas critiques the exclusion of non-Western perspectives in nursing theory. She also contends that within nursing there is a discourse that less affluent countries are still in the early stages, or “barbarian” (p.20) stage, of theory development. Nursing scholarship from the United States is seen to be bringing theory to these countries and, in effect, colonizing their nursing practices. I turn now to another area of theorizing: intersectionalities.

Intersectionality

As a theoretical perspective, intersectionality extends beyond gender as a single axis for analysis and is inclusive of other elements that influence lives (McCall, 2005). It examines how individuals are simultaneously positioned across a number of axis, for example, across race, class, gender, and age (Brah & Phoenix, 2004). This approach allows for rich and complex understandings as opposed to perspectives that reduce people to one category at a time, for example according to gender (Phoenix, 2006). Although there are different approaches to intersectionality research, in this study I situate this perspective within Postcolonial Feminism, as discussed in the previous section, and in Black Feminist thought, which is discussed in the following paragraph.

As with postcolonialism, Black Feminist Thought includes many voices and perspectives, therefore, what follows is an introduction to writers who have informed this study. Black feminism has woven race and class together with gender, focusing on the intersectionalities of these factors and the complexities that result (Hill Collins, 1989; 2002; 2006; hooks, 1984). Importantly, whereas some forms of feminism have been critiqued for excluding aging and the aged (Pohl & Boyd, 1993), Black feminist scholars, in particular Hill Collins and hooks, have also included aging as a social factor that interplays in this intersectionality. In a key work that shifted perspectives in feminism beyond the single axis of gender, hooks (1984) responded to Betty Friedan's The Feminist Mystique (1970). hooks critiqued Friedan's narrow presentation of women's lives by focusing solely on middle-class, White women, and ignoring the struggles confronting women of Colour, in particular economic survival, ethnic and racial discrimination. From this perspective, though, women of Colour are in a unique position to critique and decentre the dominant class, and introduce a new perspective 'from the margins'. As Hill Collins (1989) states, "a subordinate group not only experiences a different reality than a group that rules, but a subordinate group may interpret that reality differently than a dominant group" (p.748). Women of Colour are in a unique position of outsider/within, by being seen as members of society, yet from their marginalized space able to look as if from the outside (Hill Collins, 1998; 2004). Essential to this perspective is the importance of engaging in an active dialogue with members of the community to ensure participation by all those individuals who have been systematically excluded from the generation of knowledge through historical and social positioning (Harding, 2004; Hill Collins, 1989).

More recently, intersectionality theorists have extended beyond race, class, and gender to include a broad variety of factors that influence social positioning. Mahalingam and Reid (2007) used this approach to bring together groups of African American and Dalit Indian women to explore shared understandings and develop strategies for self-empowerment. In Canada, Ringrose (2007) drew on an intersectionality perspective to examine race and racism in a school of women's studies. In nursing scholarship, Guruge and Khanlou (2004) used an intersectionality framework to examine mental health promotion research with immigrant and refugee women. The utility of intersectionality research is also expanding as scholars begin to articulate methodological approaches (McCall, 2005). There are some cautions with this approach, however, particularly around the scope of intersectionalities. Ludvig (2006) discussed concerns that intersectionality can encompass an almost endless list of differences. Despite this concern, however, intersectionalities provide an inclusive framework to consider how multiple axes of oppression operate simultaneously, reflecting the dynamic nature of social processes.

Foucault: Discourse, Subjugated Knowledges and Power

In this study, I introduce the Foucauldian notions of discourse, power/knowledge, and subjugated knowledges as part of the theoretical perspective. Foucault defines the role of discourse as providing “a set of possible statements about a given area, and organizes and gives structure to the manner in which a particular topic, object, process is to be talked about” (Kress, 1985). Cheek (2000) extends this definition by stating “thus, a discourse consists of a set of common assumptions which, although they may be so taken for granted as to be invisible, provide the basis for conscious knowledge” (p.23).

In this sense, discourses help to frame how knowledge is produced and, therefore, what is included and excluded from the way we construct reality. At any time, certain discourses may be more dominant than others, thereby marginalizing certain knowledges (Cheek, 2000). In Chapter 2, I introduced the discourse of ageism that exists in Western culture and some of its implications for how care is organized in long-term residential care. In postcolonialism, many scholars have also used discourse in relation to race (Dua, 2007).

Foucault also brought to light the ways in which certain kinds of knowledges, subjugated knowledges, have been systematically silenced throughout history (Gordon, 1980). Similar to Bhabba's (1994) concept of 'those who have suffered the sentence of history', these knowledges include "a whole set of knowledges that have been disqualified as inadequate to their task or insufficiently elaborated...[I]t is through the re-appearance of this knowledge...that criticism performs its work" (Foucault in Gordon, 1980 p.82). This construction of subjugated knowledge can provide insight into the ways that residents and workers have been oppressed in the "racialized, classed, and gendered" (Jervis, 2002, p.14) site of LTRC.

Power is also central to Foucault's work. The way that Foucault presented power represents a shift away from traditional views of power as belonging to specific persons or groups (Martin, 1998). Power is viewed as a force which everyone can possess, which shifts depending on the situation and the context, "power must be analysed as something which circulates...it is never localized here or there, never in anybody's hands...in other words, individuals are the vehicles of power, not its points of application" (Foucault in Gordon, 1980 p.98). It is possible within this framework of power, therefore, for acts of resistance from those, possibly 'subjugated knowledges', who have traditionally been

viewed as oppressed by those who hold power. While Foucault has largely presented power as a neutral force, it has been noted by scholars that power is gendered, raced, and classed (Diamond & Quinby, 1988) and embedded in the historical context of relations (Gandhi, 1998). Along with an intersectionality perspective, therefore, power relations can be influenced by the intersecting axis of oppression that are operating in an individual's day to day life. I turn now to a summary of the theoretical perspectives that shape the theoretical perspective for this study.

Summary of Theoretical Perspective

For this study, I bring together the theoretical perspectives of postcolonialism, postcolonial feminism, intersectionalities, and Foucauldian epistemology to shape the theoretical perspective of the study. As Alcoff (1998) has suggested, “when we move beyond a single axis framework of analysis, we can also begin to overcome the limitations of the oppressor/victim binary, in which individuals are characterized monolithically as one or the other” (p.484). Postcolonialism, with its roots in political action, allows for an examination of the “micropolitics of power and the macrodynamics of structural and historical nature” (Reimer Kirkham, 2003, p.766). Postcolonial feminism introduces the element of gender into this historical and social construction of individuals and society. The intersectionality perspective prompts further examination of the complexities of the intersections of race, class, gender, and age – elements of particular salience in this study – to the framework. And lastly, discourse, subjugated knowledges, and power from Foucauldian epistemology are interwoven with these other perspectives to shape the theoretical perspective for this research.

Synthesis of Theoretical Perspective and Review of Literature

Joining together the literature review and theoretical perspective for this study brings to light issues in LTRC that invite further examination in this research study. The review of the literature introduced critical perspectives in gerontological research. Yet there remains an opportunity to extend these perspectives further to address the historically-situated relations of power from within LTRC. While previous research has, at times, acknowledged the discourses of race and ageism in LTRC, much of this research has been conducted outside of Canada and our unique universal health care system. To gain greater insight into these issues, the theoretical perspective for this study provides the scaffolding for a critical examination of issues that have, at times, been neutralized in previous studies. Moreover, this study provides a space for the ‘subjugated’ knowledges of LTRC to be expressed. This theoretical framing is being introduced here as a way of framing the complexities of how care is organized in LTRC and to acknowledge the existence and role of contextual issues in this process. Derived from the literature review and theoretical perspective for this study, the objectives of the study were:

Objective 1: To examine the everyday encounters between residents living in long-term residential care and those involved in providing their day-to-day care;

Objective 2: To examine staff members’ perceptions of how different roles contribute to the organization of resident care;

Objective 3: To examine social relations in the complex, institutional context of long-term residential care;

Objective 4: To examine how acute care services are utilized by residents of LTRC;

Objective 5: To examine the organization of care for residents living in LTRC within a broader sociopolitical milieu, and specifically within the context of the health care system in British Columbia.

Research Questions

The following research questions provided direction for the study:

- What are the everyday encounters between those living in long-term residential care and those providing day-to-day care?
- How do those engaged in providing day-to-day care understand their roles and the roles of others in how care is organized?
 - How does this understanding influence care providers' interactions with each other and with residents?
- How are social relations organized within the complex, institutional context of long-term residential care?
- How do the intersections of race, gender, class, and age influence these social relations?
- How do power relations operate within the sociopolitical milieu of long-term residential care?
- How does LTRC interface with the larger health care system, in particular, acute care services?

CHAPTER 4:

METHOD OF INQUIRY AND RESEARCH METHODS

In this chapter, I describe the research methods that guided this study. I begin by discussing the method of inquiry, critical ethnography. Next, I describe the process of gathering the data including, negotiating access and entry to the study sites, participant recruitment, and a description of the data collection methods: participant observation, in-depth interviewing, review of relevant documents, and collection of selected quantitative data. Following the research methods is a discussion of the process of data analysis. Then, I discuss how scientific rigor was addressed in the study, in particular, the areas of credibility, voice, reciprocity, reflexivity, and praxis. Next, I review the ethical considerations related to this study. I then provide an overview of the timeline of the study. I conclude the chapter by discussing the limitations of the study.

Method of Inquiry: Critical Ethnography

The method of inquiry for this study was a critical ethnography underpinned by the theoretical perspective described in Chapter 3, drawing on postcolonialism, postcolonial feminism, intersectionality, and Foucauldian epistemology. Critical ethnography has grown out of the ethnographic tradition. Grounded in the work of scholars such as Paolo Friere and feminist researchers, critical ethnography is inherently political, ethical, and social. Madison (2005) describes this as an “ethical responsibility to address processes of unfairness or injustice within a particular lived experience” (p.5). Rather than focusing on creating a description of the “Other”, as in traditional ethnography, critical ethnography focuses on the development of a dialogical relationship between the researcher and participants with the ultimate aim of social transformation

from sources of oppression (Brown & Dobrin, 2004). In this approach, researchers analyze hidden agendas, 'taken for granted' assumptions, and work towards disrupting the status quo by bringing into light systems of power and control (Madison). This process includes analysis of the influence of socially and historically-situated elements on the everyday (Thomas, 1993), elements that often contribute to power imbalances leading to unequal power relations and, potentially, marginalization (Kincheloe & McLaren, 2005; Tedlock, 2000). A central aim of critical ethnography is to contribute toward greater freedom and equity through the explication of emancipatory knowledge and discourses of social justice (Madison).

The theoretical perspective of the study had further implications for the conduct of this critical ethnography. Research from this perspective is framed through a political lens that critically examines relations at the micro and macro levels within the meta themes of race and power. These themes intersect with gender, class, and other social relations, such as age (Anderson, 2000b; Anderson, 2002; Reimer Kirkham & Anderson, 2002). This approach brings together individual perspectives with group-based social histories in order "to understand how individuals are active in producing and shaping relations and are, in turn, shaped by these relations" (Reimer Kirkham & Anderson, 2002, p.12).

In practice, a critical ethnography underpinned by the theoretical perspective for this study is enacted in a dialectic relationship between the researcher and participants. This relationship reflects a number of elements: voice, reciprocity, reflexivity, and praxis, which are enacted throughout the research process, from data collection to interpretation of the findings. The voices of participants are central to the analysis of intersectionalities,

decentering dominant discourses and bringing to the fore worldviews and subjugated knowledges have, in the past, sometimes been excluded in academic research (Reimer Kirkham & Anderson, 2002). The research process also reflects a high degree of reciprocity. Lather (1991) describes reciprocity as implying “give and take, a mutual negotiation of meaning and power” (p.57). To achieve reciprocity, the researcher engages in ongoing reflection with regards to her/his social and historical positioning in relation to research participants (Reimer Kirkham & Anderson). Reflexivity refers to this ability of the researcher to reflect upon, explore, and examine social processes and contextual factors influencing the research relationship as well as participants’ lives (Fonow & Cook, 1991). This critical approach to reflexivity brings a particular focus to the researcher’s own power and privilege, a position that can lead to tension when critiquing the power struggles of participants (Madison, 2005). Lastly, praxis relates to the political-action orientation of this method of inquiry. Praxis has been described as the ability to link knowledge and theory development to practice-relevant social, political, and ethical actions aimed at improving health, health-care, and social conditions (McCormick & Roussy, 1997). Later in this chapter I discuss how the elements of voice, reciprocity, reflexivity, and praxis, were realized during the course of the research.

Research Methods

The Process of Gathering Data

This research study, a critical ethnography about how care is organized in LTRC, was conducted at two facilities in the Lower Mainland of British Columbia. Data collection occurred between October 2006 and August 2007 (Table 4.1: Overview of Data Collection). In order to maintain the confidentiality of the sites, I refer to them

throughout this study as Site A (primary site) and Site B (secondary site). The purpose of having two sites - a primary site for prolonged immersion (Site A) and a secondary site for a shorter period of data collection (Site B) was for comparative analysis and triangulation, discussed later in this chapter in relation to the rigor of the research. As described in Chapter 2, there are three main types of LTRC facilities in British Columbia. First, there are ‘owned and operated’ facilities that are part of a health authority. Second, there are non-profit facilities which have often been created by volunteer organizations or ethnic groups and continue to be overseen by a board of volunteers. Third, there are privately owned, for-profit facilities. In the past, private, for-profit beds were often privately paid by residents. Although some private facilities still have this model, many are a mixture of private pay and health authority contracted beds, and some are entirely contracted by a health authority. In all of these types of facilities, there can be unionized staff, or a private company that has been contracted to provide staff, or a mixture of both.

Because health authorities currently contract beds in all of these types of facilities, individuals being admitted to LTRC can be residents of any type. In this study, the facilities that I included in my initial search for sites were facilities where all beds were direct funded or contracted by a health authority regardless of ownership. Therefore, I excluded facilities where residents paid 100 percent of the fee. I also excluded facilities that were ethnoculturally-specific (for example, there are a limited number of facilities for the Chinese, Japanese, and other ethnocultural groups) because these are very small in number and I specifically wanted to examine the organization of care in facilities where there was a diverse ethnocultural mix of staff and residents.

Negotiating Access

In January 2006, I began looking for facilities to serve as sites for the study. Over the past ten years, I have worked in the LTRC in a variety of roles, including: staff nurse, Nurse Clinician, and Director of Care (later in this chapter, I reflect upon my social positioning in this study). Because of this background, I was known to many of the administrators at local health authorities, which I thought would ease my access to study sites. However, I found that access was difficult through formal channels, such as operational directors of residential care at the health authorities. As well, some of the initial facilities that I approached expressed staff concerns about feeling evaluated by the study methods. When I was unable to secure sites by the Summer of 2006, I began using my personal connections from my time working in LTRC, which proved to be much more fruitful. After sending a request out to an email group of Directors of Care, I immediately received several positive responses. I began discussions with the first two respondents and these ultimately became the study sites.

The Study Sites

There were two sites for this study, the primary site, Site A, and the secondary site, Site B. From October 2006 to August 2007, I was immersed in at Site A (Table 4.2: Facility Demographics) for data collection. Site A was a non-profit facility. The staff were all unionized and employed by the facility. The facility had a Special Care Unit. This type of unit is a secured/locked unit for residents with progressive and advanced dementias with challenging behaviours (that is, at high risk for elopement, unpredictable aggression, and generally higher cares needs). Although I did not initially intend to do data collection on this unit, it became apparent during interviews, participant

observations, and collection of quantitative data that this unit was integrally related to the other parts of the facility and the overall functioning of the facility.

From May 2007 to August 2007 I was immersed at Site B (Table 4.2: Facility Demographics) for data collection. Site B was a privately-owned for-profit facility. The staff were all employees of private companies who had been contracted to provide care and food services with the exception of the Director of Care and the office receptionist who were employed by the facility's owner. I have restricted the details about the study sites significantly to protect the anonymity of these facilities. I have focused on information that is most pertinent to the study.

Negotiating Entry

Negotiating entry and becoming immersed in the day to day milieu is key to successfully engaging in data collection in ethnographic work. I spent the first month at both of the sites introducing the study. At both sites, the study was introduced to the facility's community (that is, residents, families, staff, and administrators) in a similar way. The Directors of Care were responsible for distributing the Letter of Initial Contact to residents, family members, and staff. The letters were distributed to staff with their pay stubs to ensure that all staff received a copy. The letters were mailed to each resident's primary family contact person. A letter was also put in residents' rooms. Pamphlets for the study were placed at the nursing stations, in the staff room, at reception, in common areas, and on bulletin boards. I also attended numerous meetings with staff during regular staff meetings and shift changeovers to introduce the study. I attended resident council meetings, unit-based resident meetings, and family council meetings. Lastly, I introduced the study at regular management meetings. Once this

formal process of negotiating entry was completed and I began data collection, there was a more informal process of negotiating entry for me as the researcher, a process described in a later section of this chapter.

The Sample

This study had a purposive sample. In purposive sampling, individuals are recruited based on their ability to provide rich data (Coyne, 1997; Streubert & Carpenter, 1995). At both sites, participation in the study occurred in two ways: through in-depth interviews and through participant observation.

A total of 51 interviews were conducted with participants, 28 at Site A and 20 at Site B and 3 with health authority staff. Within these 51 interviews, there were four ‘types’ of participants: administrators (Table 4.3: Administrator Demographics), family members (Table 4.4: Family Member Demographics), residents (Table 4.5: Resident Demographics), and direct care staff (Table 4.6: Staff Demographics).

Inclusion criteria for interviews and formal observations were:

- 1) the ability to speak English,
- 2) the ability to provide informed consent or consent by proxy.

For staff there was the additional criteria of:

- 3) employment at the facility.

Inclusion criteria for participation in the formal observations was the same as for the interviews.

Because each group has a unique perspective on how care is organized in LTRC, I tried to recruit enough participants for interviews to achieve data saturation in each group

so that during data analysis, I would be able to examine each group's perspective as well as the overarching themes.

In this study, the four main groups of interviewees consisted of 10 administrators, 11 family members, 8 residents, 22 direct care providers. In addition to viewing these as distinct groups, the data from all 51 interviews were used to augment and expand upon each other in the data analysis process. In addition to one-on-one interviews, I spent approximately 218 hours engaged in field work which included many conversations that were recorded in my field notes.

Recruitment of Participants for Interviews and Participant Observation

Recruitment of participants began with the introduction of the study described previously. The distribution of the Letter of Initial Contact, study pamphlet, and speaking to various groups yielded only a handful of participants. I depended on key contacts at each site to assist with recruitment. These contacts included the Directors of Care, Nurse Coordinators, Social Worker, and Chaplain. Key contacts approached individuals at their respective sites who they considered to be key informants, or individuals who were familiar with the setting and might have special knowledge and access to information (Bogdewic, 1999). Once potential participants agreed to be interviewed or take part in participant observation, I followed up with a conversation to explain what participation entailed in more detail and to answer any questions they might have.

For interviews, all potential participants agreed to the interview after I had spoken with them, however, a small number postponed their interviews a number of times. When interviews were cancelled by the participant more than once, and the individual seemed hesitant to reschedule I would let it drop. My sense was that, although they were not able

to tell me directly that they did not want to participate, their actions were communicating that message. Participation in participant observation is described in a later section.

Sources of Data

To address the study objectives, a variety of ethnographic methods was used. In this study, I foreground qualitative, or the ‘stories’, aspect of the data, using the quantitative, or ‘numbers’ data, to provide important descriptive data on how LTRC is situated within the larger health care system. Berman, Ford-Gilboe and Campbell (1998) describe this particular approach with the qualitative data as providing “a basis for researcher and research participants to engage in dialogue, reflection, and critique related to the phenomenon under investigation” (p.8) while the quantitative data can be used to document the magnitude of a phenomenon and to provide descriptive data. Importantly, the combination of data collection techniques used in this study was guided by the theoretical perspective and the research questions discussed in Chapter 3 and were used in a co-operative way (Giddings, 2006) to address the issues raised in this study.

To address the research questions, four types of data collection were used in this study: participant observation, in-depth interviews, review of relevant documents and policies, and select quantitative data related to service delivery. Each of these techniques is discussed in the following paragraphs.

Participant Observation

Participant observation allows a researcher to make observations from within a group, thereby being able to observe aspects that members of the group take for granted, for example, assumptions, rituals, roles, and other aspects of everyday life (Bogdewic, 1999). In this critical approach to ethnography, participant observation was a reflexive

act, with me, as researcher, reflecting on and critically engaging with my participation in the study sites (Tedlock, 2000; 2005). From the outset of the study, I had to situate myself within the field. Because I am a nurse and have worked extensively in LTRC, I had to explain my purpose in the setting in relation to my role as researcher to participants. I explained that I was able to do similar tasks as a volunteer, but that I could not perform any nursing work as I was not an employee of the facilities and that was not my purpose in being on-site. Tasks I assisted with included: delivering food or beverages to residents in the dining room as directed by staff, and retrieving items in resident's rooms (such as clothing from closets or face cloths) as directed by staff or residents. On three occasions, however, I was present when a resident had a fall. For one of those incidents, I was able to ensure that the resident was safe and then got a nurse because I did not know the resident's mobility history and did not want to put them at risk by moving them. On the other two occasions, staff were present and gave me direction on how to assist them with supporting the residents back to bed. On one of those occasions, the HCWs wanted me to assess the resident rather than getting the nurse on duty, however, I asked them to get the nurse so that he could do an assessment and document the fall. Overall, I found that when I explained my role to participants they were respectful of the limits on my activities in day to day routines.

At each site, I spent some time doing informal observations of the general milieu or participating in group activities. I would sit in common areas, such as common social areas or near/in the nurses' station. At both sites, there were always residents sitting outside the nurses' stations, so I would often sit among them to pass the time. When people (that is residents, visitors, staff) would inquire about what I was doing, I would

remind them about the study and explain that I was just ‘hanging out’. I also attended staff meetings, and shift changeovers, which gave me an opportunity to observe staff interactions and communication. I attended resident activities, such as coffee groups, resident meetings, and music groups.

I also spent one on one time with staff, following them during their daily routines. I did this mainly with nurses, HCW, and activity staff. These sessions lasted between 1 – 3 hours at a time. Throughout the session I would jot notes to myself, which I later expanded into full field notes. I tried to have a flexible observation schedule in order to avoid bias that may be introduced by restricting myself to a limited portion of daily life in LTRC (Carspecken, 1996). So, for example, I conducted observations on different days of the week and varied the time between day time and evening. I did not do observations during the night shift as this shift was between 11pm to 7am at both sites, a time when residents are, for the most part sleeping and there are no visitors (unless there is an emergency or end of life care is being provided) and there are only a small number of staff. Rather, I spent time at the facilities at times when there were many individuals and groups interacting with each other in order to capture the organization of care in this dynamic process.

In addition to these observations of daily routines, I also attended several formal meetings at each site to observe how individuals interacted with each other in a more formal setting. I attended meetings that were just between staff, such as nurse coordinator meetings, unit staff meetings, and committee meetings (Infection Control, Occupational Health & Safety). I also attended inservices, or staff education sessions, between guest speakers and staff. Lastly, I attended care conferences, which are annual meetings

between facility administration, staff, residents, and family members where a resident's plan of care is reviewed.

Observations were recorded by writing extensive, detailed field notes. Field notes provide a literal account of what happens during participant observation in the field (Bogdewic, 1999). In order to keep reflexivity central to the field work, I used subtitles in the field notes to delineate between the actual events and my reflections (emotional, analytical, research process). I also wrote myself into the activities because I was often an active participant in what was happening. Writing field notes with this kind of texture, rather than using a neutral tone where the researcher is absent, is reflective of the critical, feminist underpinnings of this research (Allen, 2004).

I wrote a field note for each interview. These field notes included data on where the interview took place, the participant's physical appearance, and my reflections on what had occurred during the interview. The field notes also provided a place to consider how the participant's experience fit within some of the broader policy and systems-level issues that were discussed or influenced their experiences. Field notes are an important part of interviewing in ethnographic research as they provide space to explore, understand and interpret how participants experience their worlds. They can take the individual experience and situate it within a broader societal context (Owens, 2007).

In this study, I used two steps to develop the field notes. The first step was to jot down key words and phrases to capture the essence of the observation. I always kept some paper in my pocket and a pen so that when there was a break in the action or I needed to take a break to capture something that seemed important, I could discretely write down a few words. The second step was to expand the jottings into detailed field

notes with rich description (Bogdewic, 1999; Emerson, Fretz, & Shaw, 1995). At Site A, I was provided with office space so I was able to store my computer in a locked drawer and write my complete field notes immediately after leaving the field. This was very helpful because I was able to write while details were still fresh and then, at a later time after I had reflected on what had taken place I would sometimes add more comments or reflective data. At Site B, I did not have any dedicated space so I often wrote my field notes while sitting in my car after leaving the facility.

In-depth Interviewing

In-depth interviews were conducted with 51 individuals representing four groups: residents, family members, administrators, and staff. In-depth interviewing is characterized by an interpersonal dialogue between the researcher and the participant (DiCicco-Bloom & Crabtree, 2006). As well, within the critical, feminist perspective that guides this study, interviews are characterized by their interactive nature, with the researcher and the participant often engaging in mutual self-disclosure (Cotterill, 1992, Lather, 1991, Tang, 2002). In describing these kinds of interviews, Heyl (2001) states this is:

...interviewing...in which researchers have established respectful, on-going relationships with their interviewees, including enough rapport for there to be a genuine exchange of views and enough time and openness in the interviews for the interviewees to explore purposefully with the researcher the meanings they place on events in their worlds (p.369).

In this study, interviews were arranged at a location and time of the participant's choosing. With the exception of one interview that took place in a family member's

home, and one with a family member at a coffee shop, all interviews took place at the facilities. All of the staff interviews occurred during a participant's shift so they were, effectively, on paid time. These participants arranged coverage for their work so that the interviews largely went uninterrupted. Each interview meeting started with some informal conversation about the participants, as a way of building rapport. Often I had already had several interactions with a participant before the interview began, so it was more of a continuation of a conversation than an isolated event. This process of building rapport is an important aspect of qualitative, ethnographic interviewing as it often leads to richer dialogue between participant and researcher (Madison, 2005).

Interviews typically last between ½ to 1 hour. Each interview was recorded and transcribed at a later time. Although I used an interview guide to provide some structure to the conversations, I generally began the interviews by asking the participant to tell me the story of how they came to live or work in LTRC. This provided a springboard to explore further issues. Either before or after the interview, I collected sociodemographic data about the participants (Appendix A: Sociodemographic Forms). Once the formal, recorded part of the interview was completed, there was often a period of 'off the record' chatting that took place. This was particularly noticeable with the administrator group, who would often seem to breathe a sigh of relief when the recorder was turned off and then tell me 'what they really thought'. This chatting after the interview sheds light on the participant's interpretation of the interviewer and the interview process (Warren et al., 2003). These comments are recorded in my field notes from each interview and were used to contextualize the interview during my interpretation of the data.

Interviews were tape recorded and transcribed verbatim. An experienced transcriptionist completed this work. As suggested by Tilley (2003), I had a discussion with the transcriptionist from the outset of the study about the conventions she should use when doing her work. For example, in order to keep the nuances of the conversation from tape to paper, instructions were provided to include ellipses (...) to indicate extended pauses, expressions such as laughter were included in brackets, and areas where the transcriptionist was unable to understand the tape were indicated by a series of dashes --- (Morse & Field, 1995). As I cleaned each transcript by listening to the recording while reading the transcript, I filled in the dashes when I was able to recall what was said. If I was not able to recall or could not understand the tape, then I would leave the brackets in place. This process of ensuring the accuracy of the transcripts contributes to the overall rigor of the research process (Tilley, 2003).

Review of Relevant Documents and Policies

Review of relevant documents was conducted. Documents are important historical artifacts and should be viewed as social products. As such, they provide important information but also are a source of analytic material (Hammersley & Atkinson, 1995). In this study, document review involved reviewing policies, guidelines, and procedures that affect the organization of care. When these materials were mentioned in an interview or participant observation, I retrieved the document to include with the corresponding piece of data. Examples of documents reviewed for this study included: licensing guidelines (Government of British Columbia, 2002), provincial policies such as the First Available Bed policy and Complex Care (MOH, 2008), and internal policies and procedures of the facilities.

Quantitative Data

Quantitative data were collected from both sites. A first aspect of this data was transitions in care, for example admissions and discharges, and trends in health service utilization by residents in 2000 and 2005 (Table 4.7: Care Transitions for Residents across the Health Care System). Importantly, these two time periods reflect the period prior to the recent restructuring of long-term care in British Columbia (pre-2002) and more current data (2005). Specific data collected included: admissions, discharges, and transfers to hospital. It was important to keep within a seven year time span as this is how long LTRC facilities are required to keep this information on the movement of residents. A second aspect of this data was staffing levels. I asked each site to provide staffing levels for various types of staff (Registered Nurses, Licensed Practical Nurses, unregulated health care workers, activity staff, food services staff, and others) in 2000 and 2005 (Table 4.8: Staffing Levels at Study Sites). I also asked if any of these positions had been contracted out during that time, as contracting out was made legal in 2001 in British Columbia (contracting out meaning that staff were not employed directly by the facility but rather the facility subcontracted services to a private company).

In order to collect this data, I gave the quantitative data form (Appendix B) and the sociodemographic form to each site's Director of Care. Because the information I was requesting was readily available at each site, the forms were returned to me within a week. I then created tables for the data and entered it directly into tabular form. This data supplements some of the qualitative data in relation to staffing levels and the quantity of care transitions. For example, workload issues related to rising admissions and deaths within facilities were often talked about anecdotally. This quantitative data demonstrated

that, in fact, there had not been major change in the numbers of admission and discharges in 2000 and 2005. The area where there had been a noticeable increase was in visits to the emergency department and hospitalizations. Both of these activities involved transfers to and back into the facilities, which add to nurses' workloads. Hence, the quantitative data supported nurses' comments about workload related to care transitions and helped to clarify the types of care transitions that are contributing to nurses' work.

From Data Management to Analysis: Constructing the Study Findings

There are a number of steps in data analysis, which include data management, analysis, and interpretation. The following sections described this process.

Data Management

Due to the scope and amount of data collection, I developed a systematic data management system in order to facilitate data analysis. Once data were in their final version (i.e. field notes were completed, transcripts had been checked), they were saved in files according to the type of data on a password protected computer. A file was also saved on compact disc and a hard copy was printed and put in a locked filing cabinet in my office. Any materials containing identifiable information, such as consent forms, were stored in a separate, locked, filing cabinet. Qualitative data, such as the interview transcripts and field notes, were entered into the qualitative software program NVivo7 for coding. Quantitative data, such as sociodemographic data, was entered into SPSS. The facility quantitative data was entered directly into tabular form as there was no statistical analysis required for this data.

Data Analysis

The data analysis was guided by the theoretical perspective for the study. Given the theoretical perspective that I was working within – informed by postcolonialism, postcolonial feminism, intersectionalities, and Foucauldian epistemology - I was critically examining meta themes such as ageism, subjugation, and power, and analyzing how they intersected with race, gender, and class. This analysis, however, did not occur in isolation from the field. Once the data were in their final form, as described in the previous section, I began coding. The coding started immediately when data were ready, so that there was a back and forth process between the data that was being collected and coded. By that, I mean that through coding the data, I gained insights into processes that were operating in the setting and this influenced the direction of field work. For example, in the first few interviews at Site A with staff, we discussed how the First Available Bed policy was impacting upon the triangular relationships between residents, staff, and families. This in turn influenced the questions that I asked in subsequent interviews with participants and my observations. This dynamic process continued throughout the simultaneous processes of data collection and analysis to allow me to ‘dig down’ in issues that were particularly salient to the participants.

The review of documents and quantitative data helped to inform the coding of interview data and field notes and I wrote memos about my interpretations of how different aspects of data influenced each other. Because data analysis was ongoing, I was also able to do ongoing member checking with participants, a process discussed in greater detail in a later section. By bringing my initial analysis back to participants, I was also able to ask questions about my interpretations of their experiences and they were able to

reflect back to me their insights. When gaps in my understanding were identified, key contacts at both sites helped to identify key informants who could provide more data or bring a particular perspective to the data. In this way, there was a dialectic between the theoretical perspective and the everyday realities of the participants.

During this ongoing process of data analysis, I was developing the codebook for the study. The codebook allowed me to organize the data that were similar. Initial coding categories included broad areas such as “communication”, “interactions”, “role definitions”, “admission”, and covered a broad spectrum of issues arising in the data. After I had coded a number of transcripts and field notes, I started to group common codes into themes. As Luborsky (1994) points out “themes are emergent in the process of communication and of analyses and require a systematic approach that blends interpretation with explanation” (p.207). These themes reflected areas such as “relationships”, and “impact of health policy” to name two areas. Many of the themes related to areas identified in the literature review where greater understanding could be wrought from this study. Once the data had been analyzed, I was able to move into the process of data interpretation.

Data Interpretation

Data interpretation also occurred over the course of the study. From the outset of the field work, I wrote memos to myself. Often these memos related to issues that seemed to be ‘taken for granted’ by participants and were areas that I could continue to examine during the course of data collection and analysis. For example, the issue of ethnocultural diversity among staff was an area that was very complex. On the one hand, Site A had, on the surface, an ethnoculturally diverse mix of staff. Upon closer

examination, however, it was apparent that the race and class hierarchies described in the literature existed in this setting: the administration was White, and the staff were a mixture of White and Persons of Colour. As I became more immersed in the setting and did interviews with some administrators, it became clear that there were informal mechanisms in place, such as hiring practices that maintained Whiteness among staff while ensuring, on the surface, an appearance of diversity. During data analysis and interpretation, I interrogated this practice and the implications for certain groups to obtain unionized and, therefore well paying, secure, employment. This example illustrates the synergy in critical ethnographic research between what is observed and heard (and coded), and the reflexive process of the researcher that is guided by the study's theoretical framing. This dynamic process of data collection, analysis, and interpretation occurred throughout the course of the study. The results of this process are the findings chapters.

Ensuring Scientific Quality

Several scholars have articulated ways to ensure scientific quality, or rigor, of qualitative research (Lincoln & Guba, 1985; Onwuegbuzie & Leech, 2007). As discussed at the start of this chapter, a critical ethnography conducted within the theoretical perspective of this study reflects several elements, including: voice, reciprocity, reflexivity, and praxis, and to this list, I would add credibility. These elements support the entire research process, from data collection to interpretation of the findings, and, hence, are used as signifiers of scientific quality in this study. Trustworthiness is a term that has been applied to this process, and is characterized by an accurate and credible portrayal of the participants' voices and realities in the findings

(Guba & Lincoln, 1989; J. Hall & Stevens, 1991). The following section describes how these elements contribute to the scientific quality of this study.

Credibility

Credibility ensures that study findings reflect the realities of the participants (Streubert & Carpenter, 1995). In this study, credibility was addressed in three ways: member checking, triangulation, and auditability. In order to address credibility in this study, emergent themes were validated with participants through member checking, a process that ensures that participants have input into the interpretation of their experiences by the researcher (Sandelowski, 1993). In this study, member checking was addressed by sharing emerging findings during informal interaction and through conversations with key informants once data collection was complete. Informal interactions during the course of data collection sometimes took place over lunch in the cafeteria with staff and administrators, or in hallway conversations with staff as they went about their day to day routines. With family members, member checking occurred during follow up conversations when they were visiting their resident. I also developed close relationships with some key informants, such as a nurse and social worker at Site A and the Director of Care at Site B, and had regular one-to-one conversations with them and with whom I continue to have occasional contact. Member checking in critical, feminist research can be challenging, as participants may not be conscious of how hegemonic discourses are operating in their lives and work. I was careful, therefore, in my feedback conversations to be continually gauging participants' reactions to what I was saying. I did this by being observant of their nonverbal and verbal actions. These observations are

recorded in field notes about these conversations. Elements of member checking are further discussed in relation to the process of reciprocity later in this section.

In this study, I also used triangulation in a number of ways as a way of validating, hence lending further credibility, to the findings. Triangulation involves having multiple points of view when gathering data (Carspecken, 1996; Sandelowski, 2000). This was addressed by having multiple sources of data for the in-depth interviewing, writing extensive field notes of each field experience and interview, and by conducting the study at two sites. By having these multiple viewpoints, I was able to compare and contrast the different pieces of data when doing the analysis.

Auditability refers to the ‘decision trail’ left by a researcher, which allows others to trace the methods used in the study (Onwuegbuzie & Leech, 2007; Sandelowski, 1986). In this study, the documentation of the audit trail is embedded in the log book for the study, which includes the timeline and how and why events took place, and the research report, in this case, my PhD dissertation.

Voice

Within the theoretical framing of this study, participants’ voices are the vehicles for telling their stories and experiences. In this study, voice relates to maintaining the integrity of the lived experience of those participants who are often silenced by their situation (Fontana & Frey, 2005), often shaped on multiple intersections of oppression. Therefore, the voices that were central to this study were those that have been “subjugated”, in particular, the residents and unregulated health care workers. By relying on verbatim, unedited quotes in the findings chapters, this study has the potential to become a source of resistance – “resistance against silence, as resistance to

disengagement, as resistance to marginalization” (Lincoln, 2002, p.337). By employing many direct quotes, I also hope to illustrate the linkages between the data, my interpretations, and conclusions (Corden & Sainsbury, 2006).

Reciprocity

As described earlier in this chapter, reciprocity “implies give and take, a mutual negotiation of meaning and power” (Lather, 1991 p.57). This aspect of the research was built into the relationships that were developed during field work. Reciprocity was part of the member checking that took place (as described previously) and will continue as I return to the facilities to share the findings of this study. During the course of data collection, reciprocity occurred as I would talk with participants and key informants about the data that I was collecting. They would then reflect back to me where they perceived gaps either in my interpretation of the data or in the data that was being collected. They would say things like “you should really talk to so and so” and then they would often facilitate an introduction to that person. In other cases, we would have lengthy conversations about the state of LTRC and their concerns would then be integrated into subsequent interviews, observations, and field note reflections. By sharing my emerging analysis with participants in the field, I was able to integrate their viewpoints into the analysis and interpretation of the data.

Over the course of the study, it became apparent that there were some key participants at each site, with whom there was greater reciprocity. There were residents who came to know me and I would spend time talking with them about the research. As well, there were key staff members who assisted with accessing participants and this often happened within the context of hearing where I was at with field work and then

thinking about who might be a good participant (or group of participants to approach). Family members would sometimes catch me on my way out of the facilities and walk with me to talk about new ideas they had had related to the study. At all times, I welcomed input and invited those individuals who felt particularly connected to the study to continue to dialogue with me about it. In this way, a small community built around the study of participants from various groups who provided ongoing insight into what I was learning during data collection.

Reflexivity

Reflexivity allows the researcher to include our “selves” in the research by making transparent our values and beliefs that influence the research process (Etherington, 2007). As described in relation to the method of inquiry, a critical approach to reflexivity brings a particular focus on the researcher’s own power and privilege, a position that can lead to tension when critiquing the power struggles of participants (Madison, 2005). I was challenged, therefore, in this study to engage in the reflexive process, particularly around my social positioning and how it affected my position in the field, and, ultimately, my interpretation of the data.

As with the participants, I was located in this study at the intersections of race, class, gender, and age, among other axes. In the past, scholars within nursing (Bonner & Tolhurst, 2002) and beyond (Brayboy, 2000; Lomba De Andrade, 2000) have discussed the insider/outsider binary. In essence, being an ‘outsider’ means that the researcher has little knowledge of the setting prior to immersion in participant observation and, conversely, being an insider means that the researcher already has some knowledge of the setting (Bonner & Tolhurst). In reality, however, this binary can be deceiving because, in

fact, the researcher occupies multiple identities and social positions in the research process (Murray, 2003). Part of my reflexive work of this study was to examine how I ‘fit’ within the ethnographic field.

As a white, educated, Registered Nurse, I entered the field already in a position of power according to the hierarchical structure of LTRC. Physically, I was White and female like the management staff at both study sites. I was also already known to some staff before beginning fieldwork. Long-term care is a small community with a mobile workforce so when I began at Site A, I realized that some of their staff had reported to me when I worked as a Director of Care in the past. It was difficult to move beyond the manager-employee dynamic.

Beyond aspects of my physical appearance that could not be altered, I was attentive to other aspects of my appearance as I strove to “demonstrate my roots in ordinary practice” (Allen, 2004, p.21). Because appearance is an important signifier of status and group membership (Allen), I was careful to dress in a way similar to the staff while wearing a name tag that clearly identified me as a researcher. Yet, I found myself being continually pulled to privilege other aspects of myself. For example, early on in field work a nurse that I was shadowing said to me “maybe you can give me some tips [on my practice] when I’m done”. It was difficult to respond to this in a way that would make her feel less threatened by my presence. As I described earlier, I was also asked to perform nursing assessment by HCW when I was present during a resident’s fall. I redirected them to the staff nurse, but could sense their frustration with me because I was slowing down the process. With the management staff, particularly at Site B, I was often treated as a colleague. They shared information with me as if I was another Director of

Care, in part because of my understanding of the language and structure of LTRC. I entered these conversations with caution because I felt that some of the information they were sharing was not intended to be 'data', rather they were seeking advice at the professional level. I was careful to respond in these conversations from the perspective of the research, yet the frequency of these exchanges did not diminish.

At Site B, the differentiation in power relations between the staff and myself was striking. In one of my first field notes about a meeting with staff to introduce the study, I commented on how it felt to be the only White person in the room, as all of the staff were Filipino. The staff were also very vulnerable at Site B, having just undergone a change in contracts and they were still in their probationary period. As I became more immersed in the facility, I found the staff quite hesitant to participate in interviews or even have informal conversations with me. After discussing this with the Director of Care and contract company manager, I arranged to come one evening. Staff were released from their work in order to spend time with me. Once we were alone in a private room, they became more open about their work. In one interview, I was asked whether I thought staff should be unionized or contracted. I took a moment to consider how to answer the question. In keeping with the explicitly political nature of this approach to research, I explained that what I believed was that staff should have job security and benefits, and given the public nature of our healthcare system, that staff should be paid the same for the same work regardless of the location of their work. Upon completing this statement I felt a shift in our relationship. The staff I was interviewing had decades of work experience in a unionized environment and had only recently been contracted out, losing their salaries, benefits, and pension security. I felt like they looked at me with new eyes

and almost relief that I understood, in a small way, their predicament. After this episode, I found that there was a more welcoming atmosphere when I was at the facility and, although we did not discuss the issue further in the presence of management, there was a newer openness to my presence.

Thus, negotiating the social positionings of myself, which existed on multiple, simultaneous axes, was integral to the reflexive component of this study. I recorded thoughts and issues related to this process in field notes and memos and included in the analysis. In addition to writing about this process, I also had ongoing discussions with my supervisory committee about the research process, issues arising in field work, and themes arising from data analysis. These discussions were extremely important, they provided an opportunity to step outside of the field and examine these issues with individuals who were not as emotionally invested in the places and people of this study.

Praxis

As described earlier in this chapter, praxis is the ability to link knowledge and theory development to practice-relevant social, political, and ethical actions aimed at improving health, health-care, and social conditions (McCormick & Roussy, 1997). In this study, praxis was closely linked to the notion of catalytic validity (Lather, 1991), which refers to the degree to which the research stimulates and promotes action as part of the research process. In essence, catalytic validity is the juncture at which knowledge generated from the study is taken up in practice. To a certain extent, it is difficult to assess the extent to which this dynamic aspect of the research occurs, but I attempted to address it in a number of ways. I communicated emerging findings to staff on a one to one basis and also in informal group gatherings, and encouraged dialogue about the

potential implications of the findings for practice. As described in the previous section, I responded to questions about my political motivations in a straightforward manner rather than suggesting that the study was a neutral act. I would talk with family members about issues arising from the data, as they, in turn, often asked extensively about the data that was being collected. I have also committed to returning to each site to continue a dialogue about the research once the dissertation is completed. At a broader level, findings will be shared with policy makers and health care decision makers through a final report with the intent to engage them in considering how to address issues raised through the study in policy and service delivery. Efforts will be made to also make face to face presentations with these groups. Finally, while it is difficult to stimulate action at a broader, societal level from just one study, this research lays the foundation for a program of research that I will continue after completion of my doctoral work.

Ethical Considerations

Ethical approval for the study was obtained from the University of British Columbia's Behavioural Ethical Review Board (Appendix C) and the participating facilities. All participants were provided with a Letter of Initial Contact (Appendix D) at the outset of the study, which outlined the purpose of the study, assured the voluntary nature of participation, and the participant's ability to withdraw from the study at any time. These letters were distributed to residents in their rooms, placed in staff pay stub envelopes, and mailed to the primary family contact person for each resident. Prior to formal data collection (participant observation and interviews), I went through the process of obtaining informed consent from each participant (Appendix E). Because the study involved ethnographic methods, informed consent became an ongoing process,

recognizing the continual nature of participant observation (Morse & Field, 1995). To address this ongoing nature of consent, during field work I would remind participants of who I was and why I was in the setting. I also wore a nametag at all times that identified me as a researcher. I often also had a piece of paper for jottings and would sometimes write in front of participants to remind them that I was collecting data.

In a study of this nature, it is difficult to ensure total confidentiality related to participation as I was seen spending time one on one with staff and residents and when participants were interviewed on-site, this could be noted by others. Moreover, because key contacts assisted with identifying potential participants were members of the staff, there was a lack of anonymity. Because of these risks to anonymity, I was careful to provide participants with opportunities to discontinue participation. I did this, for example, by leaving a time gap between talking with a potential participant and doing data collection so that they would have time to reflect on their consent and change their minds if they chose not to participant.

Once data were in a typed format, all identifying markers were removed (such as names and locations). Confidentiality was also maintained by storing all consents and data in separate locked cabinets, accessible only to myself. Data that had been anonymized was shared with my dissertation committee members for the purpose of discussion of analysis.

Informed Consent in Long-term Residential Care

Research with adults living in LTRC has important ethical considerations in relation to conducting research with ‘vulnerable’ populations. These challenges are reflected in the conduct of research with LTRC residents as many are cognitively

impaired to the extent that they are not able to provide informed consent (Franzi et al., 1994; Stelmach et al., 2001) and, instead, provide assent. As well, because they are living in an institutional setting, conducting research related to their care may raise concerns about any repercussions that may occur as a result of their participation. The Tri-Council, responsible in Canada for promoting ethical standards in the conduct of research, is very clear that vulnerable population not be excluded from research and that there is an obligation to conduct research involving such groups because it would be unjust to exclude them from research that may be of benefit for them (Article 5.3) (Tri-council, 2003). Thus, this research included residents living in LTRC.

Researchers have described the particular challenges involved with obtaining informed consent from older adults living in LTRC (Franzi, Orgren, & Rozance, 1994; Stelmach, Konnert, & Dobson, 2001). One of the main challenges is the researcher's ability to obtain informed consent given the high proportion of residents with some degree of cognitive impairment. In the United States, it was estimated that up to 72 percent of the LTRC population had some degree of cognitive impairment (Strahan & Burns, 1991) and while there is no comparable reporting mechanism in Canada, it can be assumed that this rate is now much higher given that only the most complex adults gain admission to LTRC. In this study, therefore, I used a combination of informed consent, and informed consent by proxy and assent to obtain informed consent from residents.

With informed consent by proxy and assent, the resident's consent is provided by someone in a caregiver capacity, often a family member or physician. In British Columbia, every resident of a LTRC facility is required to have a substitute decision-maker under the Adult Guardianship Act (Government of British Columbia, 2000b).

Essentially, the substitute decision-maker is able to make decisions on behalf of the resident. Given this individual's decision making authority, informed consent in this study was sought from the residents' substitute decision-makers when the residents were unable to provide informed consent on their own behalf. Solely relying on consent by proxy, however, excludes the residents in the research process, despite their role as participants (Dewing, 2002). Given the ethical issues associated with exclusion, it was important to ensure that, to the extent that they were able, residents understood that they were participating in research and were given the opportunity to agree or refuse to participate. In this study, I relied on the clinical expertise of staff who worked with the residents on a daily basis and, in a few cases, family members to tell me if a resident was able to provide consent. If a resident was deemed unable to consent, I obtained assent from them after written consent was provided by their family member. During the process of assent, I spoke with residents about the research project using language appropriate to their cognitive status. I relied on my expertise as a gerontological nurse to engage in these conversations.

Timeline for Completion of the Study

This study took place between December 2006 and Spring 2008 (Table 4.9: Timeline). Ethics approval for the study was obtained in July 2006. Data collection at Site A occurred between October 2006 and August 2007 and at Site B between May 2007 and August 2007. The first stage of analysis and interpretation took place concurrently with data collection. Between September and December 2007, more in-depth analysis and interpretation continued as I engaged in discussions about emerging findings with my

dissertation committee. Writing of the dissertation chapters occurred during this time until February 2008.

Limitations of the Study

This study was limited in a number of ways. First, the sites were self-selected. Although there is some consistency in care among LTRC facilities, they have each evolved separately and have developed, over time, a distinct culture and approach to the organization of care. Although the study findings are not generalizable in a quantitative sense, they do have implications for LTRC that are similarly organized. Secondly, because site participation was voluntary, only facilities interested in participating in research volunteered to be part of the study. Third, participants at each site were self-selected. Again, this meant that certain perspectives were not captured in the interview data and participant observations. For the resident group this was particularly significant, as many residents were unable to verbalize due to the disease process of dementia, stroke, or other debilitating process. Lastly, participation in the study was contingent upon being able to speak English. This meant that residents, family members, and some staff who had a language barrier were not able to take part in interviews and, to a large extent, in observations. Because this study was a doctoral dissertation and I collected all of the data in English (the only language that I speak and understand), this limitation was unavoidable. Future studies, however, should have more inclusive participation to reflect the ethnocultural diversity of LTRC. As well, all LTRC facilities need to be encouraged to participate in research so that the diversity of care that exists in this sector of the healthcare system can be thoroughly analyzed.

SECTION II: INTRODUCTION TO THE STUDY FINDINGS

This transition section introduces the study findings. The findings are presented in three chapters and are introduced in the following section. In keeping with the methodological framework for this study, the findings are largely presented using direct, unedited quotes from study participants. In particular, I included many quotes from residents and health care workers, individuals whose voices are often silenced in discussions of the place where they live and work. By offering a space for public dialogue with these voices of subjugated knowledges, it is my intention to foreground those who are too often relegated to the shadows. The following section provides a brief overview of the three findings chapters and is followed by a description of the ethnographic field.

Overview of the Findings Chapters

The findings are organized into three chapters. In Chapter 5, I focus on those who live in LTRC. I begin with the residents' perceptions of what it is like to live in LTRC. I then present findings about how they pass their time in this setting. I introduce some of the newer groups emerging among the traditional resident population, that of younger residents and non-English speaking, immigrant residents and consider the unique challenges confronting these groups.

Chapter 6 examines the informal, interpersonal organization of care. I begin by introducing family members, a group that is often on the periphery of LTRC, not residents and not workers. I then discuss the many workers in LTRC, which comprise groups that often work alongside each other but not necessarily as a cohesive team. From here, I move into the interactions that take place, which are embedded in relations of

power. I present a number of stories of resistance, which illustrate the agency of those who live and work in LTRC. Next, I consider the valuing of care of older adults and, by extension, of those who work in the setting and how this is influenced by the discourse of ageism. In the last section of this chapter, I explore the complex intersectionalities that operate in the institutional context of LTRC.

In Chapter 7, I move into the formal structures that influence the organization of care in LTRC. I begin by situating LTRC within the larger health care system. I then explore issues around public and private funding that reflect the current model of care. Next, I present findings about transitions in care for residents, particularly the influence of the First Available Bed policy on care transitions and other key changes over the past decade that resulted from health care restructuring. The last section of this chapter considers the erosion of knowledge, care, and leadership in LTRC and the implications for the organization of care. The chapter ends with a summary of the three findings chapters. Importantly, while the findings are organized into three chapters to provide some clarity about the many issues that influence care in LTRC, these issues are occurring simultaneously and should be read in this context.

The Ethnographic Field: Long-term Residential Care

In this study, the ethnographic field was comprised of two long-term residential care facilities: the primary site, Site A, and a secondary site, Site B. In Chapter 4, I briefly introduced the study sites. For both sites, I have intentionally left out descriptive information that could lead to identification of the sites. I have not provided information on the number of beds or the physical attributes of the sites. I have included information

about facility ownership and characteristics of staffing that contribute to understanding of the findings.

As described in Chapter 4, Site A was a non-profit facility. All of the staff were unionized or on individual contracts with the facility. Health Care Workers (HCWs) HCWs were typically responsible for between 15 to 24 residents on a day or evening shift (there were fewer staff at night), with slightly lower assignments on specialty units such as the Special Care Unit, which received extra funding. As described in Chapter 4, Site B was a privately owned, for-profit facility. Care staff, food services, and housekeeping staff were employees of private companies that had contracts with the facility to provide staffing. Staffing assignments were typically lower than at Site A.

CHAPTER 5:

LIVING IN LONG-TERM RESIDENTIAL CARE

In this chapter I present findings about living in LTRC. The chapter is largely guided by the voices of residents, voices that often fall silent once they are behind the facility doors. I begin with a quote that foregrounds many aspects of living in LTRC, namely, the lack of choice, living among a group of individuals from disparate backgrounds, dependence on others for the basic necessities of life, a sense of powerlessness, and, importantly, acts of resistance:

Well, we have a new fella at our table, he thinks everything is wonderful, you should talk to him. “Oh that food is terrific and everything is just wonderful”, he thinks he’s going to be happy here and I’m muttering to myself, “just wait a little while brother, you haven’t been here long enough”, you know. Well [another resident], he’s been here longer than me a good deal, I don’t know how he stands it, I really don’t, of course, I’m a very independent person, you see I’m told go down there to the end and wait for someone to push me up this thing [ramp in dining room] well today I didn’t like the [other female resident] that was swearing at me for nothing, I just wanted to pass and she said, I won’t repeat it but it was very ugly, and I thought “well I’m getting out of here” so I climbed it [ramp] myself, you see, so there’s certain times I do go up it and right now I’m going to go for myself because there’s nobody there [to help me] at tea time.

- 93 year old White female resident living at Site A for three years

Life in LTRC is a complex web of interpersonal relations in a sociopolitical milieu that requires adjustment for people who come from diverse backgrounds.

wheelchair], you know it's almost impossible, it's physically impossible, and so I – look there's a sign up over my sink – they're supposed to help me up this ramp, but sometimes they do and sometimes they don't.

This resident alludes to the seemingly arbitrary rules and changes that were imposed on residents with little regard for their input or how it impacted upon their day to day lives.

These restrictions on choice and autonomy may begin before a person actually moves into a facility, often beginning when they lose control over even the decision to move into LTRC. In one interview with a recently admitted resident and her daughter, the resident expressed some of her anger and frustration at the situation she found herself in after living independently in a seniors' housing complex for many years. During the interview, she loudly announced “this is crap” and I asked “what is crap, this conversation” and she said “yes”. Later, though, I realized that the interview had taken up precious visiting time with her daughter and that while her daughter was very interested in participating, the resident may not have been as enthusiastic. During the interview, she and her daughter had the following exchange:

Daughter: Don't you think the good thing about living here mum is that there's people around all the time, you go to meals, you go to breakfast, lunch and dinner, there's activities if you want to participate in it, there's activities to do?

Mother: Yeah but it still is not home.

Daughter: Oh no, of course its not home.

Mother: Its not home.

Daughter: But you couldn't stay in your own home because you needed too much help so that's where these facilities come in because a lot of people can't stay in their homes as they get older because of health reasons.

Mother: Well when we got older before our kids looked after us. My generation looked after, well you know how long I had granny with me.

Daughter: That's true they did but also most people in your generation didn't work either, your children have all worked all of their lives so it's a bit different I think and I think at that time there weren't facilities of this nature.

For this resident, there was a tremendous sense of disempowerment about her situation.

A daughter commented on the differences between living at home in the community and the loss of control her father experienced when he lived in a facility:

And of course when we [daughters] went up there [home prior to admission] he'd give us orders because, as people start to lose their independence, they, you know, there was nothing he could control. It was hard. He was losing control of everything. He had no control. And then of course when you come into a facility you've totally lost control and that's a hard thing to accept.

Another family member, who spent the majority of each day at the facility with his wife, captured the monotony of life in LTRC:

It's like everything else. I always say if you'd rather stay in a Four Seasons Hotel for three years, be locked in a penthouse suite, you'll feel just the same. There wouldn't be any difference between here and there because it becomes, no matter how luxurious, it becomes nothing. It becomes everyday, and so with the food,

because no matter how fancy the menu... all it is, is repeated, repeated, repeated, and it's the same here.

During a field visit in which I participated in a music group with about fifteen younger residents, the music therapist posed my question to each resident as they took turns choosing songs from a song book. While the responses varied, this group raised the issue of living with a large number of people. As one participant said, “there are people above, below, sideways, and in-between.” By the end of the hour the music therapist was in tears and afterwards reflected to me that she had found it to be a profound experience, having never posed this type of reflective, thoughtful question to a group of residents. For me this illustrated how residents are perceived, even by those who are with them everyday, that their compliance with their situation, with the daily routines and activities of the institution, somehow reflect a lack of insight into their situation.

While some people found life in LTRC restricting, one resident, who was still able to take care of most of her personal needs said, “don’t need a car, don’t need to shop, the food is good, can do what you want, go what you want. Belong where you want [laughs]. Yeah I’m happy here.” This woman was 99 years old and had moved into the facility at a time when people could self-waitlist. At that time, potential residents could choose the facility where they would live and often waitlisted when they were still functioning in the community and had time to anticipate and prepare for the move. This contrasts with the current system where there is no anticipatory waitlisting and people are placed in the first available bed when they can no longer manage in the community. This resident had chosen to live in a facility that was in the neighbourhood where she had

spent most of her later years. She had many friends who visited her in the facility because they lived nearby and her hairdresser and bank were within walking distance for her.

In sum, there are many ways that residents and family members described life in LTRC. Monotony, restrictions on movement, crowding, and lack of choice were just a handful of their perspectives. Some were also able to see a better side of life, where meals and laundry are done by staff and there are few responsibilities, yet this also meant little autonomy or individuality as the following sections illustrate.

Passing the Time in LTRC

Passing the time day to day was also part of the residents' stories. There were the typical daily routines, getting up, eating meals, preparing for bed. On every occasion that I went to the sites for field work there were groups of residents sitting at the nurses' stations. This is a typical scene at almost any LTRC facility. Some residents chose to sit by the nurses' station and some were placed there by staff to be observed. When I would go to the nurses' stations looking for staff or residents, some of the residents would ask who I was looking for and point me down the hallway where I was most likely to find them. Sitting at the nurses stations seemed to be a way to be part of the action as opposed to sitting alone in a room or in a less busy area. As when I needed help, it was also a way to offer assistance and interact with visitors to the unit.

Keeping Busy

When I asked residents about how they passed the time, most of them spoke about the importance of the recreational and rehabilitative activities in their lives, and their relationships with direct care staff (i.e. HCW, housekeepers, food service staff). Nurses and physicians were secondary players, who were important if the resident became sick

or needed more medical intervention. However, if they were physically able, residents found fulfillment in purposeful roles as described below.

For some of the residents, having a purpose and role within the facility apart from being a resident was very important to their identity. This role was often enacted as a volunteer. These activities included ‘working’ in the facility gift shop, being a greeter for new residents, helping to get items ready for bazaars, to name a few. One 15-year resident told me about his volunteer activities before he became too physically dependent to carry on:

I managed the thrift shop for over seven years, no, ten years. And I enjoyed it, I shouldn’t admit that to them though should I? Someone came in one day and asked me how much I got paid, I said you don’t get paid for being a volunteer, at least you don’t here. Then I used to iron all the table cloths and all the aprons, uniforms and such, I enjoyed it.

The difficulty was that, with increasing dependence, residents were no longer able to perform volunteer tasks and became, instead, the recipients of volunteer services.

Activities were also important to residents as a way of making the time pass. At Site A, there were a variety of activities and programs available for residents. For example, one resident talked about the art classes and guitar lessons she was taking. However, participation in some activities was dependent on a resident’s level of physical and cognitive functioning. In an institutional environment where residents have diverse backgrounds and abilities, providing activities that meet all of their needs is extremely challenging. Therefore, some residents passed the time in isolation, watching television, reading, or just vacantly staring into space. Designing activities to meet the needs of

residents with advancing dementia was also a challenge. At Site A, where there was a secured unit and a Special Care Unit (SCU), there were staff dedicated to working with this population. At Site B, where there was no separation of the resident population, there was also no specialization of activities.

Having appropriate activities, therefore, was complicated by having only a few staff to provide recreation for a diverse resident population. At Site A, for example, there was one recreation staff person during the day for almost 90 residents, whereas there was one for about 20 residents on the SCU as the facility received dedicated funding for this position. At Site B, there were a couple of recreation staff for almost 100 residents, and these were supplemented with volunteers. One administrator reflected on the challenges of providing activities for a diverse resident population:

The people who were cognitively not well were jammed into activities for the cognitively well. Like, what are we really doing when we're taking mom away from, you know, hurrying away from her lunch that we've had to feed her, changing her, propping her up in her wheelchair so she misses her nap so that she can go out in a scenic drive in rush hour traffic. This is an act, I mean, it... the insanity, like, it's like the system is so fragmented that nobody has control and can pull together something sensible.

In sum, finding ways to keep busy was an aspect of day to day for residents in this study. For those who were physically and cognitively fit, they were able to exert some independence and choice over how they spent their time, apart from the routines of meal times. With increasing dependence, though, residents became more dependent on staff to take them to activities or else they would spend long periods alone.

Spiritual Reconciliation

Another aspect of resident life was spiritual reconciliation. A younger, First Nations woman, who was a recovering crack addict and has since passed way, shared this perspective on her spirituality:

I've survived and by the grace of God I found the ability not to be bitter or blameful, you know, angry, whining, you know, pack your bags I'm going on a field trip type of thing, its just, it just is, I mean God knows what he's doing so I get choked with him a lot and he knows that, I don't like his sense of humor, you know, yeah, but that's mainly what pulls me through is my strong belief in God.

One of the sites had a chaplain on staff so residents had the opportunity to connect with someone about their spirituality, regardless of their religious or spiritual backgrounds. The importance of this role was evident in the number of residents who spoke about the chaplain to me during field visits, and, although they often said they were not religious or spiritual, speaking with the chaplain was a key part of their life. Staff also went to the chaplain when they were experiencing stress or concerns, often related to emotional issues at work, such as after an unexpected death.

The chaplain reflected on her role in the facility:

My role is to be supportive of anything, any issues that are to help them maybe reframe or rework some of the frustrations they've had in their life, some of the sorrows, some of the resentments, some of the angers that have sort of impeded their happiness along the road, you know, and meant to share and, of course, any other joys that they experience while they're here, you know, to share in that and let them know they're cared about and that somebody is here to talk to that's not

going to judge, to be completely unjudgmental which isn't always easy, you know.

The chaplain went on to describe her philosophy around working with a diverse group of residents and staff in a secular facility like Site A:

I would say that 99 percent of my conversations are non religious but when I was in my training one of my professors said something to me that really impacted me and makes me free to not always talk religion even as a chaplain, he said when you go to speak to somebody and you talk with unconditional love and with an open heart he says every conversation becomes a prayer.

Considering the full lives that residents have had prior to moving to LTRC, it should not be surprising that many of them valued having someone to speak with about their 'unfinished business' or what lay ahead for them.

Connecting with Other People

In addition to keeping busy, connecting with other people was another facet of resident life. Many residents spoke about the difficulty of developing relationships or friendships with other residents. There were a number of reasons why relationships with between residents were challenging. For example, residents passed away or moved away, or residents would become progressively cognitively impaired, and sometimes, other residents were verbally or physically abusive, making people cautious about approaching others, as illustrated in the opening quote of this chapter. One resident described her perceptions of cognitively impaired residents:

Participant: Well I can't communicate at all with them. So I stay away in order to keep myself not getting upset. Yeah I kind of sort of say that you've got to look after yourself too.

Researcher: And do you find that there are lots of residents here that you can talk to?

Participant: Communicate?

Researcher: Yeah.

Participant: There's only three girls on this floor that I think I can communicate [laughs]. [Name], way at the other end. Who else is there? Who else? There is not much too good communication here. But I go take my walker I go in that corner there and put my feet on my stool and knit away. Before you know somebody comes and we talk and jabber around, have our laughs [laughs].

Some residents were reliant upon family visits and phone contact with their social network to keep them busy. One daughter described her father's pleasure at receiving visitors at the facility where he had lived: “

Well, yeah we had them [beer] hiding in his cabinet there in the room, just the little beers, you know. Then if we came to visit, he'd say, “Well close the door, would you like a beer?” [laughter] Then, the last few times... the last few months of his life, he lived for the social interaction and split a beer, and you know, go out even in his wheelchair.

She went on to relate a story about a visit when one of the grandchildren had come along and when she and the grandchild were chatting to each other too much her father broke in and said “who did you come to visit here anyhow?”

Perhaps to fill the void left by limited relationships with other residents and the availability of family and friends to visit, residents developed connections with staff. A family member who was geographically distant from the facility where her aunt lived explained the connectedness between residents and staff to me:

Another thing that I think is very important is the relationship between staff and residents and, you know, when there were the, I'm trying to think now if it was people were laid off like care aides even, well the care aides know the residents, **they become part of the resident's family circle** in there and it's a big deal when one of them disappears like if they're laid off, you cannot just take the care aides or half of them and replace them with strangers, you know, because they're performing very intimate services for a lot of people and it takes awhile for that trust to develop and I don't think that they're interchangeable and the same with the nurses, you know, and even housekeepers like they're all important.

Similarly, HCW and recreation staff described their relationships with residents in familial terms, often saying that it was similar to a grandparent or aunt or uncle. Food services staff also played an important role in acknowledging a resident's preferences and individuality: "they get to be seen as like family to the resident because they're going to be the one that remembers that, you know, they don't really care for something, some vegetable and they're going to make sure that they get some other vegetable or whatever on their plate." These relationships became highlights in the residents' days. In sum, creating and maintaining points of connection with other people were key in the day to day lives of residents in LTRC.

Receiving Care

Although residents and staff can develop close personal relationships, there were potential issues in receiving care. These issues often arose when the residents and staff appeared to be at cross purposes, for example, when the resident had a particular preference about how care was provided but the staff member provided it in another way, for whatever reason. There were also issues in receiving care that related to the availability of staff, as described in the following paragraph.

An important issue for residents was waiting for staff to arrive and provide assistance. This was particularly salient for residents who were more physically dependent. In some situations, the lack of staff and the needs of residents had potentially dire outcomes:

I had a fall, yeah, one night here, the door was shut and nobody came and I was yelling and I was lucky it was pill time and [nurse] came and said “Oh what have we got here?” and so he lifted me off the floor, I tried to crawl from there to the bed but do you think I could, couldn’t motivate at all, you know, so he came in and then he put me in bed and turned out the light and that was okay.

Even when residents were able to call for staff, it could take a long time for someone to arrive: “It takes ages if you want a care worker, and you have to ring for them, it takes ages for them to come.” One family member described the multiple phone calls that she received from her mother when her mother was waiting for staff to arrive if she has rung her call bell. There were even occasions when the daughter would call the nurses station from home and request that someone go and check on her mother.

There was also a tension between the resident's preferences and the regulations around how staff did their work. A resident described for me his opinion of the mechanical lift used to transfer him from bed to wheelchair just as a HCW entered the room with the afternoon snack:

Resident: Do you want to take the torture machine with you?

Researcher: The what?

Resident: The torture machine.

Researcher: The torture machine, I don't know what that is. What torture machine?

Resident: That one.

Researcher: This? (pointing to mechanical lift)

Resident: Yeah.

[Field note] Care aide comes in to drop off afternoon snack, overhears conversation, and says: "That's not a torture machine. It's a good machine, it saves everybody's back." And leaves the room.

In this situation, the resident was too heavy to transfer physically and required the lift. It also illustrates the chasm that can exist between what is desired in terms of care and what is available.

The Resident Population:

The Space for Difference in LTRC

The resident population is evolving to reflect the population of adults needing residential care and the lack of housing available for individuals who require extra support. There is the 'traditional' resident - an older, White, woman or man, who initially

participates in activities and they progressively becomes more dependent on staff. One day when I arrived at Site B, there was a female resident in a geri-chair (a reclining-type wheelchair with foot rests and arm rests that residents cannot wheel by themselves) who had been left in the middle of one of the long hallways. She was dressed in a hospital gown and had a blanket over her legs. Her head was tilted back slightly and she was vocalizing but not using words. There was no one in the hallway. At one of the study sites there were quite a few residents of this type and many more who remained in bed all day. This, for me, was a typical scene at this facility but also similar to several that I had worked at and visited in the past. While there remain many of these kinds of residents, there is also a growing difference in the resident population, which is visible in the number of 'younger' residents and immigrant residents as described below.

The Socially Complex 'Young' Resident

A chronologically younger group of residents was becoming a visible group within the resident populations at the study sites. In speaking with staff and administrators, these younger residents were a diverse mix of people who had histories of mental illness, acquired brain injuries, progressive diseases such as multiple sclerosis, or other issues that led to living in LTRC. According to administrators and staff, these residents were often more socially complex and many had struggled with addiction to illegal substances.

Addiction was an issue that these residents continued to work on in the facility. Nurses were administering methadone as a normal part of the medication rounds. The First Nations woman in her forties whom I interviewed described her life: "I became a widow before I became a debutant, you know, so now that I've been in, living in an old

age home, they say life starts at fifty I'll be ready." While she joked about being in an 'old age home', she also felt a sense of stability that may have been lacking in her life: "to come here and be treated equal to everybody else no matter what our age, our ages are just numbers and to be respected by the staff and the other residents is, you know, just I'm one of the gang, its done a lot for my mental health."

Yet, it was apparent that this population was not overly welcomed by everyone in the facility. They were viewed as being very challenging to work with by many HCW who told me they felt ill-prepared to work with them. One HCW commented on the difference between the 'traditional' addiction of alcoholism and the newer substance abuse issues among younger residents:

Well we have residents now who I mean there would have been a time when the extent of it would have been an alcoholic, I mean we have residents who are alcoholics well that's, you know, it can be frustrating and now its different but you just, we've had some that have a drug past.

There was also a sense that these younger residents could cause a physical safety risk to staff and the more frail, older residents. A HCW said to me:

I see it as a threat to some other residents if you get certain residents that are more confrontational, younger, you know, physically they'll be a bit, a bit more of a threat than it would have been if it was just older, older residents.

Some older residents had refused to leave their rooms or to live in a unit with a high proportion of younger residents because they had concerns about their personal safety.

There was also one younger male resident at Site A who lived in the Special Care Unit because, although he did not have dementia, he had a brain injury that caused him to

exhibit behaviours that were so irritating to some of the other younger residents that they would be physically violent towards him.

A Director of Care referred to the younger residents with concern, particularly those of 'no fixed address' (that is, homeless). She said that she would often avoid admitting younger residents like this because of the complications they brought with them. She also commented on the impact of Canada's poorest neighbourhood, the Downtown Eastside of Vancouver, on the future of the resident population:

We know now what the Downtown Eastside is like right now, so let's wait another 10-15 years when the people who live on the Downtown Eastside streets may come to facilities. Well they have to, eventually they will. If they don't die on the streets, and they continue to live, they will probably... And I think down the road, yeah we have hospice, but we'll see in the next five to ten years the clientele is going to change to a lot of more HIV positive.

In sum, the challenge of creating space in LTRC for this younger group was an emerging issue for administrators, staff, and the 'older' resident population. Yet, for the younger residents, LTRC was often a place where they could live safely and experience a sense of acceptance that was lacking in previous parts of their lives.

The Immigrant Resident

Unlike the younger residents who were quite visible in the facilities, the immigrant residents who did not speak English seemed to be at particular risk for isolation. Although non-English speaking residents were not interviewed for this study, they were talked about by other participants. Neither of the facilities had accessed formal interpreter services to assist with communicating with non-English speaking residents.

Issues for this group arise at the time of admission. A nurse shared a story of one non-English speaking woman who was placed in LTRC by her family:

I can think of one lady who, going from child to child to child for respite, and when it came to this one daughter - the eldest daughter had gone away on holidays, and at that moment she got on the plane, the daughter where the mother was being housed, phoned up long term care and a case worker and said “my mother is being unreasonable and she’s having all these negative behaviors and she needs, I mean its an emergency, she has to go into care.” Well, when we received this lady, we saw no negative behavior, we saw no problem, the lady was quite high functioning, she was, English was a second language to her so her English was limited but she had a lot of moments of lucidity and it was fine, we didn’t see a problem with that and we moved her into another area of the building because it wasn’t appropriate for her to be in special care.

The issue of placement of non-English speaking residents in the SCU became apparent at Site A when the quantitative data was obtained for this study. In the overall resident population, 7 percent were non-English speaking as compared to 35 percent in the SCU. Upon further discussion with the Nurse Coordinator for this unit it was apparent that she had experienced several inappropriate admissions of non-English speaking residents into this unit who were later moved into the general resident population. She said that once these residents settled into the facility and staff learned how to communicate with them and were providing consistent care, their behavioural issues disappeared and there was no sign of dementia. On the other hand, she talked about two other residents who remained in the unit even though it was not necessary: “we had two Korean ladies in [SCU] and

again we see no behavioral concerns but now that they're together we don't want to move them because they have each other to communicate with." When I asked if their families were opposed to having them live in a SCU, the nurse looked at me puzzled and then said that the family also did not speak English and probably did not understand the distinction of being on a different type of unit. Of course, for staff, the benefit of having these residents stay in the SCU was that they did not have the behavioural issues associated with people with advanced dementia and, therefore, were likely much lighter to care for than a typical resident on this unit.

Non-English speaking residents also lived in among the general resident population. For these residents, isolation was an aspect of their existence. Some remained in their rooms and relied heavily on family members and staff who spoke the same language for social contact. As I wrote in one fieldnote after interviewing a English-speaking, White resident's daughter:

There's a non-English speaking South Asian woman living next door to her mum and she says every time you go by her she grabs for you, she hugs you, she kisses you and how sad it is in a way because this lady doesn't speak any English and there's maybe one staff member that can speak the same language as she does and so she's always reaching out for some emotional connection and the daughter talked about that a bit.

At a staff meeting an English-speaking housekeeper talked at length about the same resident, particularly how she would reach out when the housekeeper was cleaning and hold on to her. The housekeeper vacillated between feeling sorry for the resident and feeling that she was an irritation, saying that "someone should do something about it."

Overall, LTRC staff had very limited resources for communicating with non-English speaking residents. Neither of the facilities in this study had access to professional interpreter services without cost (although these services are available at most acute care hospitals), and so relied on staff or family members to provide interpreter services when necessary. A nurse illustrated the importance of communication and understanding the resident's perspective on care:

There's a Greek speaking lady and we found out just last week that, she stopped, didn't stop eating but we had a hard time getting meals into her, and she didn't want to come down to the dining room and she'd be in her room and then we'd bring her tray service and she wouldn't eat it and it got to the point where she was getting quite ill from not eating, we were so concerned, hemoglobin went down so, you know, we were just really concerned about this so we had a family meeting and the daughter doesn't speak English very well so we had the granddaughter in and she was saying well, no, her, her grandmother is not eating because she's waiting for you to sit down to eat with her, it was, you know, you've brought your food, you brought your food to me, I must sit and share with you, you know that was just, that was mind boggling to us that, of course, that's what she thought that we were bringing food from our kitchen to share with her because she had nothing and, of course, **she couldn't just sit there and eat it without us being there to share it with her.**

In addition to weight loss, there were other potentially harmful consequences when residents and staff could not communicate because of a language barrier:

We see more aggression with people whose English is not their first language and is it because they're not understanding English so or we're not understanding them, I should say, you know, we're not understanding what their needs are so we can't, you know, provide for them appropriately.

A Director of Care also commented on this issue:

We have more and more families coming, or residents admitted from foreign countries, who come, live with their children, never learn the language, and then are being placed in care facilities and have no way of communication. I have six residents who don't speak or understand English. That's tough for them, eh?

R: It's very isolating.

P: Yes. And they speak to you, eh? And you try to answer, and you have no idea.

And I think it's **really hard when somebody gets really sick very quickly, because you have no way of communicating with them, no way.** And they might be in pain, and you don't even know the word pain.

A resident's son also shared what it was like when his mother was in the hospital and she did not speak the same language as her care providers:

She had times, listen I don't mind telling you, she had times she was in the hospital sitting in her bed screaming in Italian. Everybody around her was wanting to sedate her. My brother goes in says, "Ma what's the matter?" She says, "My stomach is killing me. I need to go to the bathroom, I can't go." In Italian she was explaining, "I'm constipated". My brother said, "Hold it, don't sedate her, give her something that will help her go to the bathroom." They gave her medication up the backside and she was fine within two hours.

R: Did they ever once in the hospital have an interpreter come in and see her?

P: Not once.

It's important to note that this woman was in the hospital for close to a year without any way to communicate in the same language as her care providers.

In summary, the resident population in LTRC is changing and greater difference is emerging in this group. This change is conflicting with the institutional nature of LTRC, where services and food are set up to serve a homogenous, Western European population. It also makes it very challenging to foster an inclusive and cohesive community.

Chapter Summary

This chapter has presented findings about what is like to live in LTRC through the voices of residents and family members. After describing in broad terms what it is like to live in LTRC, I presented findings about how residents pass time in this setting.

Residents who were physically and cognitively well were able to exert more control over their daily activities as opposed to residents who were more dependent. Keeping busy in the facilities was also reliant on the types of activities provided by the recreation staff.

Some residents spoke about the spiritual reconciliation that occurred at this point in their lives. Connecting with other people was also an important aspect of passing the time.

Residents found it difficult to make connections with each other and so often relied on family members and staff for interpersonal relationships. Of course, a large component of living in LTRC is receiving care. This aspect of day to day life was often portrayed as a source of tension between residents, who wanted care in one way, and staff, who provided care according to the rules of the system. Next, I presented findings about what

it is like to be a resident who is part of a visibly different group. In particular, recent years have seen growth of a younger population in the study sites, which has highlighted the knowledge gaps among those who work in LTRC to provide care for this population. There is also the non-English speaking, immigrant resident who is at risk for isolation in this setting. Facilities have few resources, such as interpreters, to be able to provide appropriate care for this group. Underscoring the findings of this chapter is the influence of the discourse of ageism on how care is organized in an environment that was explicitly developed for older adults. The residents and family members frequently pointed to the powerlessness felt by lack of choice, rote routines, and seemingly arbitrary decisions to meet the needs of staff and not those who lived in the facilities. As one family member succinctly stated: “it’s a system that seems to me to have failed miserably the idea or the mandate of preserving life and it’s one of ‘look, once life seems to be on a downward slide, let’s see what we can do to end it’.”

CHAPTER 6:

RULES OF ENGAGEMENT:

THE INTERPERSONAL ORGANIZATION OF CARE

Having spent most of my nursing career working in long-term residential care (LTRC), I agree with scholars who have written about the clear “chain of command” (Jervis, 2002) and hierarchies that play out in these settings. Walking into any facility, it is not difficult to figure out your role or those of others. Very quickly too, you learn about how to interact with these other players. In this chapter, I present findings about these interpersonal interactions that contribute to the organization of care in LTRC. The chapter begins with a section about a group that plays an integral role in the organization of care, yet are often viewed as having a secondary role to staff, that is family members. Next, I present findings about what it is like to work in LTRC, specifically about being a staff member. I move from describing these groups and their roles to examining interpersonal interactions and the relations of power that underpin these. I then consider the valuing of caring for older adults, and by extension, how this constructs those who are doing the care provision in LTRC. The last section of this chapter focuses on the intersections of difference that operate in LTRC.

Cautious Alliance: Informal/Unpaid Family and Formal/Paid Staff

Upon admission to a LTRC facility, the role of family caregivers can go from intense, hands on care to one of outsider, now a visitor who watches the ‘experts’ provide care. This can be a tremendous change for caregivers who have been providing day to day care in the community. Of course, there was great variation in the roles that family members played in the study sites. Some were largely absent, but others maintained close

relationships with residents, often becoming another group involved in the day to day life of the facility. In this section, I describe various aspects of the family member's role in the study sites.

Having someone move into a facility is a time of role transition for family caregivers. It can be very emotional, as they may experience self-blame for the admission, perceiving it as a reflection of their failure to provide adequate care in the home. They may have to deal with the resident's anger and confusion and they also have to learn an entirely new system of care provision and figure out how the system works. One daughter shared her initial reaction with me: "I was not impressed. I broke down and cried. I thought the hospital was better than this. I thought, 'This is just dreadful.'" This woman went on to tell me that her adult sons refused to visit their grandmother in the facility because they found it too depressing. Another resident's daughter told me that she has four brothers, and two would not visit their mother because they blamed themselves for their mother's entrance into the facility could not bear to see her in her current circumstances. These stories illustrate how entrance into LTRC can be an invisible boundary that some people will not cross, with tremendous consequences for relationships.

Not all facilities have staff with the educational and professional background to support families and residents through this transition. For example, there was a social worker at Site A but not at Site B. As a Director of Care commented: "I think that you don't only admit a person. It is basically families you admit. We should have support services in place for them, and we don't." One day, a Nurse Coordinator joked to me about doing care plans not just for residents, but for families.

For a variety of reasons, some residents had largely absent families. Staff members often referred to these absent families with disdain. A health care worker (HCW) told me about a typical interaction with a resident whose family did not visit:

And then they will say, “Can you sit with me? Can you talk to me?” It's like, you know, “Oh my God.” “I don't have my daughter with me. I don't have my family with me. They never visit me.” So sometimes, when I have time, I sit with them.

And you don't believe it, sometimes I cry.

Sometimes the absence was related to lifelong patterns of interaction and other times it was because of geographic distance between the resident and their family. When distance and travel were an issue, family members stayed connected through phone calls and sometimes by email.

Families often drew upon staff knowledge to keep abreast of what was happening in a resident's day to day life. This communication took place with a variety of staff and depended on the issue. When it was perceived to be a crisis or big issue, family members would go to administration. Big issues that family members told me about ranged from misplaced laundry to resolving conflict between residents and staff. On a day to day basis though, they often talked with the direct care staff – HCWs and food service staff. A daughter told me:

The lady who takes care of my mom, she told me tonight, and often she does this to me, she'll say, “Oh, your mom didn't eat much. Apparently she's not eating much at supper time.” And I said, “Well, I'm not really too worried about it, because I think if she's hungry she'll eat.” And she says, “Well, they've changed

her diet. They've got her on mashed-up food or something." And I said, "Well, why would they do that?" And she said, "I don't know, it's the nurse did it."

So even though families communicated with staff, sometimes the direct care staff did not have the necessary information on why things had changed, making family members feel left in the dark. The daughter went on to comment on this lack of communication between staff and family members: "So nobody told me why they did that [changed diet texture]. I don't know why. She's a big person, she can eat, cut up her own food, or whatever. She can chew it, certainly. So why they had her on some sort of baby food diet, I have no idea." So while there appeared to be good lines of communication between family members and direct care staff this was probably because these staff were present when family members more typically visit, such as in the evening. However, the staff responsible for making changes were often not present at this time of day to provide explanations for changes, leading to frustration on the part of families and, at times, conflict with staff.

When it came to care, antagonism sometimes existed between staff and families, particularly when staff felt the context of their work was not recognized or understood, just criticized. In this quote from a HCW, she described her interactions with some family members and also illustrates the go-between role that HCWs often play between families and nurses:

To the family you gotta, you always have to listen to what they want to be done with their auntie or their mom or their dad, right? You gotta listen for what they say. Let's say they want like-this, like-that, and so you [that is, HCW] gotta sit down to the nurse and tell them. Yeah, you treat them like, you know, it's like a

customer, they're always right. Sometimes they're very rude, yeah. Yeah, sometimes they're very rude because, well, maybe sometimes, "My mom didn't get this, and my mom is not like this, and my mom, why she's not getting proper care?" or stuff like that, or maybe, you know, sometimes you just change them, and they become mess, and all of a sudden the family is there, and it's like, there's lots of them [residents] to take care, and you cannot... You only have two hands at the same time, so you cannot do it right away. So when the family come, and it's like that, you just gonna say, "Well, I'm really sorry that it happened, but she was clean earlier." You just explain it to them, but I know, they're so rude.

In addition to families that were largely absent and those who visited the facility regularly, there were also family members who were part of the day to day milieu of facility life. When I would go to the sites to do field work, there were a number of family members who were always there, and many of them were spouses. Three of the husbands of residents who participated in interviews for the study spent the majority of each day with their wives. These spouses had made changes in their lives in order to spend large amounts of time at the facilities. For example, one of the husbands had retired to care for his common-law wife at home before her care needs exceeded his abilities and she moved into a facility; another husband had sold the family home to move within walking distance of the facility where his wife was placed. These family members had a number of roles in the facility.

Some of these family members made large contributions to hands-on care. One of the daughters I interviewed told me that she came three evenings per week to get her mother ready for bed, one of her brothers came two evenings per week, and they paid a

private caregiver for the other two evenings, thereby eliminating evening care from the HCWs' assignment. During a field visit, I was observing lunchtime in the Special Care Unit (SCU) and one of the resident's husbands helped staff by delivering food and beverages to various residents and by keeping everyone entertained with his talking. Another husband who assisted staff with all of his wife's personal care (dressing and washing) told me "I'm the second care aide. I should get paid."

In addition to providing hands-on care, family members who were at the facilities on a daily basis for long periods of time became 'experts' at knowing the idiosyncrasies of different residents, knowledge that they shared with staff: "I get to know most of them and the kitchen people they come in here, they rely on my knowledge and the way the people eat so they serve the meals to the right people." These family members were also a source of information for families who visited less often:

Family Member: They asked me how things were going, some do because they know.

Researcher: They know you're here.

Family Member: Well I'm here, they know I'm here all the time and I guess they figure they get a better concept of what's happening here from me than they would be from the staff. I mean I don't have, to hide anything.

Family members also played a surveillance role in the study sites. A son described his perceptions when he entered the facility where his mother lived:

There are times when I walk in and it won't matter what care facility, where you've basically got three people sitting behind the desk talking about what they did last night. And maybe that's just a few minutes in their day and I'm seeing it

at the exact wrong moment. But there are very few times when I go in there and everybody is busy working. And those times when I see that are typically when the administrator is around who is leading the way by being busy working. That's my way of saying there's a system that isn't necessarily self motivated.

He used this information to give feedback to the Director of Care when commenting on the lack of care his mother received in the evening. Besides just making observations, family members were also active advocates for residents who did not have an informal support network actively involved, making formal complaints to the facility administration when care issues arose. This was particularly reflected at Site B where most of the residents were in shared rooms. The family members who visited often would take an interest in the roommates and would, at times, become surrogate families for these individuals.

It was of concern however, to hear that family members were also sometimes the first ones to notice that there was a medical issue brewing. A son of a non-English speaking resident related this story to me:

Family Member: Went in, mum was nowhere near where she needed to be in terms of stability and ability to communicate with us. She was mumbling, she was hunched over in her chair. "Hey guys, there's a very strong smell of urine here. What's going on?" "Well maybe that's a UTI." "Well could you check it?" Sure enough, she's got a UTI, doctor's got to come in, prescribe antibiotics.

Researcher: And so you guys are the ones that figured that out?

Family Member: Yep. Yeah went in, I went... I mean my brother went in one day and the smell of feces was strong right from the door. She was sitting in a poeey diaper. Door shut, she had thrown some stuff.

Another daughter told me that she had arrived one day to find her mother limping. When she pointed it out to staff, they told her that her mother had fallen the night before. The daughter asked the staff if she should take her mother to the emergency department for x-rays and the staff said if she felt like it she could. The x-rays determined that the resident had a fractured knee.

In addition to the ways that families made themselves involved in day to day care, the facilities also had expectations of the family's role. As an administrator told me:

We have families that aren't prepared for the amount of support that they have to do, on-going support. Just because you bring mom into a facility doesn't mean that the [Canada] Health Act is going to take over for you now and provide all... there has to be a recognition, I think, that families need to be involved and a part of the team. And when mom or dad goes to emergency, that maybe they should go into emergency with them and see them through that whole experience. Not be calling the care coordinator later and saying, "Well, you know that they were in emerg and, you know, they wandered off."

There was also an increasing expectation that if a resident's care needs exceeded the services provided by the facility and the family were not going to provide the hands-on care themselves that they would hire a private caregiver. I observed a Care Conference where this was the solution the facility presented to the family to address the resident's behavioural issues and consequent care needs.

In sum, the role of the family in LTRC is evolving. While past research indicated that families provided primarily emotional support, the family members interviewed for and observed in this study were often providing hands-on care for their resident family member. They also played a key role in being on-site watchdogs and providing an informal surveillance system. The facility's expectations of families in terms of contributing to care either by playing an active role or purchasing additional services was also presented in these findings.

Arriving and Remaining in LTRC:

Perspectives on Being a Staff Member

Just as residents and family members bring the perspectives of people living in LTRC to this study, those working there day to day bring an important perspective on 'what it's like' as well. In this section, I present findings about the staff in LTRC. I describe how some of the staff came to work in this setting, which is often not a first choice among health care providers. I also discuss role issues and team (dis)functioning. The section ends with consideration of some of the pressures that influence the way in which staff were able to provide care.

Becoming Part of the Staff

When I asked staff how they had come to work in LTRC, many responded in the same way: "necessity", or "there was a job available". Not surprisingly, for many LTRC had not been a highly desirable workplace. The staff who had immigrated to Canada as adults had often had other occupations in their countries of origin, such as working in business or computer-related jobs. Yet despite their entrance into this place of work, most were committed to staying in LTRC. The exception to this desire to stay was among

the younger LPNs at Site B, many of whom were gaining experience and hoping to eventually work in an acute care setting. For staff who had been long-term employees at either site, their commitment was often related to a passion for working with older adults or an inability to obtain employment in another area of health care.

Defining Roles and Team (dis)Function

In addition to observing staff during their day-to-day routines, I also asked them to describe their roles for me during the interview. For Registered Nurses (RNs), in terms of resident care needs, there had been a tremendous shift over the past few years in relation to the complexity of resident's medical needs. These changes in care needs were reflected in the expectations of nursing knowledge and ability. A Nurse Coordinator described the changes she had seen in her 20 years of nursing in LTRC: "when I first started we just had the pleasantly confused little old ladies and gents who were, the majority of them were in their late seventies, eighties, we had very little issues with mobility" as opposed to now "as nurses we're being challenged by a lot of complex issues like tube feeds and we just brought a gentleman back from the hospital last month with a PIC line in." She went on to describe the introduction of residents with HIV, hepatitis, and other diseases that they had not seen when she started. The expectations of nurses to be knowledgeable of the many health-related issues that arise in this population were matched by expectations that nurses be able to perform skills that are often used in hospital settings but have not been a typical part of the nursing role in LTRC.

Licensed Practical Nurses (LPNs) often described their roles as being very similar to RNs. The LPNs at Site A worked alongside RNs and had very similar roles and responsibilities, although they occasionally also carried a load of residents for personal

care. At Site B, there were a number of new LPNs who had worked exclusively at that facility and, therefore, had very limited understanding of the RN role because Site B does not have a large contingent of RNs. One LPN explained her role in a way that situated herself between RNs and HCWs:

LPN: Actually it's very much the same as a care aide with the exception of the added responsibility of assessing the residents and giving out medications – oral, subcutaneous. Yeah.

Researcher: It's interesting that you describe it that way, because other LPNs have described it as being the same as an RN with...

LPN: And it is in that sense too. Yeah, it is as well. When there's no RN we're running the show – we're the in-charge nurse.

This LPN worked in Site A's Special Care Unit, a unit where residents were presumably quite complex. Yet the facility's administration had decided that LPNs, not RNs, would be the charge nurse and also assisted the HCWs with personal care in this setting. At Site B, the LPNs carried the same workload as the RNs they had replaced. This overlap of roles contributed to lack of distinction between LPNs and RNs and, at times, hostility on the part of LPNs at Site A where they felt they were expected to do a combination of RN and HCW roles and, thus, had a greater workload than either of those groups.

In speaking with HCWs, they often described their roles in terms of tasks, but would add an extra comment about the emotional connection with residents. A HCW explained to me the pragmatic and the personal aspects of the role:

I try and make a person's life a little more comfortable by providing all the ADLs, the Acts of Daily Living. From getting someone out of bed to, depending on the

shift, putting them back to bed and doing all their daily care. Like mouth care and bathing in some cases. Cheer them up when they're feeling down.

Another HCW, a Filipino woman, spoke about her work in more familial terms: "care aide does... is like, you're a mother, [laughs], you're everything." Even though they articulated their work in very practical terms, they also recognized that there was an emotional component. This emotional component and the ability to include it in their day to day work among the demands of their assignments contributed to stress in some HCWs, described later in this section.

Within every LTRC facility there is a group of staff who provide recreational activities for the residents. Their work can range from doing group activities, such as reviewing the daily news and doing trivia to working with residents on a more one to one basis. There can also be a number of specialists within this group, such as at Site A where there was an art therapist and a music therapist who worked regularly at the facility. As discussed in Chapter 5, residents placed tremendous value on the work of this group. Because of the low number of recreation staff, it can be a challenge to meet the needs of the residents, as one staff member explained: "there is usually one activity person to about 50 residents, you know, if you can imagine. That's like, you know, one person trying to keep track of 50 birthdays, 50 sets of needs, 50 social events." There are also challenges around the variation in the educational preparation of recreation staff, as described by a music therapist:

Often what happens in long-term care is that the activity department is led by a very well-meaning, wonderful human being who has very little training in long-terms care, disabilities and the needs of residents. So, they often put on wonderful

activities, but they don't match up with the needs of the residents. And it's not their fault, I mean, they don't have the training.

She went on to say: "If the staff aren't nurtured, and trained, and education, and taken care of, then how can they possibly give." With increasing diversity among the resident population, the demands for creativity in terms of activities but also stretching scarce resources across time and space was a challenge at both sites.

With all of the various groups contributing to resident care, there should be an element of team work involved. In observations and interviews, I noticed that team work was not necessarily a formalized process beyond exchanging information at shift change. When I asked staff about how they worked as a team, they often responded by only commenting on how they worked together with other members of the same work group. When I pressed further, they would talk about communicating during shift changes or if there was a change in resident status, but still not in a way that reflected any cohesion among the groups.

During field work, it was noticeable that there were few opportunities for staff to work together across groups. For instance, at Site B, the LPNs were usually sitting at the centralized nurses' station doing paperwork and would move out of the station as a group with their medication carts while the HCWs were down each hallway in resident rooms or feeding residents at mealtimes. Similarly, the food services staff spent the majority of time in the kitchen unless they were giving out food and the recreation staff were in their offices when they weren't facilitating an activity with the residents. Team work, then, seemed to come down to an individual's attitude and overall approach to work rather than something that existed in the structure of work. For example, one RN described her

approach: “like if they’re [HCW] really tied up and if there’s a, you have a little bit extra time you can carry on a little bit like sending the tray to the resident or maybe pick up resident’s personal care, ADL. It’s kind of that way and you have to just choose.”

Depending on individual approaches like this nurse, however, meant that effective team work was not always apparent in the organization of care.

The Little “Extras” and Stolen Moments

The pressure on staff to complete their ‘work’, that is, get residents up, washed, dressed, to and from meals, and back to bed, or administer medications, or provide recreational activities for a large group of residents, contributed to an air of efficiency that was not necessarily needed or a reflection of the purpose of the facility. One HCW described her day:

Like for example, in the morning, I want them to have a breakfast, like those people, on time. But some people, they don't wanna get up, right? They wanted to sleep in, so we just leave it. So that's what I do. I like to team up, because I want the residents to be on time with every meals, whatever function, though it's gonna happen, and I want them on time.

For her, the intrinsic, and likely external, rewards of work related to getting her residents to where they needed to be ‘on time’. An administrator commented:

Something like having a bed bath, having my breakfast fed to me, getting me up, there’s a lot of emotional exchange. And we stress our staff out to the point where they’re doing assembly line care, you know, they’re feeding one person and they’re looking over there.

This perceived need for efficiency, having a very high resident assignment load, created stress for staff because they were unable to meet the individual needs of the residents. As a music therapist reflected:

Imagine trying to keep track of 200+ people, and every one of their needs is so important, and so special, and unique. So, we try and target, and we miss often, but every now and then we hit it right on too, and it's so great. So, that's the hardest part for me, is trying to detach from that. It's a tough part of the job.

A Director of Care described a conversation that she often has with HCWs:

They feel pressured, you know, pressure to get things done and I sometimes talk to staff who say 'I just wish I could just sit there for five minutes and I feel guilty leaving', you know, we all do, I feel guilty leaving, you know, because I know I can't spend forty-five minutes chatting in your room, its hard.

I did witness a stolen moment when I was following a HCW on his shift and we walked into a resident's room and discovered a housekeeper was reading the resident's mail to her. Both the resident and housekeeper were smiling and obviously enjoying a few minutes of connection that went beyond the daily routines. The HCW had come in to ask the resident if she was ready to go for her shower but she said that she wanted to wait a bit longer and then the housekeeper laughingly said to us "now get out of here so we can finish the mail." It was a rare occasion when I saw the housekeeper appearing relaxed and not diligently going about her duties.

In sum, staff came to work in LTRC for a variety of reasons and remaining in LTRC was often related to desire or need. There are many groups that contribute to care and each perceived their role and function in the facility very clearly. It was more

difficult, however, to describe how groups worked together as a team, instead members of groups tended to view their ‘team’ as others in the same work category rather than in different groups. Thus, there appeared to be a system of organization of care in which the various groups worked in parallel processes to each other, communicating as needed and helping each other occasionally. This issue and its consequences re-appears in other sections of this chapter. Lastly, there was a tension between the desire to provide the ‘little extras’ of care and the ability to provide these in the context of working in LTRC and so these ‘extras’ tended to play out in stolen moments rather than as an integral part of everyday care.

At the Interface:

Hierarchies, Power Relations, and Acts of Resistance

It was within the day to day milieu of living and working in LTRC that these diverse groups – residents, family members, staff, administrators, and others – converge and interact. I have already presented findings that relate to each group’s purpose and, to an extent their motivations in these settings. In this section, I present the findings that relate to the interpersonal level of interaction in LTRC, particularly the informal systems of negotiation, rule breaking and, ultimately, punishment, that help to maintain the organization of care at an informal level. At this interface, the complex intersectionalities of age, race, class, and gender play out and often position individuals in ways that can liberate or repress their abilities to make choices and feel empowered. Examples of acts of resistance were also evident in some of these interactions. The following section describes these findings.

The ability of residents to have input into their daily routines was largely dependent on their abilities to express their needs and their physical ability to make changes themselves. When daily routines were changed for staff and it impacted upon residents' daily lives, there appeared to be little negotiation around these changes. For example, a number of residents talked to me about the change in dining room seating arrangements at Site A. From the staff perspective, I had been told that the change was to place residents who lived close to each other on the unit together at the same table in the hopes that this would foster relationships. From the resident perspective, though, this change was made for the convenience of the staff. One family member explained how it impacted her relative:

They just restructured the table, all the tables and moved everybody around and she said it was for the nurses so that I guess all the residents of a certain wing would be sitting in one place so that the meds could be given out easier. She wasn't as comfortable with the new people at the table. I think it's a huge part of your day, a huge, huge part and especially in a facility like that, you know if you're sitting at a table where people are pushing their false teeth out, you know, and all covered with food or gumming their food and their mouth is open and are taking half chewed food out of, you know, its nauseating.

She went on to explain how the resident dealt with the situation: "

So finally she just moved herself, "no, I'm sitting here, I can't sit there" but again her doctor probably would have backed her up but as I say she's very independent, she's very feisty, she's not shy to share her views, her beliefs, you know, she's really quite a character.

In this situation, the resident was able to move to her preferred spot because she was physically able to get there and was able to articulate her point of view. She successfully resisted the change in routine. This contrasted with the resident who complains about this issue in Chapter 5. She was not able to move to a preferred table because she was physically dependent, confined to a wheelchair, and was placed in her spot by staff. Negotiation in this situation required physical and cognitive abilities to place oneself on a similar plane as the staff, and, if necessary, mobilize family members or ‘physicians’ to speak on their behalf.

Even residents who were not able to verbalize sometimes engaged in quiet acts of resistance. On a day when I was following a HCW during his shift, we were asked to assist a laboratory technician who had come to collect blood samples from various residents. One of those residents was a younger woman who was not able to verbalize, yet vocalized in loud yells. In this excerpt from my field notes, I describe how the resident attempts to control her environment and actions imposed on her by others despite her physical and cognitive limitations:

She [resident] is sitting in a wheelchair with her back to us watching a show on television. Her body is like a board, the knees don’t bend and it doesn’t look comfortable. The HCW starts to move her out of the room and she starts to yell/shriek loudly. There isn’t really a verbalized word, just short, loud shrieks. He stops moving her and says ‘ok you can watch your show’ and she immediately stops. He goes and gets a lab person to take her blood in the room. There isn’t a lot of room to move in the resident’s room with her wheelchair and bed so the lab tech steps over the resident’s straightened legs and

puts her supply bag on the bed. As the lab tech leans in to find a vein the resident starts to shriek again as the TV is being blocked by the lab tech's body. The lab tech and the HCW can't straighten the resident's arms enough to take blood from the usual spot so the lab tech says she can see a good vein in one of the hands and asks HCW to hold the resident's hand in place. As the blood is being taken, the resident continues to shriek. I hold her other hand and try to console her but she is just trying to stretch her neck so that she can see the TV. Once the blood has been taken the lab tech stands up and goes to her bag which is still on the bed and starts writing on the vial and putting things away. She is directly blocking the TV and the resident continues to shriek. The lab tech then looks at the resident and yells at her 'STOP IT STOP IT STOP IT'. I really felt that at that point she was almost intentionally blocking the TV because she knew that it bothered the resident so much and she was the all powerful blocker of the screen. The HCW didn't say anything he just kept stroking the resident's hand and said "it's ok" although he did glance at me quickly and rolled his eyes a bit. Finally the lab tech left and almost the moment that she was gone and the TV was in clear view the shrieking stopped. We left the room.

In this example, the resident resisted the actions of the laboratory technician in the only way her body was able to express her desires, through loud vocalizations. In this singular act, she was able to assert her desires despite her physical limitations.

Health care workers were another group that was perceived as having little to no power in the LTRC setting. For one HCW, her sense of accomplishment in this setting was intimately related to her work, particularly the outcome of her work – the

accomplishment of tasks and appearance of residents in her care. As the story illustrates, relations of power and acts of resistance in LTRC are complex and, at times, there may be multiple resisters among those who are typically viewed as powerless. A Filipina HCW related this story to me about caring for a younger White man:

Sometimes when I think about it, I realize it's kind of, when you put yourself to them, it's kinda hard to. It's like they live in a jail, someone to tell them to what to do, and what not. So for me, it's kinda like, what to do with them is just kinda respect what they want. I ask them what they want to be done, and which one they like to be. So I just gonna say, "Okay, I respect what they want." So that's what I do with them. But still, some are very challenging. A couple of residents here, three or four of them. One time I forced the other, [resident], he's very... he doesn't want to have a shower, but you can see it, he's very filthy, right? And he's wet and everything. So he doesn't want to stand up, he doesn't want to do anything, he's just sitting on his wheelchair. You know what I did to him? Two of us, so I said, "Okay, you just watch me, and help me." I said to the other care aide. So what I did to him, I take off his shirt, and he doesn't want to stand up. So I said, "Okay fine, you don't want to stand up." So I shower him with the pants, and with the chair, it's wet. I said, "Well, I need to wash him, I can't stand it." So I wash him and everything, and then he still... I thought that he will stand up because he's wet, but no. It's very aggressive, so what I did, I went to get the [mechanical lift], I put him there, me and the other one. I said, "Help me." So we put him there, and then we stand him up, and I took the thing, and then I wash him, and he said, "You're a bitch." He goes like that to me. I said, "Well, I'm a

bitch, but I'm just trying to help you. I want you to be clean." I said like that.

"You're wet already, so we need to change you." And he's just like, "Bitch, bitch."

But then, after we done him and everything, and he said, all of a sudden he said,

"Thank you lady!" [Laughs].

Despite her claims of respecting the residents, this HCW also felt strongly that she has a job to accomplish, which included making sure that 'her' residents were clean, and her pride was closely connected to this work. She persevered through a verbal onslaught and possible physical confrontation with a single-minded intention. For her, this was a story of success, she had used her physical strength and the support of a colleague to complete her work and left satisfied by the resident's 'thank you'. The resident through his best attempts to resist care may also have left with his pride intact.

Power relations, such as the one described above, were often illustrated in acts between HCWs and residents, perhaps because they spent the most time interacting with each other. As described in Chapter 5, at Site A there was a large group of younger residents. Although initially welcomed as an innovation in providing care for this population, there were a number of growing conflicts between staff and this group of residents. Because some of the residents continued to struggle with addiction to illegal substances, staff viewed them as a threat and were quick to label their visitors as drug dealers. At an in-service on working with residents struggling with addiction, one HCW spoke at length about her experience of having a sibling with a similar addiction and the terrible consequences it had for her family. It seemed that she saw every young resident as a mirror of this sibling, to the point where she threw up her hands and said she was fearful and refused to provide care in some cases. When I spoke with the Nurse

Coordinator later that day, she agreed that some staff were retaliating against the younger residents that they had been in confrontations with by refusing to provide certain aspects of care. She was unable to find a solution to address the situation.

Between staff, there were also examples of power relations and, at times, staff would use their heavy workloads to avoid 'helping' other groups of staff, yet ultimately the ones who suffered from these acts were the residents. For example, resident participation in recreation activities, particularly for physically dependent residents, relied heavily on HCWs bringing residents to activities because there simply were not enough recreation staff to get all of the residents. However, HCWs were often perceived as being resistant to bringing residents to activities, claiming they were busy with providing direct care. Because of the small number of recreation staff, this meant that some residents who may have participated in activities did not because they were not physically able to get to the activity without assistance. This also impacted residents' participation in religious activities because they were on Sundays, when there were fewer or no recreation staff to help transport residents. Often only a chaplain and volunteers were available to bring large numbers of residents to the room where services were held. Thus, the large care assignments for HCW was used as an excuse for not getting some residents to activities and services that brought meaning to their existence.

Another example of power relations among the groups working in LTRC took place at a staff meeting I attended. All the staff from the unit were at the meeting: RNs, the Nurse Coordinator, HCWs, the Housekeeper, the Unit Clerk, and Activity Staff. There were also three administrators: the Director of Care, the Activities Director and the Manager of Housekeeping. The meeting centred around the unit's smoking room, which

was becoming increasingly messy because residents were spilling coffee and cream and leaving garbage all over the room. The group had come together to discuss the issue and to talk about solutions. The discussion went back and forth and there was a lot of finger pointing about which residents in particular were responsible. However, there came a point when the staff most affected – the Housekeeper – became very frustrated and spoke out. The following is from my field notes:

When she [Housekeeper] spoke to another resident who made a mess right in front of her, the Housekeeper said that when she asked the resident to clean up her mess (spilt coffee), the resident replied “Fucking bitch, I didn’t move in here to work.” None of the directors made any comments or showed reaction to this, rather they focused on what could be done to change the situation. No one offered any support to the Housekeeper for having to deal with this verbal abuse from residents. The Housekeeper and Unit Clerk also pointed out that the worst mess is made after they leave for the day, in the evenings when there is no cleaning staff. At this point it finally comes out that the reason this has become a topic for this meeting is that the night before there was a huge spill of coffee in the smoke room and, rather than get a mop out and clean it out, the evening staff had placed a caution wet floor sign outside the smoke room and left the mess for the Housekeeper to clean up in the morning in addition to her regular work. The Unit Clerk sitting next to Housekeeper said “we are peons [that is, Unit Clerk and Housekeeper], they [residents] won’t respond to us when we ask them to clean up, they will only listen if it’s one of you” and gestures towards the administrators, “they know who has power to enforce stuff and who doesn’t.”. None of the

administrators responded, then the Nurse Coordinator said “I am willing to enforce cleanliness if people tell me right away when there is an issue” and then the activities director said “yes, you can come and get any of us at any time.” Thus, here was a situation where everyone silently acknowledged that the Housekeeper and Unit Clerk were viewed as powerless by the residents who were willing to take advantage of that. When I spoke with the housekeeping manager later about this incident she went into great detail for me about the external Workers’ Compensation Board guidelines around cleaning a smoking room and said:

Brings in the fact that the level of our resident care needs are going up and the people that smoke need more attention, I guess, is basically what that was showing in terms of how we negotiate, how we deal with that truly is a negotiation process.

She continued to ignore the interpersonal issues that were brought up by staff at the meeting, around power and place on the hierarchy of LTRC instead operationalizing the situation in terms of changing resident needs. Thus, the administrators, people in positions who might have addressed the power relations operating along lines of hierarchies of class in LTRC, appeared to be oblivious to the frustrations of the staff or were unwilling to address these issues.

Family members, particularly those who spent large amounts of time at the facilities, were also part of this power dynamic in the informal organization of care. Like the residents and staff, if they overstepped their boundaries as outsiders/informal care providers, there could be consequences. A family of siblings who provided the majority of evening care for their mother were quick to complain to the Director of Care if they

saw shortcomings in care, particularly if they missed an evening and care was provided by staff instead. The relationship between the family and the facility's administration had become quite antagonistic. The daughter told me that she had just attended a meeting with the Director of Care and facility's owner where she was threatened that if she and her siblings continued to make 'unreasonable' requests about their mother's care that the facility would waitlist her for another facility. Despite their significant contributions to care, this family was viewed as an irritation because they had pointed out shortcomings in care and were now in such a tenuous position that they had decided to 'back off' and redouble their efforts to provide the hands-on care that they did not trust the staff to do. In a similar example, a husband of a resident, who spent the majority of each day at the facility, told me what happened when he complained about the behaviour of one of the food services staff to the manager:

I had a little set to with [manager] in food services awhile ago. We had one of, that serve the lunches, you know, was just being a, just being a, you know, picking at people and stuff like this, you know, and then I reported it, you know, just so they know and I was like the bad guy. Laced me down, up one side and down the other because, you know, we're not supposed to be, family members are not supposed to be behind that [kitchen] counter in any way, shape or form, the only people that are supposed to be down behind that counter is if they have a food safe certificate. Which I think is a crock because they've got people [residents] out there in the main cafeteria setting tables they're not food safe, and that's, I brought that to her attention, she said "well, we like to let these people help when they can" but I said "you're telling me I can't do it there". I go in there

and I always wash my hands before I go near the food place or anything and usually they're in there, they put the food on the plates and I just deliver them to the table, most times its, sometimes like I stay around for afternoon snacks, well, some of them are fine, they, they get the tray ready for the snacks, a lot of times they're busy taking their breaks and they don't, they don't do it so if I don't, I said well, if they're not there, who, how do I get the snacks, they said well you ask someone to do it for you, you'd be surprised, you know, I said who do you ask when there's nobody there.

Here was the husband supplementing the low staffing by assisting with distributing food and by doing the afternoon tea and snacks, yet after a complaint was threatened with having these activities restricted. Of course, the likelihood of these administrators to carry out these threats is probably small, but for family members the possibility that they might come to fruition were enough to make them back off. It was an example, too, of administrators in positions that provided them with a lot of power, explicitly using their power to control others, thus reinforcing the hierarchy that existed and using it to their own advantage.

The physical environment was also a constant reminder of people's roles and social positionings within these facilities. At both sites, the staff rooms were windowless rooms in the basements filled with what appeared to be leftover furniture.

Administrators, on the other hand, had their offices on the main or top floors. On only one occasion during ten months of field work at Site A, I went to eat lunch with the administrator group. When the staff saw that I was taking food to the elevator, the janitor jokingly commented "so you're going to the penthouse today are you?"

In summary, relations of power in LTRC are complex and reflect the hierarchies, or ‘chains of command’, discussed by scholars previously in the literature. Acts of resistance grew out of reaction to this hierarchy, as individuals struggled to assert their identities and desires, sometimes shifting the power relations. Those in traditional positions of power were covertly and overtly complicit with this structure, making it difficult to imagine a LTRC setting where it would not exist. Even the physical environments were set up to support the existing hierarchies.

The Valuing of Care of the Older Adults and of Their Care Providers

The previous section presented the findings related to the interactions between various groups in LTRC. This section shifts to examine in more detail how the conceptualization of care of older adults, particularly the value placed on care and type of care providers, also contributed to the informal organization of care. I begin by presenting findings related to conceptualizations of care of older adults and then shift to consider the class stratifications, or hierarchies, in nursing that also influence the valuing of care for this population.

Valuing and Devaluing the Aging Process in Nursing

Approaches to caring for older adults were often influenced by an individual’s understanding of how care should be provided. Because many of the staff in LTRC are immigrants, their views on care for older adults was often related to how older adults were treated in the person’s country of origin. At both study sites, many staff were originally from the Philippines, where a similar model of LTRC did not exist when they were growing up, rather older adults were cared for in the home by their families. At Site A, a nurse described her experiences of elder care in China for me: “I mean the personal

care belongs to the family, it's the family's responsibility, if you have daughter, you have son, if you don't take care of your parents then that will be a thing and its not acceptable." Because many of the staff came from places where care of older adults was provided by family members in the home, and perhaps where aging is seen as a natural life process that was not overly medicalized, they had to adjust to the notion of institutional care. While there was a respect for older adults in general, these staff often expressed disdain for families of the residents as institutionalization was viewed as a failure on their part to provide care in the home. As well, in describing their relationships with residents in terms of familial relations, some staff may also have carried the belief that care of older adults is the domain of the family, not of the medicalized institution.

The devaluation of nursing care of older adults continues to be ingrained in Western education programs. One of the administrators commented on how nursing students are introduced to gerontological nursing:

The contact point for older adult health is right at the very beginning when you first do your first clinical practicum and you learn how to do a bed bath. And you go to an old age home or geriatric unit and you do a bed bath with old people and you help them with their meals or you do incontinence care or whatever it is that you're doing and that is your idea then for the rest of your schooling as to what it is to provide nursing care for older adults. Whereas in reality it should be at the end because the health needs are so complex for this population.

Valuing of care for older adults was also reflected in the lack of interest in LTRC as a 'chosen' workplace. Many of the staff had come to this setting by default because of the availability of work or because of the convenience of location. Even worse, though,

were the staff who came to LTRC because it was perceived to be an area requiring less knowledge or skill than acute care. This was the reason provided by one nurse who explained to me that when she came to Canada and received her license she worked in LTRC because she did not want to do a refresher to work in acute care. In sum, care of older adults was influenced by how a person understood how this care should be provided, whether by the family or in an institutional setting. These beliefs translated into how care was provided and influenced relationships between staff, residents, and families. Because many staff who were immigrants had not lived in countries where institutionalization of the elderly was common place and there continues to be a lack of gerontological nursing preparation in nursing education programs locally, there is an overall gap in valuing the specialty area of practice of gerontological nursing in residential care settings.

Class Stratifications in Nursing

The valuing of care of older adults was compounded with the valuing of different types of care providers. Within the nursing staff at the sites, there were the typical three main categories: RNs, LPNs, and HCWs, and they functioned in a clear class hierarchy. In part the hierarchy was maintained through poor understanding of each other's roles and lack of appreciation for the demands of each others' work. An RN explained how she felt the other staff perceived her work: "they thought 'oh except medication we don't really do anything else' because they felt maybe after medication you can pick up maybe some other things for the personal care but they, no, they understand a little bit but not a lot."

Within the sites for this study, there was beginning to be a convergence of RN and LPN positions, as direct care RN positions were deleted and became LPN positions. The lack of understanding of the different roles, therefore, was not surprising when they could be interchanged so easily. As mentioned in a previous section, this situation contributed to feelings of hostility in some LPNs who saw themselves as doing the same job as their RN counterparts, but for less pay and, sometimes, with additional responsibilities for hands on care that the RNs did not have. An LPN who worked in the Special Care Unit at Site A compared her work to the RNs: “It’s really... it really is the same thing. But virtually, in a long-term care setting we [LPNs] can do almost everything the same and do just fine.” At Site B, many of the LPNs who were new graduates had worked exclusively at that facility and consequently, were not really aware of differences between the RN and LPN scopes of practice because they had never worked alongside RNs.

There was also a class distance between the RNs and LPNs, and the HCWs. Although care of the body had in the past perhaps been the auspice of the RN, all personal care related to the body was now provided by HCWs. At both sites, the RNs and LPNs were busy mainly with medications and paperwork and relied upon HCWs to tell them if there was a change in a resident’s health status at which point they would do an assessment. One RN at Site A actually articulated her dislike for the “dirty work” that was the domain of the HCWs. Her preference was for the paperwork and physician contact that she perceived as the domain of the RNs. This attitude about hands-on care contrasts sharply with the HCW who forced the resident to have a shower in order to get him clean, which was how she felt pride and accomplishment in her work.

The divisions between these groups could be visibly observed in a number of ways. First, there was where they physically spent their time, with the RNs and LPNs remaining mainly at the nurses' stations unless they were doing medication rounds or wound care, while the HCWs spent their time with the residents doing the hands on care. Second, there were differences in the way that staff dressed. At Site B, for example, all of the HCWs and LPNs wore scrubs while the RN Program Manager and Director of Care wore street clothes, probably because they were less likely to get their clothes soiled through close contact with the residents. Third, as described previously, when asked about team work, members of these various groups rarely mentioned each other as part of a cohesive team, rather they viewed their work as separate, and largely independent of each other.

In sum, the class stratifications in nursing in LTRC were clearly defined in this study. These class lines illustrate how intersectionalities were operating: the majority of staff were Filipino and female, and so the class differences fell along the lines of education and pay (with HCWs at the bottom of the hierarchy). Thus, the valuing of different kinds of care, such as paperwork versus hands on care of the body, compounds with the social positioning of individuals and groups grounded in intersecting axes of oppression, resulting in clear class stratifications among those caring for older adults.

Intersectionalities: Constructing Difference among Staff

Within the study sites, race, gender, class, and age operated to support the traditional hierarchies and relations of power of LTRC. In this section, I discuss findings that illustrate in more detail the complex workings of some of these intersections.

Long-term residential care is traditionally considered a female work place. In this study the majority of staff at both sites were women, but there were also small groups of men working as RNs, LPNs, and HCWs. Because HCW work entails personal care of residents (that is, bathing, dressing, toileting), the male HCWs that I interviewed talked about the gendered nature of their work: “There’s some challenges [when you are a male HCW] and, you really have to work on some level of trust with some of the residents because they’re, you know, I mean its an invasion of privacy so they have to really, they have to really trust you so that, I think that’s the biggest challenge building that trust.” This staff member also commented though, on the similarities of difference he saw between being a male HCW and being from a different ethnic background than the mainly White resident population: “there’s residents who have never, people who have never really dealt with somebody from China before really or, you know, they’re dealing with some people I bet sort of might have sort of an ethnic barrier to cross in dealing with the residents so its different for everyone.” Although there were issues around ethnic differences, residents were allowed to refuse care from a HCW of the opposite sex, which could add significantly to the workload of female HCWs, but they could not refuse care from a HCW from a different ethnic background. There were also some different expectations of male care providers. They were often called upon to provide ‘muscle’ if residents had fallen or were intoxicated and needed assistance to get up. This tendency to call upon the men to do heavy lifting could put them at greater risk for injury.

Essentialization of groups of staff who shared a common cultural background was also evident. Many LTRC facilities have a large proportion of staff who are people of Colour. I have worked in facilities where the majority of HCWs are Fijian and also

where there are large groups of Filipino staff. At Site A, there was a diverse mix of staff, likely due to hiring strategies of administrators. One of the administrators commented on the tendency of LTRC facilities to hire staff according to skin colour:

When I first got here I was surprised because the facility I came from it was very, the staff was very, very white so when I got here and it really struck me actually the first, the first whatever, couple of months I was working here how non white it was right so that was kind of interesting and it made me think how probably hard the hirer at my last facility was working to keep it White.

Yet this was juxtaposed with her comment about the senior leaders and board at Site A: “its hard too because there’s, there’s an influence from our board too that’s very White again, so its White bias, the board, and its also age bias because they don’t, support the younger residents in our organization, they feel that they should be all seniors.” She further reflected on the Whiteness of the administrative team in comparison to the staff population. Her colleague, who managed the housekeeping and food services staff, explained to her hiring practices to me, in which she ‘balanced’ her staff:

There’s a lot of ESL people that come through those [training] programs and what I try to do is I try to like balance that somehow, you know, if I’ve got a lot of people out of that type of program then I also want to look at people that have like hospitality type of background as well. I will say that the institutional aide tends to be the East Indian cultural people that come through that and which, which is fine but you try and sort of balance that and not, and make sure that you haven’t got too many of one sort of culture in your staff mix.

She used education as an excuse for excluding South Asian applicants from being hired. When these hiring practices are considered at a broader level, they can have insidious implications for equitable hiring and access to unionized work environments where pay and benefits can vary significantly from non-unionized work settings.

Site B contrasted from Site A in that almost all the care providers were Filipino. In one of my initial meetings at the site when I was introducing the study to staff, I comment in my field notes about being the only White person in the room. Perhaps because there was such an obvious ethnic grouping in the staff, participants from Site B tended to comment on it. Residents and family members spoke about people of Filipino descent as being ‘made’ to be caregivers:

Participant: I can’t say enough about the Filipino girls. They have to be Filipinos though.

Researcher: Yeah?

Participant: They do because there were two white ones here and they’re gone, two Canadian ones.

Researcher: Why are they gone?

Participant: Well, I don’t know the reasons. I can imagine...

Researcher: They weren’t any good or they just...

Participant: No, they probably said, “I’m not going to work for this bloody money wiping bums all day.” That’s the difference. It’s not a pleasant job. And you’re dealing with all kinds of people [that] are out of their minds, and they scream and they shout and they call you names. The Filipinos are born caregivers.

Filipino staff were, therefore, not just seen as being good care providers, they were also seen as being willing to do a particular kind of work and for less pay than a White person. This was articulated as a character trait that they were 'born with'. They became then almost invisible supporting players, rather than legitimate members of the health care team, as this comment by a family member illustrates:

The biggest issue in medicine right now, in medical care, is there are no longer champions. There are pill pushers, pill dispensers and a **bunch of Filipino people** all around to try and support those pill pushers and pill dispensers. And that's not intended in any way as a prejudicial or comment that's putting down anybody. I'm stating what I see as I look at our medical system. People who prescribe pills, people who dispense the pills and then a whole bunch of folks who are around basically to support those people who prescribe and dispense.

The Filipino staff were not seen as being knowledgeable to prescribe or dispense but rather to be there to do all the "dirty works" that are left over.

These essentialized and racialized ideas about people of Colour who work in LTRC were justified by other participants in relation to issues around language proficiency. In a field note I recorded this comment from a White administrator:

It's nice that we live in a multicultural society but in LTRC (particularly those facilities that that are contracted out) you have staff that don't speak English providing care to older adults who are Caucasian, have dementia, and are hard of hearing - how are they going to understand what their caregiver is doing if they can't understand a word they say?

A colleague of hers added:

People who are not proficient in English and are now trying to figure out how best to work with those people because it's hard enough to supervise and lead a group of staff when you speak the same language, you know. Beyond... when you get into language barriers, it does get pretty tricky.

This recalls again the hiring practices of the manager at Site A, justified by expectations around education.

In sum, complex intersectionalities were operating in LTRC to construct roles and individuals across race, gender, class, and age. At times, this positioning contributed to a redistribution of work, with a greater load going to those with in the lowest position in the hierarchy: female workers of Colour. There were also essentializing notions about members of large groups of immigrants, particularly those from the Philippines. White administrators and family members often justified their words and actions towards these individuals and groups by attributing blame to poor education of immigrants and language barriers, and were, ultimately, acting in the 'best interest' of the residents.

Chapter Summary

The informal organization of care in LTRC was a compilation and contradiction of efforts among disparate groups. I began the chapter by considering the role of a group that exists on the periphery of the institution – family members. These individuals play many roles, from the absent, to the devoted caregiver, to the vigilant watchdog. Although their contributions to care were almost an essential supplement to the formal care provided by the facility, the role of families was strictly monitored by administrators and staff and there were consequences for family members who asserted themselves beyond this peripheral role. Next, I presented findings about the formal care providers, the staff.

There are many groups that contribute to care in LTRC, and while they were all clear about their roles, there were difficulties in distinguishing between groups contributing to some role overlap, and consequently, tensions between the groups. Not surprisingly, a cohesive sense of team work across these different groups was lacking; rather they mainly worked within their groups. Given the workloads in the study sites, many staff also expressed distress about not being able to engage in more emotional, relational care with residents. I then moved from considering roles to the day to day activities in LTRC, which were characterized by power relations and acts of resistance. These dynamics worked against the backdrop of class hierarchies in LTRC. Next, I discussed the value of care of older adults and the consequences for valuing gerontological health work. Within the ‘work’ of caring for residents, there was a class stratification, with those at the top concentrating on paperwork and those at the bottom actually providing hands on care. The last section of this chapter focused on intersectionalities of difference operating among those who work in LTRC. In sum, the informal system of care in LTRC was maintained by a strict hierarchy of groups and work. Within this hierarchy, however, there were acts of resistance by those rebelling against the rules and routines, sometimes leading to shifts in the traditional power relations. In the following chapter, I move on to consider some of the formal systems that influence how care is organized in LTRC.

CHAPTER 7:

THE BUREAUCRATIC ORGANIZATION OF CARE

In Chapter 5, the residents spoke about what it is like to live in long-term residential care (LTRC). Chapter 6 focused on the informal systems that shape what it is like to work in LTRC and the organization of care at the interpersonal level. In this chapter, I turn to the formal structures that influence the organization of care, such as the operationalization of health policy and the structure of the health care system, structures that I call the bureaucratic organization of care. I begin by situating LTRC within the larger health care system. Then, I describe LTRC as a multi-tiered system itself, which is increasingly a blending of public and private. Next, I describe staffing issues, with particular attention to unionization and contracting out of staff. I move then to findings about the structure of surveillance and accountability in the LTRC system. I shift then to present findings related to care transitions for the residents of LTRC, including issues related to admission, care transitions within the health care system, and the influence of complex care on these processes. Next, I present findings related to leadership in LTRC, including primary care, nursing, and administration. The chapter concludes by considering how the discourse of corporatization is becoming a driving force in LTRC.

LTRC as Part of the Larger Health Care System

LTRC is not part of the Canada Health Act and, hence, the values put forth in the Act are not guaranteed to LTRC. This sector does function though, alongside acute care as an integral component of the health care system. Throughout the study, participants expressed a tension between LTRC and acute care, in which LTRC is constructed as a system that is dependent on acute care and that places high demands on the acute care

sector. For instance, LTRC does not have access to the diagnostic and treatment equipment available in acute care and so residents must be transferred to hospital for procedures. As illustrated in Table 4.7, as the medically complexity of residents has risen over the past decade, so have hospital transfers for those living at the study sites. Although the number of new admissions at each site remained stable, visits to the Emergency Department by Site A's residents more than doubled between 2000 and 2005. Similarly, hospital admissions for Site B's residents almost doubled in 2005 compared to 2000. As the following paragraph illustrates, while acute care is viewed as a powerful driver of health care, those who work in that environment may not fully understand the workings of LTRC and its capacity to provide complex medical care.

As one administrator commented, "we're very driven by acute care, you have people in acute care making decisions that have no idea what long term care is." Decisions made in acute care often reflected the pressures in hospitals to discharge complex patients in order to make room for new admissions. Discharges that were particularly complex and highlighted the lack of understanding of LTRC resources were those that happened on weekends. For example, staffing levels are typically lower in LTRC on the weekends and they often have limited access to their pharmacy in order to obtain medications for a new or returning resident. An administrator from the health authority (HA) characterized these discharges and expectations of LTRC facilities: "the need for facilities to go 24/7. And yet not having the leadership support on the weekend. Some of the worst admissions are the one's that are highly stressed. 'We need to move you out, the hospital is in congestion, we need to move you out from the weekend'." Throughout my field work, the expectation placed on LTRC by the hospitals to continue

to accept residents more quickly either as new admissions or as returning from a hospitalization was continuing to grow.

There were also issues related to the care received by older adults in acute care in general. One administrator described the impact of a premature admission to LTRC for an older adults who was discharged from hospital:

You know, they're [older adult] not residential, they should be able to go home but acute care won't give them long enough time to get better and we know that, you know, there's all the research out about elderly take longer and they don't get better in three weeks when you have a fracture like a younger person would but we don't give them time. It's a time frame, 'you have this amount of time to get better, if you're not better then you're in residential' and then six months later after that I'm coming in to help somebody to go back home.

She went on to explain then when this occurred, a resident or their family may have sold their home or vacated their rental accommodation. Therefore, if they were able to return to a level of functioning to return to the community, their home and possessions were often gone.

Some residents who ended up in the study sites had spent long periods in acute care settings before moving to LTRC. When their family was involved, the family members had strong opinions about the quality of care provided in hospital which could impact their initial impressions of LTRC. One wife referred to the hospital unit where her husband had been as a "holding place". In another interview, a son described his experiences of having his mother hospitalized for a fractured hip, which ultimately led to placement in LTRC:

In the time she was at the hospital, she was treated like an animal. There were times... she reacted very badly to the sedation they gave to her, to the morphine. Their response was to tie her down. There were times, I mean we would go there at all hours of the night and there were times when we would go there to see her, where she was literally laying in a pool of urine with the wound where she had just had surgery, laying in that pool of urine and I could not get a nurse to come out and deal with that.

Not surprisingly, when families had these experiences, they often arrived at the LTRC facility very cynical and angry. This situation had consequences for relationship building between residents, family member, and staff. In sum, although LTRC is part of the larger health care system, it is often poorly understood by those in acute care, making it challenging to have smooth transitions between hospital and LTRC. Pressures from acute care can contribute to LTRC admissions that are premature or that occur when the facility does not have staffing or access to resources, such as a pharmacy, to adequately admit a new or returning resident.

LTRC as a Multi-tiered System: Public and Private

I turn now to present findings related to the public and private aspects of LTRC as part of the larger public health care system. As described in earlier chapters, LTRC in British Columbia is a mixture of not for profit, for profit/privately owned, and health authority owned and operated facilities. In this study, Site A was a non-profit facility and Site B was a privately-owned, for-profit facility, yet all the beds in both facilities were contracted by the health authority meaning that all beds received public funding. This led

to the perception that, because the funding for each facility came from a public source, the provincially-funded health authority (HA) that care was part of the ‘public’ system.

It was apparent however, that the values underpinning care delivery in the sites differed between the non-profit and the privately-owned, a difference discussed by a variety of participants. As one administrator from the non-profit site said about privately-owned, for-profit facilities: “It’s a lot of money to be made and I don’t think it can be stopped. It’s a different goal. The ultimate goal here is to yield a profit.” A family member echoed: “It’s a business for them, the owners. It’s just a business.” As an administrator from the non-profit Site A observed: “I do see the private guys not having the same goal, and it’s totally ‘What can we charge? What can we do? What is the responsibility of the public and how can I make my money?’ We [non-profit] don’t think that way at all.” The drive to create a profit puts pressure on staff at the private facilities to keep their beds filled, which is how income is generated in LTRC. An administrator from the HA said: “They all have pressure to fill the beds because the health authority pays for those beds. But if they’re private, they’ll be getting pressure from their owner. Fill the beds, fill the beds.”

Funding

Funding for the facilities came from a number of sources. Each resident in a publicly funded LTRC bed pays a per diem rate that is needs-based according to their income on their annual tax return. Every six months or so, the provincial government publishes a new funding rate for LTRC residents, which is based on cost of living and inflation. The other main source of funding is the per diem rate for each occupied bed from the health authority. The HA negotiates a per diem rate with each facility

individually for the care they provide. Although per diem rates are not in the public domain, rates received by the study sites which the administrators provided me with ranged from \$118 to \$195 per resident per day.

Again and again administrators who participated in this study talked about the lack of standardization of per diem rates. Much of the current funding model was historically based, so facilities like Site A, which used to have a population with lighter care needs, was funded lower than facilities that traditionally had residents with higher care needs despite the reality that all facilities must now meet the needs of the complex care resident population. It was difficult for facilities to knowledgeably argue for an increase in per diem rates, however, because these rates are not in the public domain so there is no way to compare with other facilities unless an administrator chooses to share the information. An administrator at Site A explained that some small non-profits were unable to provide care within their current funding levels and have considered selling. She said that the large for-profit corporations are eager to purchase these facilities and add these beds to their funding base. Ultimately, she saw a future where almost all LTRC facilities could be owned by private companies. The lack of equalization across funding was juxtaposed with the expectation that all facilities provide a similar type of care, particularly those that are under the licensing act.

When the combination of the HA funding and resident contributions were not sufficient to meet the costs of running the facilities, the administrators had to find other sources of revenue, and often this meant creating extra charges for the residents. Administrators described for me some of the strategies that facilities have developed to meet funding shortfalls. I heard of facilities where residents were charged if they wanted

to change rooms. At Site A residents had access to a full spectrum of recreational activities including music and art therapies which were largely funded through fundraising campaigns from external sources. At Site B, on the other hand, there was an extra charge for music therapy and for other activities that did not fall within core services. At Site B, there was also a room differential for a semi-private or private room, whereas at Site A all rooms were private and there was no differential. At Site B the privately-owned, for-profit facility, some of these charges also contributed to the profit for the owner. In sum, funding issues in LTRC highlight the inequities in funding across multiple sites. To make up any shortfalls or to turn a profit, facilities are becoming increasingly creative in finding ways to charge residents for services than may have, at one time, been part of their care. As discussed later in this chapter, it is important to underscore here that residents do not have a choice as to the facility they go to because of the First Available Bed policy, raising further questions about the equitable distribution of resources (that is, funding) by the health authority across the many sites it funds.

Staffing

Currently, there are no provincial standards around staffing levels in LTRC, so they can vary greatly. In Chapter 6, I described the different groups of staff working in LTRC, their roles, and team work. In this chapter, I focus on broader issues around unionization and contracting out. As an administrator said about staffing levels and staff mix in LTRC: “there are no good tools for staffing measures so nothing to measure adequacy of staffing other than failures.”. Table 4.8 illustrates the changes in staffing levels and staff mix that occurred at the study sites between 2000 and 2005. At Site A, there had been a shift in RN positions to create more Nurse Coordinator position,

meaning that while the absolute amount of RN time had increased, it had moved away from direct care. Most of the work groups, including HCWs, Housekeeping, Food Services, and Recreation had seen small decreases in staffing, while there was an increase of LPNs to reflect the change in the RN model. At Site B, where staffing services had been contracted to a private company, there had been a sharp decline in RN positions, which were replaced by LPNs. For HCWs, there had been a shift away from full time to part time positions, which may have forced some staff to obtain additional jobs. Because services were contracted to a private company, information about the staffing levels for food services were not provided (although the company providing care services did supply this information). Overall, there was a decrease in RN presence in direct care at both sites and, despite the increasing complexity of residents there were not any marked increases in staffing at either sites to address rising resident care needs. Again, this likely relates to the largely unchanged funding levels from the health authority.

Unionization and Contracting Out

As discussed in the literature review in Chapter 2, the provincial government in British Columbia made it possible for facilities to contracting out for care staff in 2001 under Bill 29. When contracting out was introduced, facilities had a choice to make as to whether to keep their unionized staff or contract services from a private company. There were a number of reasons why a facility may have chosen to contract out, the main one being cost savings because the staff could be hired at less cost than union staff and the facility was not responsible for benefits or pension costs. In my field notes with one of the health authority administrators, she offered additional reasons for contracting out:

[she said] there are two reasons why facilities chose to contract out earlier this decade when it became allowed: the first was to break the strong union culture that existed in some facilities. She said that the care aide [HCW] union basically out priced itself when they demanded wages that were close to those of LPNs. As well, in some facilities, the care aide group was so strong that they would 'have fun' breaking new RNs and refuse to do work when requested. The second reason for choosing to contract out was to save money. While this is a pretty obvious reason, some facilities rushed into contracting out without really thinking through the contract and ended up with bad contracts that have had a very negative impact on quality of care. With this comment of hers, I would agree.

Because contracting out had not existed prior to this, those facilities that did decide to go this route were entering new territory. As the HA administrator suggested: "definitely those that made the choice to contract out are paying the price. Some contracts were made without thinking them through very well and there are very bad consequences for care." One of the consequences that affected residents was the turnover of staff: "the flipping, flipping, flipping of contracts, instability of staff so increased stress on the staff leading to, you know, increased movement, flipping, you know."

Families who experienced the transition between union staff and contracting out also noticed differences. As a husband of a resident said to me: "most of the homes, years ago, they were all unionized. And of course when you have a union you have more staff. That's one thing the union insists on." This family member had witnessed the elimination of RNs from Site B and the shift to an almost exclusively LPN/HCW staff. For residents and family members, there was a personal cost of contracting out to the

relationships they had forged with staff. At Site B, many family members talked about discontinuities in care with ongoing changes to the contract company.

At Site B, the owner, who did not have an educational background in healthcare management or a clinical designation, did choose to contract out. He told me: “we were going to be running a deficit and basically looking at closing our doors because we couldn’t... you can’t run a business if there’s no profit. And so we were able to create a profit again and also increase our staffing levels.” The part he neglected to talk about was that in order to create a profit and increase staffing levels, the direct care staff (HCWs) had significantly reduced pay and lost all benefits. While no one would tell me directly how much the HCWs earned at Site B, the range provided by Site B’s Director of Care based on her knowledge of several companies was \$13 to \$17 per hour compared to about \$20 per hour for unionized HCWs. I did not find out what the differences would be for housekeeping staff or food service workers.

It’s important to note that in addition to a differential in pay, contracted workers often do not have the job security, medical and dental benefits, or sick leave benefits of their unionized counterparts. RNs and LPNs with contracted companies, on the other hand, were paid higher than their unionized counterparts. In the market driven environment of contracting out, where there is an international shortage of RNs and growing competition for LPNs, they can earn more working for a contractor. Thus, these higher paid, higher educated staff had little motivation to advocate for better working conditions for their low paid co-workers.

Many of the staff, particularly HCWs, at Site B were reticent to talk with me about what it was like to work in an environment where care was contracted out. At Site

A though, there was a HCW who I had previously worked with at another facility. I had left that facility before care was contracted out and she shared her experiences of what had happened after I left:

It [contracting out] doesn't work, I don't think it works. Because the... I think a lot of it is the care staff that they hire isn't from... they're mostly from private schools. If you attend a private school, it's very expensive. I don't believe that you can fail the course. I don't... I've never heard of anyone that paid whatever it was, the ten grand for the course that failed it. So it doesn't really matter how good or how bad you are.

She had remained at the facility after contracting out for a time. Because she had been at the facility for almost 20 years, she was often asked to provide orientation for the new contracted staff. She shared with me her perception of the newly hired staff: "I would orientate someone for, usually it was about three or four days and they wouldn't come back and I found that the language barrier, like a lot of the care staff had very poor English." She also told me about the reaction of the residents to the change:

Well they resisted care a lot and a lot more. Like I found that some of the residents that normally wouldn't resist care, would from these particular... of course, from these particular people. And another thing was the uniforms. Like I've worked one day [as unionized employee with facility] and the next day I was scheduled to work with the contractor and then we were all wearing these awful uniforms. And a lot of the residents were freaked, crying. Because I think they felt that they had moved. That they were in a different place.

Since leaving that facility she had gone back to visit and described for me what one of the more vocal resident's opinion had been:

...like she doesn't recognize a lot of the people, right? It's not that family oriented anymore. Because these guys are too tired. Like the care staff are so tired because the wages are so low. You punch your time there and then you go to your next job, right? And work your other shift. So you're... you don't care, you're too tired. You're too tired to care.

Now that the HCW had settled in at Site A, she reflected on her experience of having been contracted out: "I think it worked out, well you have to make it work out, right? When they slap you in the face like that." She also had a new sense of caution and was constantly concerned that Site A may also become contracted out.

Union jobs, like those at Site A, have become very attractive in a competitive job market for low paid, low status workers like HCWs. Yet there were barriers to obtaining these unionized positions. For example, there were the hiring practices of individual managers, like those discussed in Chapter 6. The Director of Care at Site B also mentioned a program for HCWs which she no longer allowed to have student placements in her facility because "none of them spoke English." The potential consequence of this situation was that students, often recent immigrants, who attended certain educational institutions have their employment opportunities severely limited because of the reputation of the school.

In sum, the lack of standardization around staffing levels in LTRC has created a system where each site has evolved its own staffing model. With the introduction of contracting out in 2001, there have been consequences for care. The impact for residents

and family members has been around continuity of care with frequent staff turnover. For staff, there has been significant losses around wages, job security, and benefits. As well, there remain many unanswered questions about the outcomes of this new model of care.

Licensing, Surveillance and Accountability

Within the LTRC system there are mechanisms for surveillance and accountability. Licensing is one of the main sources of surveillance. In describing the role of licensing, one of the health authority administrators talked about using these guidelines as a way of ensuring that facilities meet minimum standards for care provision. However, licensing guidelines do not provide any standards around staffing levels or staff mix. So, at Site A for example, there was one HCW assignment that was a 1:24 ratio. Importantly, not all LTRC facilities were even covered by licensing. Site B was an example of this historical anomaly and it was covered by the Hospital Act. Consequently, elements of Site B may not have met licensing requirements and there was no way for the health authority to enforce even these minimum standards.

To address this gap, the HA had recently reorganized its residential care portfolio to include facility case managers. These staff provided liaison services between the HA and facilities, mediated unresolved complaints and conflicts between the resident/family and facility, and served a policing role in areas that were not covered in licensing (or bring in licensing where they deemed necessary). New residents now received a letter stating that they could take complaints directly to the HA if not able to resolve with facility. One of these administrators described the perspective of facilities on this new system of surveillance: “there are facilities that have a very strained relationship with the health authority, a real concern, you know, the big brother of being watched.” Although

there was a strained relationship with some of the facilities, the introduction of this role by the HA also demonstrated the growing recognition of its accountability for care provided with public funding. In sum, there is a system for surveillance of care in LTRC: licensing. However, because not all facilities are under licensing¹⁰ and with growing recognition that there is some accountability for care being provided with public dollars, the HA where this study took place has instituted another layer of accountability within the system.

From Warehouse to Way-Station

One of the participants referred to LTRC as a “warehouse”, yet recent policy changes have shifted this a bit and also made it a ‘way-station’, or a place where people stay briefly and then move on. This section presents findings related to transitions in care beginning with admission and the First Available Bed policy, then other types of care transitions and, finally, the complexities of complex care.

Admission and the First Available Bed Policy

In 2001, the system of chronological waitlisting for LTRC facilities was discontinued and the First Available Bed (FAB) policy was adopted. In essence, this policy meant that rather than having a choice of facilities, potential residents were placed in the first available appropriate bed. From that facility, residents could then request to be placed in a preferred facility. I describe the consequences of FAB later in this section, but begin with a description of how the admission process has evolved over the past decade.

¹⁰ A number of facilities are not covered under licensing. Rather these facilities tend to fall under the Hospital Act. The facilities that remain under the Hospital Act were often private hospitals prior to becoming LTRC facilities. The Hospital Act entails a somewhat different set of standards than licensing for LTRC facilities.

Over the past several years there has been a shift from admitting residents from their homes to admitting residents directly from hospital. When I was a Director of Care in 2000, I would accept two residents from the community for every one from the hospital. A Director of Care told me that now she must take three admissions directly from hospital for every one that she takes from the community or her transfer list (that is, residents who were admitted to another facility under FAB and would like to go to the study site as their preferred facility). Many potential residents therefore, arrive in LTRC after spending long periods in hospital. For example, one resident who was interviewed for this study spent 11 months in hospital and another, whose family were interviewed, spent one year in hospital. Hospitals have therefore become holding stations for people awaiting transfer to LTRC contributing to the labeling of older adults as ‘bed blockers’, people who are inappropriately using hospital resources because there are no alternatives for them but to wait for a LTRC bed to become available. Because of the priority for hospital transfers, people who are on waitlists for their preferred facilities can wait years before they are offered a bed.

Because there are no longer chronological, or anticipatory, waitlists, for many residents and families, the notion of not returning home and going directly to a LTRC facility is introduced in the hospital. One daughter described her perception of hospital staff after this experience: “The social workers at the hospital, their main agenda is to clear the beds. Clear the beds. Clear the beds. That’s their biggest push.” This push to clear the beds did not only create stress for families and residents but also contributed to antagonism between hospital and facility staff, as alluded to earlier in this chapter. The Director of Care at Site B explained to me that she often tried to see potential residents at

the community hospital where most of her admissions were from in order to assess whether the information about the potential admission reflected the reality of the individual's health status and care needs. She said that she had stopped phoning the hospital in advance because she had too often experienced seeing over-sedated people in the hospital and then, once admitted and the sedation wore off, having a person with much higher care needs than anticipated. Therefore, she would drop by the hospital at unexpected times to see the person and could then make a better judgment about her staff's ability to meet their care needs. Although refusing a potential resident is not typically permitted, by seeing the people in hospital, the Director of Care was able to justify her reasons for not accepting someone.

Like the Director of Care at Site B, some families had found ways to work around the lack of choice and flexibility in the system. For some, the antagonism that had developed over a long hospital stay provided the fuel for asserting choice in where a person would eventually end up. As a son explained to me:

The transitional person at [hospital] was saying, "Well, you know the policy is, First Available Bed." And I remember looking at her and saying, "let's make something really clear okay? Our mum isn't going any place that we don't approve." They were wanting to move her to [geographically distant facility]. The only links my mum has is us and her brothers. Nobody would have gone to visit her at [that facility], it's out to hell and gone.

Other families found more charming ways to work the system. A husband described his experience of looking for an appropriate facility for his wife: "I came in here and right away I thought, 'boy, it's spotless.' It was sunny, bright, close to our house. That's key. I

managed to get in because I knew the girls at the hospital and once you get to know them...” There were also allies within the hospital staff who provided tips on how to get into a preferred facility, or at least a preferred geographical area:

Unless you’re smart enough, and you change mom’s address quickly to yours, then you just say, “Oh no, mom lives with me. Mom is under my address as you can see.” That’s the only way that you can fool First Available Bed policy, and then they can’t make mom go and transfer to the first available bed. Well, I learned that the hard way, but anyhow that’s how you can avoid First Available Bed. Some social workers mention those tricks, and some social workers don’t. Thus, there was a covert system developing in response to FAB that could, potentially, slow down the process of transitions even more. For some families, despite trying to be part of the process by touring different facilities, they were still pressured by the system to go to the first available bed.

For residents and families, the FAB had consequences for their transition into care:

You’re placed where ever the first bed comes up I think that adds a lot of anxiety to the resident or the future resident if they’re with it and certainly for the family members and sometimes people have both their parents going in at the same time, the parents may be split into different facilities in different, even in different municipalities and it makes it very, very difficult even to think about.

It can also set a negative tone for relationships with facility staff from the outset: “That new system, that First Available Bed, lots of families come here so angry, it’s unbelievable and every little thing actually irritates them right away. They just... they

can't tolerate anything because they are so upset that their mother or father had to come here."

A group that may be completely left out of this process due to other policy issues are sponsored immigrants. As one HA administrator pointed out: "a lot of people, I think, are sponsored immigrants with older ones and they're actually not all eligible." For this population, there is a risk that older adults who would benefit from being in LTRC are not even identified within the larger healthcare system.

Care Transitions in LTRC

Care transitions are common place for LTRC residents. Once someone is admitted to a facility, there are often still transfers to hospital when an acute medical crisis arises that cannot be handled within the facility. As mentioned previously, there are a handful of residents who eventually go back to live independently in the community. Over the past several years, a number of LTRC facilities in the communities where the study sites were have been decommissioned, meaning that those residents are transferred to other facilities.

Some of the residents at Site A who were interviewed had previously lived at another facility which had been decommissioned. Decommissioning took place earlier this decade when all facilities were expected to have complex care residents and were no longer permitted to transfer residents whose care needs became heavy. The facilities that were decommissioned were typically older buildings that were not set up for wheelchairs and therefore, had very limited access to washrooms. For the residents who participated in the study, decommissioning meant that there was another move in their life that had not been anticipated. It also meant leaving the community of residents and staff of which

they had been a part. The Director of Care at Site A told me that the HA had begun another round of decommissioning assessments to see which facilities could be closed in order to move those beds to areas with higher demand.

As mentioned previously, with the FAB policy residents were allowed to waitlist for a preferred facility after they are admitted. This meant that there was a parallel waitlist system to the people just waiting to be admitted. Residents and families were told that it could take years to be transferred to the preferred site. Some of the families in this study explained that, although the resident may have been on a waitlist, once the preferred site became available the resident was settled where they were and the family did not want to move them. This created conflicts though, for families who were geographically closer to the preferred site but did not want to take the resident out of a facility where they had adjusted to living. Because many people start out in a facility that is not their preference, it also creates a lot of resident turnover, which has workload consequences for the staff and also has consequences for how relationships developed between residents/families and the facility staff. As a staff member commented:

We have a huge turnover in the residents. That's what I've noticed and I've noticed that this facility kind of becoming just a transition, transitional place for them. They're all on the waiting list to get somewhere else and it's kind of... yeah, that's, like more work for us and it's kind of getting sad as well. That, you know, the people are changing so fast. Before it was kind of steady and I don't know, maybe we have more extended care people now. They are more sick and that maybe, you know, lots of people are dying. Like it wasn't like that when I

just started. It was, like more steady. But now it's huge turnover, that's what I find.

There could also be breakdowns in relationships between the resident/family and the facility staff. In extreme cases, the conflict between the resident/family and the facility and an outside mediator needs to be brought in to find a solution, such as described by a health authority administrator: "by the time we were being called in, the facility hates the family, the family hates the facility, everybody is unhappy and there's no place to go from there but move." While the reasons for these antagonistic relationships cannot be assumed, the stories from families of their experiences in hospital and interactions with healthcare providers can certainly set the stage for challenging relations in the LTRC setting.

Sometimes the outdated physical environment of a facility was the reason for a resident's move. For residents who have very advanced dementia and require a certain type of physical environment this could be the case. A nurse at Site A explained some of the turnover in the SCU:

One man went back to the facility he was at previously. The only reason why he was moved here was because it was closer to his family. But ultimately it was a brand new facility that was set up with super wide halls, and a circuit for them to walk around, and it was just too closed in for him. This place was built after the fact.

In this case the lack of an appropriate physical environment had consequences for proximity to the resident's family. The nurse went on to talk about a younger resident

who had left: “And the other person went to a group home. I believe there’s younger people and only males there, so I think that was a better setting for him.”

The Complexity of Complex Care

Several years ago, there was a change from a system of categorizing people according to their care needs – personal care, intermediate care 1, 2, or 3, and extended care – to ‘complex care’. While in the past, facilities typically accepted ‘intermediate’ and/or ‘extended’ care residents according to their physical and staffing capacity, facilities must now accept complex care residents and, technically, can no longer easily transfer people to extended care facilities when their care needs increase. Theoretically, therefore, all facilities can now accept the range of residents thereby facilitating the FAB policy.

For the study sites, the change to complex care presented many complications. At Site A for example, the building was designed for residents with personal care or ‘lighter’ care needs and, in the past, when care needs increased, they were transferred to an extended care facility. As the Director of Care from Site A said, “now we’ve got the ceiling lifts in a lot of the rooms, we’ve clustered so we’ve our more extended care unit and we, you know, we don’t even have a wheelchair bathroom in this place, its crazy”. Site B was experiencing a different complication, but in the same vein. As a facility designed for mainly extended care residents, they were not able to accommodate ‘wanderers’ or people who were at risk for ‘elopement’. During my field work, however, they installed an alarm system for residents who required a secured environment. This meant that all residents would wear an electronic bracelet and if they left the premises an alarm would sound. The benefit of this system was that it allowed admission of a group

of potential residents who required a secure environment and could potentially decrease empty beds, which pleased the owner. The Director of Care, however, had concerns as there was no air conditioning at Site B and during the summers they usually kept all of the outside doors and windows open to provide air circulation. With the inclusion of residents requiring a secured environment, this would no longer be an option. As an administrator commented, “the complexity of people going into facility, means that people are no longer fitting the buildings because they’re changing the types of people that are going in”. This could be seen at both sites, where they were being made to accept residents who were not appropriate to the physical environment.

In addition to adaptations to the physical layout of the facility, there has also been an increased need for knowledge around end of life care. At Site A, in the past, they had transferred residents to extended care facilities as their care needs increased and, therefore, had less experience with caring for residents at end of life. There were also extra staffing needs for residents needing end of life care. The program that provided funding for this was called Added Care. Years ago, each episode of Added Care required an application to the HA for funding. Typically Added Care money was used to provide 1:1 care by a nurse or HCW for dying residents or very sick residents. When I asked the Directors of Care at both study sites about this, they told me that Added Care is now part of the base budget provided each year by the HA. When I asked what happened if they ran out before the end of the year, they just shrugged their shoulders and said they had to be careful when allotting it. Consequently, residents at the end of life might not only have staff who do not have the clinical knowledge to appropriately care for them, but there may not be money available to pay staff for the extra care required.

Complex care is not only related to medical complexity, physical dependence, and end of life care. As an LPN at Site A explained:

I'm not sure why that happened [changing resident population], but I suspect it has something to do with [psychiatric hospital] shutting down. We would never consider having some of the people back then that we do now. They're just way more difficult, way more complex, behavioural issues going on with them.

These residents with mental health issues also presented extra challenges for staff. Many of the staff commented that they had not had any education related to this population and felt at a loss to provide care for them.

In summary, the role of LTRC facilities is shifting somewhat from providing long-term residency to becoming a transient place where people move in and out and continue to transition across the health care system. With changes to the admission process, particularly the FAB, there has been an elimination of choice in regard to who moves where, contributing to stress for those working and living in LTRC and with consequences for their relationships. There also is recognition that the first facility a residents goes to is not necessarily their final destination. The current policy structure has also created a system of continual movement between facilities. The introduction of complex care has influenced the makeup of the resident population in facilities, straining the knowledge base of staff and the skills available to work with a diverse group of residents.

The Erosion of Knowledge, Care and Leadership in LTRC

In this section, I present findings related to the erosion of knowledge, care and leadership in LTRC. I begin by considering the shrinking access to primary care. In the

literature review in Chapter 2, I included research related to the general absence of physicians in LTRC. While this has never been a site of particular appeal, the physician shortage is contributing to even greater absence and therefore, lack of access to primary care. There is also an erosion of nursing knowledge in LTRC. Many RN positions are being replaced by LPNs, such as at Site B, despite the growing complexity of the resident population. Lastly, administrative leadership is also fading from LTRC. The culmination of these issues is a potential crisis for the ability of facilities to continue to deliver appropriate and effective care based in gerontological knowledge.

Absent and Inaccessible Primary Care

Access to primary care was a growing concern at the study sites. For many residents, entering LTRC meant the end of a long-time relationship with their physician. As a nurse coordinator explained to me, the majority of physicians would not follow their patients once they were admitted into a care facility. When this relationship ended at the door, it meant that nurses at the facility had to scramble to try to get another physician to agree to take the resident onto their caseload. The loss of a long-term relationship with a physician who was familiar with their health care needs also meant that many residents were being treated by primary care providers who did not have the benefit of knowing how they had functioned in the community or how they wished to be treated when their health started to decline.

A nurse described a common relationship between residents and their physicians, and the way in which primary care is carried out in LTRC:

We have a very difficult time finding even medical coordinators for our facilities.

Most of our residents have a family doctor's name beside their name on the chart

but the reality is they don't get visited very often by their physicians. And to be in residential care these days' means that you probably can't get out to a doctor's office so a lot of the care is episodic rather than preventative and is done by phone or fax rather than by an in-person assessment.

When physician decisions were reliant upon the expertise and knowledge of the nurse at the end of the phone, the need for a high level of clinical knowledge and expertise in the nursing population becomes critical. However, with the erosion of nursing knowledge at the point of care as described in the next section, this source of knowledge is also fading from LTRC. A family member expressed his concerns about this situation:

If a doctor's prescribing Loxapine which the nurses are then giving as a PRN [as needed] to shut her up, then that's not the way it's supposed to be used. And especially if it's not being monitored by anybody proficient in the understanding of the results of chemicals on the body.

This family member clearly articulated the risk of having limited knowledge among the nursing staff to effectively carry out doctors' orders.

The Erosion of Gerontological Nursing Knowledge at the Point of Care

With the emphasis on cost savings in healthcare and the concomitant nursing shortage impacting upon the entire healthcare systems, RN positions were easy victims of staffing changes in LTRC. Both Site A, and particularly Site B, had seen a decrease in direct care RN positions between 2000 and 2005. At Site B, RN positions had been a casualty to contracting out and the majority of RN positions had been changed to less expensive LPN positions. Typically, when these positions were changed to LPN positions, RNs became further removed from the bedside or absent altogether.

In addition to losing positions, there were accommodations made for RNs that could compromise care. For example, at Site A, where there was still a large contingent of RNs, the Director of Care was working with other facilities to accommodate RNs' schedules when they had positions at more than one site. In an extreme case, the Director of Care was working with another facility to coordinate shifts and ensure that there is no overlap for a RN who had two full time permanent positions. At Site B, I interviewed an LPN who worked two full time positions. Staff with multiple commitments like this meant that they often worked a shift at one work place and went immediately to the next work place. For RNs and LPNs making key clinical assessments and decisions, it was of concern to consider their ability to exercise clinical judgment when they must be fatigued from long hours of work. Administrators however, seemed satisfied that they had a 'warm body' present at the site.

With fewer RN direct care positions in LTRC, there may be less nursing knowledge available to meet the needs of the very complex care needs of residents who were being admitted from hospital. One administrator described her feelings about this crisis: "...that whole knowledge base and the whole knowledge base of nursing is being lost. I think that's a crime. And the hospitals do not recognizing what facilities can and cannot support." A nurse coordinator at Site A described how she thought the RN role would evolve in her facility "I think that the RN role will be more of a, a traveling one, it will be one RN and she'll just be going along picking up medical concerns to notify doctors about". Again, though, these concerns could only be picked up if there was adequate knowledge at the point of care to recognize when issues were arising. It also

speaks to the valuing of other aspects of the nursing role, when RN involvement is diluted down to contacting physicians about urgent medical concerns.

With funding frozen, it was anticipated that the elimination of RN positions would continue to be viewed as one of the few areas where cost savings could still be garnered. One administrator indicated that the next level of nursing positions, such as nurse leadership roles like the nurse coordinators at Site A, would be the next to be cut back. Even now, when a staff nurse shift was vacant, the nurse coordinators at Site A were pulled from their regular work to do the staff nurse role, meaning that activities such as staff education and long-term resident planning were put on hold.

In addition to concerns about the presence of RNs in LTRC, there is a need to recognize the gerontological nursing knowledge held by the LPNs and HCWs at the study sites. While these groups could be seen as potential sources for developing knowledge and clinical expertise at the bedside, many were experiencing serious physical disability because of the demands of their roles. Just as the RN population was aging, so were many of the LPNs and HCWs who had worked for decades in this field. One LPN with 20 years of experience told me: “I’ve just been doing this too long, and it’s just too much on the body.” She was just 50 years old and her physician had already told her that, at most, she could work in LTRC for five more years and then would have to find a less physically demanding job.

Many of these staff, though, were passionate and committed to their work and had desires to return to school and go into another nursing role in LTRC. Although the desire and capability were there, for many there were practical barriers to attaining this goal, particularly money and time. As a LPN told me: “I would love to go on to psych nurse,

but ultimately I can't not be working and afford tuition and books and stuff all at once.” A HCW had similar comments: “Maybe I'll do that next year, and then... I always say, ‘Next year, next year, next year coming.’ And then it's... the thing is, I can't really... money, money, money is the issue.” This desire was echoed by many staff, yet the mechanisms to fill the growing RN vacancies did not exist. In sum, there are many issues influencing the erosion of nursing knowledge in LTRC, including the shortage of RNs, the transfer of RN positions to LPN positions, and an aging population of workers who are committed to working in LTRC but may have to leave the setting.

The Absence of Clinical Knowledge in LTRC Leadership

In addition to primary care and nursing shortages, there were also concerns about the erosion of leadership in LTRC. The CEO at Site A, who was a highly regarded leader in LTRC, reflected on the state of leadership in this area during my interview with her. She began with talking about when she started in LTRC in the 1990s:

And because it [LTRC] always had such a bad history before, you got a job in long-term care because you couldn't get another job. A lot of people in the system just basically were here for a long time. They weren't leaders, they were basically doing, you know, mundane leadership.

Then there was a shift in the 1990s with a number of Masters prepared administrators moved from acute care to LTRC. However, they found many challenges in working in partnership with the larger healthcare system: “there's all these gatekeepers, who I see have a very personal vision, which is to keep their own jobs but not to move beyond it.” Now many of the leaders who entered LTRC in the early 1990s were retiring and there were few people prepared to replace them.

Along with the loss of these LTRC leaders were consequences for relationships with senior administrators in the HA. As some participants commented, many of the HA administrators involved with LTRC had no experience and very limited knowledge of this sector. Many of those with authority over LTRC had it as only as part of a large portfolio. Because it was not a focus for these administrators, LTRC was at risk of being overshadowed by other areas of the healthcare system, such as acute care. Like the residents who had resigned themselves to living in an inflexible system, many leaders in the LTRC had also resigned to working in an unchanging system: “the system is old, the system comes from a very autocratic, man-driven, not creative system, and you know what? Ain’t going to change.”

Chapter Summary:

The Corporatization of LTRC

LTRC remains one of the last vestiges of institutionalization in our health care system. Those who worked there had grave concerns about its current state: “the whole thing has the appearance of multi-headed monster.”, “it’s a quagmire, it is and, you know, I work with lots of people, we talk to each other. Does anybody sort of have a glimmer of hope? Not at all.”

This chapter has presented many aspects of health policy and their impact on the everyday in LTRC. Many of these areas have intersecting concerns, often based in the increasingly corporate approach to care for the elderly. This is illustrated in the way that private, for-profit facilities have quietly begun to receive public funding to provide services, a situation that is greeted with loud protests when it is suggested for acute care services, which are typically perceived as being for younger, active members of society.

There are also more overt systems of corporatization within some facilities, as indicated by the growth of service charges for residents. It is also illustrated in the removal of choice around where one lives, as enacted through the FAB policy. With regards to staffing, cost savings have been obtained through contracting out, with questionable outcomes. Within this quagmire, there are a shrinking number of voices advocating for the type of care that Canadians have come to expect from their health care system.

Corporatization is, in part, able to flourish within the pre-existing discourse of ageism in our society:

Its just like the answer is to institutionalize the elders, its like the holy grail, we just need more long term care beds, we just want to warehouse our elders period, that's what we want to do, you know, we spent so long getting rid of the [psychiatric facility] and all that stuff, you know, every, for kids we did it [deinstitutionalization] for kids and we just went 'oh shit, we made a mistake' and then we stopped that, then we did it with people's mental illnesses and we said, 'oh, oh, that wasn't a good thing to do', so we stopped that, and now [laughs] its weird like other industries have done this and figured out better ways and yet we just keep, we've just medicalized aging, that's what we've done, we medicalized getting old. (Administrator, Site A)

As the participant suggests, other alternatives have been explored for other groups, yet institutionalization remains a main solution for caring for our dependent elderly population. The findings of this chapter suggest that there is no end in sight to the institutional system, instead, it is becoming a profit-making venture with costs to the individuals who live and work in these facilities.

Conclusion of Study Findings

These findings illustrate the complexities in the organization of care in an evolving system. In Chapter 5, I presented findings about what is like to live in LTRC through the voices of residents and family members. There were many different perceptions of living in LTRC, yet many of these were underpinned by commonalities about lack of choice, autonomy, and eroding identity. Passing the time was the main activity for residents. For some, they were able to contribute to care through volunteer work, yet as they became increasingly dependent, they lost this role. For most of the residents, the recreation offerings at the facilities were key to passing the time. They placed a lot of value on those staff and their roles as compared to the more medical and physically-oriented nursing staff. Because residents found it difficult to connect with each other, many forged close relationships with staff, who sometimes served as surrogate family when a resident's own family was absent. A trend in both study sites was greater, visible diversity of the resident populations, with an increasing number of younger residents and Persons of Colour. These residents often found fitting into the traditional, Western-driven institutional setting of LTRC.

In Chapter 6, I moved into findings related to those who work in LTRC and the interpersonal organization of care. I began by examining the roles that family members play in this setting, which ranged from the absent, to the very involved. Expectations around family members' contributions to care, whether through additional services fees or hands-on care were changing to meet the complex needs of residents. Staff in LTRC often came to work there by default, if they were unable to obtain work in other health care settings. Although some became very passionate about their work, others remained

because of the lack of other employment opportunities. Among the different groups contributing to care, there remained issues of ambiguity of roles, which could contribute to tensions when there were perceived workload differences between groups. As well, there were few instances of team work across the groups, rather staff tended to work with others in the same group. From describing the staff, I moved into the interactions that took place during day to day life. All of these occurred within the bounds of the hierarchical structure of LTRC, yet were also characterized by ongoing power relations and acts of resistance by the oppressed. I also considered how the value of care for residents of LTRC and older adults in general was influenced by a discourse of ageism, which also had consequences for those working with this population and the type of work that they were assigned. Lastly, this chapter examined the complex intersectionalities at play among those who work in LTRC. These intersectionalities of race, gender, class, and age influenced how individuals and groups were constructed and could potentially limit their activities.

In Chapter 7, I presented findings about the bureaucratic aspects of care. This chapter situated LTRC within the larger health care system. Next to acute care, LTRC was constructed as a subsystem in which care is often directed by what is happening in acute care. I then presented findings related to the multi-tiered, public/private aspects of LTRC. There were a number of factors influencing the growing privatization of LTRC, including: funding of beds in private, for-profit facilities with public funding from the HA, and the growth of additional service charges for residents living in ‘publicly’ funded facilities. Next, I presented findings about staffing. Similar to other aspects of care, staffing was increasingly becoming a privatized venture, with contracting out for care

services by private companies as an example. The consequences of this approach had consequences for residents and family members in relation to the stability of the workforce and continuity of care. There were also consequences for the largely female workforce, with staff in Site B now employed by a private company. The least educated staff, HCW, were lower paid than their unionized counterparts and did not have similar benefits or pension benefits. Next, I presented findings about licensing, surveillance, and accountability as the HA worked towards developing a system to monitor care that they were, ultimately, funding. I then moved into findings about transitions in care. I began by discussing the admission process, again largely based in the pressures of the acute care system. I also included findings about the impact of the First Available Bed policy on care and relationships in LTRC. Other transitions in care, including hospitalizations, end of life care, were also presented. I concluded the section by discussing the shift in resident population with the policy of Complex Care. In the following section of this chapter, I presented findings about the erosion of knowledge, care and leadership in LTRC. With physician and nursing shortages it is increasingly difficult to ensure that there are individuals with advanced clinical knowledge about care for the older population working in LTRC. Additionally, administrative leaders in this area are retiring and leaving a vacuum at that level to advocate for appropriate resources to provide care to HA administrators who often do not have backgrounds in LTRC. The chapter ends with consideration of how the compounding discourses of corporatism and ageism foster a system in which institutionalization remains a main element in care of dependent, older adults.

In conclusion, the findings of this study illustrate the multiple, intersecting issues that converge to set the stage for day to day care in LTRC. Importantly, none of these issues are occurring in isolation, rather they are simultaneous and dynamic. In the next chapter, I engage in a discussion of these findings.

CHAPTER 8: DISCUSSION

In undertaking a critical ethnography in LTRC, I was challenged to listen to and observe the many players in this setting, in particular the residents, family members, staff, and administrators. In Chapter 5, I foregrounded the voices of residents who told what it is like to live in the institutional setting of long-term residential care (LTRC), voices that have tended to be subjugated and silenced in the public discourse about LTRC. In Chapter 6, I focused on what it is like to be part of care provision in this setting, from the perspectives of informal caregivers (family members), and the perspectives of staff. These findings illustrated the relations of power that operate within the institutional setting. They also reinforced other scholars' descriptions of class hierarchies among those who work in LTRC (Jervis, 2002), and portrayed the intra-gendered nature of the oppression operating in this hierarchy. In Chapter 7, I focused on the formal aspects of the organization of care. I began by situating LTRC within the larger health care system and then presented findings about the intermingling of public and private funding in this area. I examined issues of staffing, in particular unionization and the contracting of care services from private companies and I described the role of licensing, surveillance, and accountability. Chapter 7 also included findings related to the erosion of clinical knowledge and leadership in LTRC. The findings of this chapter were underscored by discourses of ageism and, increasingly, corporatism in this setting.

The sections of this chapter are organized according to three key themes that arose in the study. These themes reflect the complexities of care in LTRC, particularly interfaces between interpersonal relations, the institutional setting, and health policy, which ultimately, together, shape the organization of care. The first theme is the

systematic decommissioning of citizenship for those who live and work in LTRC. The second theme is the impact of health policy on the everyday in LTRC. The third theme is about the ‘stolen moments’ of relational care that occur within the context of LTRC and the broader sociopolitical milieu of care in this setting. These themes are discussed in relation to the literature reviewed in Chapter 2 and the theoretical perspective that guided the research, which drew on postcolonialism, feminist postcolonialism, intersectionalities, and Foucauldian epistemology.

Decommissioning Citizenship

For both residents and workers, there was a systematic decommissioning of citizenship that was deeply connected to their association with LTRC. When an individual enters a LTRC facility to live or work, they cross a border and become invisible to the many people who are not part of this microcosm within our broader society. The findings from this study raise issues that intersect around identity, difference, and, ultimately, citizenship for those who live and work in LTRC. This section is organized into two subsections relating to residents and staff.

Decommissioning Citizenship of LTRC Residents

For residents, the border between living ‘on the outside’ and living in a long-term care facility represents important elements of Western society – the perception of going from being part of the ‘productive’ world to being a dependent member. Stafford (2003) likened this process to a ‘double burial’, that is, residents experience a social death upon moving into LTRC, effectively removing them from the world of the living. As discussed by Walker (2006), this transition is related to how old age is constructed in a welfare state, where older adults go from being in the workforce to drawing a pension

and being supported by their younger, working counterparts. Thus, there is a societal acceptance of the erosion of one's identity and citizenship with growing dependence.

Going from having one's own living environment to being part of an institution where rules and regulations dictate almost all aspects of one's life can contribute to a progressive loss of identity. The voices of residents in Chapter 5 illustrated some of their frustrations with this process and their feelings of impotence to have influence and enact choices in their lives. This process was not different whether the resident was 90 or 40 when they entered the facility, although individuals responded to it in their own unique ways. Such feelings of invisibility and loss of identity were similar to those experienced by residents and reported in ethnographic studies over the past thirty years (for example Gubrium, 1975, Foner, 1994, Stafford, 2003, to name a few).

In this study, the erosion of identity began with the absence of choice about the facility in which people would spend the remainder of their lives, in a situation that offended their dignity as adults and illustrated their muted power as old, dependent/disabled persons. Dignity is a concept closely related to identity and involves being able to make day to day choices, a luxury that is limited in LTRC. Franklin, Ternstedt, and Nordenfelt (2006) described how the dignity of nursing home residents is eroded as they lose control over their bodily functions, and become more frail and dependent. The link between identity and ability was illustrated in my research. For instance, a 99 year old resident at Site A was often admired by staff for being "so young" because she had no cognitive impairment and was physically able to do most of her personal care. This contrasted with residents who were completely dependent on staff and were no longer able to verbalize. At Site B in particular, these residents often spent

their entire days and nights in bed, only to be occasionally gotten up into large wheelchairs. Even when they did get up, these residents were often left in hospital gowns rather than being dressed in their own clothes, which would serve as an expression of unique identity.

In contrast to individual identity was the notion of difference and how being perceived as different was problematic for residents. As described in Chapter 5, residents were categorized in groups by staff, for example the ‘typical’ residents (i.e. White, middle-class, and chronologically old), the ‘young’ residents, the ‘smokers’, or the ‘immigrants who do not speak/understand English’. These groupings resulted in individual differences being erased and instead residents became part of an essentialized group. Furthermore, being part of a group that was different than the “typical” resident was problematic. These resident groupings tended to be synonymous with requiring greater attention, and there was often societal stigma associated with group membership as a person with addiction issues or mental health problems, or as an immigrant. This contributed to a pervasive sense of disdain among staff and administrators that these groups were somehow misusing resources or were a drain on what was available. For example, many staff commented during field work and interviews that they had not been trained to work with younger, recovering addicts, or that they felt these residents were manipulative. The result of these perceptions was that staff would withdraw services, such as room cleaning or personal care. In another example, the non-English speaking residents were often perceived as requiring more time because staff needed to make extra efforts to communicate with them. As well, responsibility for some aspects of care, such as the provision of preferred food choices, were sometimes placed back with the family if

residents would not eat the standardized menu that was offered. In essence, these individual's unique identities were wiped away and characteristics were attributed to them based on assumptions about the group as a whole. Other scholars have discussed similar concerns in relation to perceptions of immigrants in the health care system (Brotman 2004; Reimer Kirkham, 2003) and, to a lesser extent the presence of younger adults in LTRC, yet this issue would benefit from further examination given the diversity of the population that now accesses LTRC services in British Columbia.

Postcolonial theorizing helps to inform this problematizing of difference, which effectively led to essentialization of difference and consequently fostered an atmosphere where staff were not expected by administrators to provide the same level of care to these 'different' residents. Historically, concepts of race, ethnicity, and culture were signifiers of difference (Reimer Kirkham & Anderson, 2002), and in the case of LTRC, 'mental illness', 'addiction', and 'immigrant' take on these guises. The difficulties in adapting to the growing diversity in the resident population also signified an unwillingness of administrators and staff in LTRC to shift away from the ingrained, institutional routines. For residents, the consequences included isolation, marginalization of individuals and groups, and loss of citizenship.

Decommissioning Citizenship of LTRC Workers

For people who worked in LTRC, identity and difference were also important elements in the process of decommissioning citizenship. As described in Chapters 6 and 7, many of the lowest paid staff (that is, unregulated health care workers and food service workers) were immigrant Women of Colour from the Philippines and South Asia. At this intersection of gender, race, and class, women were placed in a very vulnerable situation

within the current employment context of LTRC. This situation was illustrated in the differences in employment between the study sites. At Site A the workforce was unionized and there was an ethnoculturally diverse staff mix of women and men, many of whom were long time employees. This contrasted with the workforce at Site B, a facility where almost all staff were employees of a private company that provided care services at the facility on contract. At Site B, almost all of the nurses and healthcare workers were Filipino and, because the contract had turned over several times in the past year, many of the staff had only been working at the facility for a short time. One health care worker was an anomaly in this situation in that she had been working at Site B for 20 years, however, within the past year she had been hired and laid off and rehired again by three separate companies. She said that the majority of her colleagues who had been at Site B when it was still unionized were no longer there. After twenty years working at the facility, she was just nearing the end of her probationary period with the current company. Although I have not found any research with the workers of these private companies, perhaps because this model of care was only introduced in 2001, my interviews with staff highlighted a number of differences between being in a union and being employed by a non-unionized company. These differences included lower wages, lack of job security, and lack of extended medical benefits.

The immigrant Women of Colour who worked for the private companies also tended to have limited access to educational programs that would provide opportunities for them to obtain other work. This limited access was related to the cost of education, both in terms of tuition and also their inability to take time off of from work; their pay was very low and many were already working at multiple jobs. The high turnover and

replacement of workers at Site B speaks to the lack of identity of individual people, rather they were perceived by the facility's owner as easily replaceable, making many fear for the security of their jobs. Few were willing to express their voices about the inequities in the system that robbed them of their identities and opportunities for changing their situation. Although one of the women in the study was leaving her job to pursue education as a Licensed Practical Nurse, the majority were located in a situation where their employment was vulnerable and they had few options. As Mohanty (2003) suggested, we must be attentive to exploitative structures, such as this, where Women of Colour are working for low pay with tenuous job security, and collectively work to address these inequities. Within these structures, those who benefited from the "dirty works" of the health care workers were the nurses, illustrating an intra-gendered form of oppression between groups of women working in LTRC. Findings from the study demonstrated how, through the allocation of work, a distance is maintained between these women rather than fostering a cohesive workforce that might work together to address inequities among staff.

In addition to Women of Colour who worked as unregulated Health Care Workers, there were also a number of Registered Nurses (RNs) in this study who were recent immigrants. These nurses had come to Canada with their families as part of the influx of nurses from the South, many of whom come to Canada expecting a higher quality of life than in their home country. The Philippines, for example, is the source country of a quarter (26 percent) of the Internationally Educated Nurses (IEN) in Canada. In British Columbia, 40 percent of the RN workforce is foreign trained, the highest proportion of IEN in any province (CIHI, 2006).

Although many RNs come to Canada with the intention of obtaining employment in their field, they are confronted with barriers once they arrive. For example, a nurse from China described for me the challenges of learning English to work in a Canadian health care setting. She had postponed pursuing her licensure upon coming to Canada until she felt confident with her English. She told me she knows several Chinese RNs who have not pursued licensure in Canada because of the language issues. Another nurse I interviewed had been a Masters prepared nurse educator in the Philippines but upon moving to Canada found her Masters degree was not recognized. She chose to work in LTRC because she perceived that it was the least difficult area of practice and she was gradually building her skills to go to acute care. Yet another nurse from the Philippines was working as a Licensed Practical Nurse while trying to obtain her RN license. Thus, nurses who have obtained professional status in their countries of origin often lose this status upon entering Canada and start an arduous process to regain their nursing licenses. Quayson (2000) had written about the “conundrum of attaining citizenship whilst becoming alienated subjects” (p.103), a situation illustrated in the plight of RNs immigrating to Canada. While they are, on the one hand, being aggressively recruited to Canada, they are, at the same time, being constrained in their ability to obtain the work they are qualified to do. This downward mobility of immigrants has been discussed by scholars (Li, 2000; Picot, Hou, & Coulombe, 2007; Reitz, 2005). Once qualification in nursing is obtained, Women of Colour may be directed towards working in LTRC by employers, a form of systematic racism that aligns with a discourse of ageism that suggests that working with older adults requires less knowledge and skill than working in

acute care with younger adults or children. This situation has been discussed previously by Das Gupta (1996) and I continue to explore it in the following paragraph.

The difficulties in obtaining licensure, and lack of recognition of their past educational accomplishments, are reflected in an intersection of race, gender, and age for Women of Colour. Returning to Das Gupta's (1996) discussion of cases where Black nurses were funneled towards LTRC despite their qualifications to work in other specialty areas of practice, the nurses who were recent immigrants told me similar stories of how they came to work in LTRC. The Masters prepared Filipino nurse, for example, was working in LTRC to hone her skills in order to be seen as qualified for a job in acute care. The nurse from China, who had previously worked in critical care settings, also worked in LTRC because of the perception that the work was less demanding of clinical expertise. Thus, there is a convergence of the perceived lack of expertise among nurses of Colour and the perception that gerontological nursing requires less knowledge or skill. Hence, as Foucauldian epistemology about discourse suggests, the assumptions around the competency of immigrant nurses of Colour and the presumption that care of older adults is less taxing than other areas of practice "provide the basis for conscious knowledge" (Cheek, 2000, p.23) which then translates into actions that lead to these highly-qualified nurses working in LTRC when they may wish to be in another area of practice.

In summary, decommissioning citizenship was a key theme in this study in the experiences of both residents and workers. Citizenship is closely linked to ideas of equality, and civil, political, and social rights. It has also been implicated in discussions of relations of power and the inequities in rights between some individuals in relation to

others (Bartlett & O'Connor, 2007). Throughout this section, as I discussed the losses related to individual identities and the essentialization of groups in LTRC, there were concomitant erosions of rights. Spanning from the lack of the civil right to choose where one lives, as in the case of residents, to the political and employment rights of workers, there were many aspects of living and working in LTRC that would be unacceptable to those of us who do not share their situation. For residents, the loss of citizenship is perhaps more extreme. As Davies (2003) stated in her historical study of LTRC in British Columbia, "in exchange for shelter, food, and care in their aging years, applicants [residents] gave up the basic tenants of citizenship – the right to personal privacy and the right to determine where and how they would live" (p.115). Another element of citizenship is being part of the workforce, or doing paid work (Craig, 2004). For adults living in LTRC, there are clear implications for their absence from the workforce in terms of how they are perceived as members of society when they are unable to work and are dependent for their personal needs. Able and Sankar (1995) commented on this notion of independence in relation to the aging population:

Perhaps the greatest challenge posed by an aging population is to create a society that values interdependence as well as independence, that acknowledges vulnerability and invalidity as part of all human life, and in which self-respect no longer rests on personal control (p.6).

Citizenship also functions in a cyclical relationship with identity and dignity (Craig, 2004). Hence, when these elements are considered together - the dissolution of identity, it's consequences for personal dignity, and their meaning in relation to citizenship - there is a decommissioning of citizenship for many who step across the border into LTRC.

The Impact of Health Policy on the Everyday

In keeping with the theoretical perspective of this study, I undertook a critical analysis of the interface between the macro-politics of the health care system and their impact on the micro-politics of the everyday. As Reimer Kirkham and Anderson (2002) suggested, “a feature of postcolonial scholarship is situating human experience (e.g. everyday reality) in the larger contexts of mediating social, economic, political and historical forces” (p.11). Restructuring of elements of LTRC, described in Chapter 2, occurred within these mediating factors, and were also influenced by discourses of corporatism, with consequences for the everyday lives of those who live and work in this setting. The restructuring issues included: the closure of LTRC beds and shift towards less clinically-oriented models of housing such as Assisted Living, the introduction of the First Available Bed (FAB) policy, and legislation to allow the care provided within LTRC facilities to be contracted from private companies. In the following section, I discuss the impact of restructuring, situated within the larger contexts of social, economic, political, and historical forces, on the everyday in LTRC.

The first area of restructuring that I discuss is the closure of LTRC facilities, in which 2,529 beds were closed between 2001 and 2005 (Cohen, Murphy, Nutland, & Ostry, 2005). At Site A, I interviewed several residents who had lived in a facility that had been closed. The rationale for closing the facility was that the physical environment was not able to accommodate the rising physical care needs of residents, many of whom require mechanical lifts and wheelchair accessible bathrooms. For the resident, though, this closure meant the loss of a community of which they had been a part. Because the previous facility had catered to higher functioning residents, many had developed

friendships with each other which were lost when they were all reallocated to different facilities. The arbitrary moving of residents to other facilities where there were vacancies was also another signifier of loss of choice.

A second area of restructuring is the First Available Bed policy (FAB). Although this policy has been discussed to some extent in the media, with stories of couples who were married for several decades being placed in separate facilities, or older adults moved to facilities at great geographic distance from their relatives, these stories have waned and FAB is becoming accepted as the norm in the public sphere. In this study though, FAB was an issue that was raised often by participants. Families and residents found the urgency associated with FAB and the lack of choice very stressful. While a handful of families in this study had successfully resisted the policy, many families and residents were not able to mobilize the resources to challenge the system during this stressful time.

For staff and administrators, the lack of choice and time for preparation meant that residents and families often arrived at the facility very angry or unprepared. In a setting where residents tend to stay for a long time, regardless of whether or not they are on a waitlist to leave again, the repercussions of this policy on relationship development is important. The transition into LTRC is a difficult time which is being exacerbated by a policy that is often presented to future residents and families in acute care settings as a rationale for not offering any options and, therefore, delaying discharge. Some legal scholars have begun to question the legality of FAB, particularly around the areas of consent, or lack thereof, from residents to be moved from hospital to whichever facility

has a vacancy (Advocacy Centre for the Elderly, 2006). They further attribute some of the underpinnings of this policy to systematic discrimination based on age and disability.

A rationale put forth for introducing FAB was that it would increase the efficiency of the admission process to LTRC but minimizing vacant bed days. At both study sites, there was a dominant language around keeping beds filled. If a bed was vacant for over 24 hours for example, facilities could lose funding. At Site A, the Social Worker was responsible for minimizing vacant bed days. She described the pressure to admit a new resident and how it contrasted with her professional desire to provide time for a potential resident to adjust to the idea of moving in to LTRC. By eliminating chronological waitlists, the FAB policy has effectively eliminated anticipatory planning. The quick notification and admission process, often created anxiety for residents and families. For the Director of Care at the private, for-profit Site B, there was pressure from the facility's owners to fill beds even if there were no appropriate residents on the transfer list. This pressure to fill beds meant that she sometimes had to admit residents who were not suited to the facility's physical environment or whose care needs really required a secure environment, which the facility could not provide. These varying pressures culminated in a system where residents were not viewed as individuals even before entering the facility, rather they were a necessary component of the financial structure of the system, regardless of who they were as individuals or where they may have wanted to live out their lives.

The FAB also speaks to tension between lack of choice in residency and the absence of standardization of care among LTRC facilities. One family member explained this to me in the sense that while a resident has no choice in which facility they

go to, there is great variation in the quality of care being delivered from one setting to another. Between the two study sites, there was great variation in staffing levels, staff mix, and even in whether facilities were governed by licensing. The lack of a standard of care even around licensing in part contributed to the creation of another layer of bureaucracy within the health authority to monitor complaints and intervene. The health authority has not, however, stepped forward to address broader issues of standardizing staffing levels and staff mix, likely because this would require accountability related to funding, which at present is far from a transparent or consistent process.

These differences between facilities are historically-based. During the 20th century, LTRC facilities in British Columbia often grew out of a need in the community and, thus, were tailored to particular groups or situations (Davies, 2003). Although these facilities previously functioned with varying levels of autonomy from the government, over the past decade there has been an increased clustering of facilities under contract with the health authorities. The common source of funding raises the conundrum of who is accountable for the care being provided – is it the health authority, the facility's administration, or the company that employs the staff? A further critical analysis of these issues is required to address the concern that, while we offer older adults little to no choice about where they will live, we also cannot provide any assurance that the care they receive in one facility is comparable to the care in a neighbouring facility.

A third area of restructuring took place was around staffing, specifically the legislation to allow contracting of services from private companies. As discussed by administrators in this study, the legislation allowing LTRC facilities to contract out for care services (that is, staff) from private companies, has allowed many facilities to realize

significant cost savings while maintaining or increasing staffing levels. On the surface, this appears to be a winning situation – saving money and having more staff. Yet, staff also talked about the consequences of this for relationships between staff and residents, particularly in relation to continuity of care and the loss of expertise of staff who had worked, sometimes, for decades in the same facility. As well, in critically analyzing the connection between cost savings and increased staff, the conclusion can be made that to achieve this outcome the cost savings *came* from staff salaries and benefits. Thus, in a workplace recognized as a predominantly female workplace (Steckenrider, 2000), the bearers of the cost savings were women who were already in some of the lowest paid positions in health care.

The growing demand for institutional solutions to an aging population has pushed LTRC to the forefront of one of the most contentious debates in Canada – the introduction of a second tier of private, for-profit care into our public health care system (Courchene, 2003; Kirby & Keon, 2004). The momentous shift to introduce privately-owned facilities funded by public dollars is being missed by many Canadians, as LTRC is rarely mentioned in this debate and many are not aware that this part of the health care system is not covered by the Canada Health Act. While interviewing family members for this study, it was apparent that a number of them did not understand the subtle, but substantial difference between a non-profit facility and a for-profit facility, because both types receive funding from health authorities to provide ‘the same’ service. Within a few short years, LTRC has evolved into a system where public funding from the provincially-funded health authorities is contracting privately-owned, for-profit facilities to deliver services. Even some non-profit facilities are taking public money and paying private

companies to provide staff. Thus, at various points in the current funding model, public funds are becoming profits for private companies.

In sum, multiple factors have contributed to ways in which restructuring has occurred in the LTRC sector over the past decade. The need for facilities with physical environments that can meet the care needs of the changing population was a factor that contributed to the closure of facilities. Yet, these closures impacted resident relationships with other residents and staff who were part of those communities. Another factor influencing restructuring has been the push from hospitals to move medically-stable adults requiring LTRC out of the hospital bed and into a residential care bed. Yet another factor was the need to decrease costs and maintain current funding levels despite an increasing need for higher levels of care. All of these factors reflect the growing pressures on the health care system as a whole, yet there have been consequences of these decisions on everyday care within LTRC. Although these changes are couched in the language of cost savings and effectiveness of the health care system, they also reflect the general acceptance of a discourse of rationing of health care services for older adults discussed in Chapter 2.

As well, the options chosen for restructuring were influenced by discourses of ageism and corporatism that underscore care of the aged. Creating a system where there is no choice or input into residency implies a certain disregard for the civil rights of those affected. Within a broader societal discourse of ageism, the introduction of FAB has now become almost an accepted part of the system rather than a bureaucratic policy to resist. With the exception of a few families, the participants in this study generally went to the facility that they were directed to by hospital staff. The discourse of corporatism is also

creeping into LTRC, with the funding of private, for-profit facilities by health authorities and the introduction of contracting out of services to private companies by both non-profit, and for-profit facilities. The offloading of costs onto residents is also continuing with service charges once they are in a facility for a variety of ‘additional’ services. These services include extra charges for private rooms in some cases and, in others, for simple acts of choice such as changing rooms. Thus, additional service charges within facilities mean that residents who can afford these charges have access to a different level of care than those who do not have financial resources. Within these broader discourses of ageism and corporatism, and the intersectionality of class and gender among the mainly female population of LTRC residents, a system has evolved in which those who receive the minimal amount of care are those whose voices and knowledges have effectively been subjugated and silenced.

‘Stolen Moments’: Finding Space for Care in LTRC

In addition to the influence of health policy on the everyday lives of residents and staff, there are further implications of the current system of LTRC on the *relationships between* these residents and staff. Throughout the findings, there were stories and examples of relational care that took place, but often this was behind closed doors or in ‘stolen moments’. For example, there was the housekeeper reading a resident her mail; there was also the HCW who took great pride in her work, particularly ensuring that her residents were “presentable” (i.e. clean and well groomed). In addition to examples, there was also a great desire on the part of staff to just spend time with residents, despite the demands on their time to complete their work assignments. Within this system, then,

there were moments where care flourished. Yet, there were also many factors that could inhibit this kind of relational engagement as discussed in the following paragraphs.

These moments fostered what Bhabha (1995) described as the ‘Third Space’. This space is where individuals from different social locations can come together to create a new, hybrid space. It is in this new space that “identities can be recast, negotiated, and reorganized, and what becomes the culture is constructed in this in-between space” (Reimer Kirkham et al., 2002). Thus, we could see in the ‘stolen’ moments in LTRC, places in which the residents and staff who come from disparate backgrounds transcended their differences and created a new, relational space. Given the core purpose of LTRC – to provide a living space – there is an opportunity for the moments of the ‘third space’ to become a vital and accepted part of day-to-day life in this setting. As well, I often witnessed these moments in hidden places, and behind closed doors, rather than in open spaces, which is where they need to be.

Staff who participated in the study acknowledged, however, that it was challenging at times to foster these spaces and to provide care in the way they wanted to because of their large resident assignments. Family members also commented on the demands on staff to meet all of their residents’ personal care needs (e.g. washing, dressing, toileting, feeding). What has evolved is a system where efficiency has been invoked at the cost of effectiveness. Stein (2001) describes how efficiency becomes “silent about values, neutral about goals” (p.28). In the case of LTRC, where making residents feel cared for would seem to be a goal, the need to complete large amounts of work in a short time frame all but makes this goal impossible. Recall the resident assignment at Site A where one HCW is responsible for 24 residents with complex care

needs during the day shift. The daily routines in LTRC reflect additional efficiencies. For example, mealtimes are set so that the kitchen staff produce the same meal for all the residents at one time. Individual access to food and beverages is limited and choice of food is also minimized.

Lopez (2000a, 2000b, 2007) discussed the work in LTRC, describing how limited resources to hire more staff fosters a situation where staff must break rules in order to complete their work within the time allotted (e.g. completing residents' personal care before breakfast). He further described how this mismatch between staff/time and tasks/resident care fosters a culture in which rule breaking, such as physically transferring a heavy resident rather than using a mechanical lift, is permitted. In this study, rule breaking was evident among all of the groups. For example, during observations and interviews, staff talked about negotiating with each other to complete their work. Sometimes this meant that they 'traded' residents depending on who could complete the care with the least amount of conflict. Other times, staff negotiated with residents, for example, whether or not they wanted to have a time-consuming bath when the staff member knew that the resident would refuse.

Although these negotiations could have outcomes that suited both parties, as described in Chapter 6, negotiations sometimes invoked demonstrations of power, power struggles, and somewhat arbitrary acts of punishment for those involved. These power struggles illustrated how individuals in traditional positions of power, such as administrators, used rules and regulations to uphold policies when convenient. For example, there was the family member who reported a food service worker who had treated the residents in an uncaring manner and was punished by an administrator by

having his activities restricted. Yet, because rule breaking tended to benefit the smooth functioning of the system, it also opened up spaces for acts of resistance. Drawing upon Foucauldian epistemology, these acts of resistance reflect the dynamic nature of power in relationships between individuals. Again, in the example of the family member, despite being chastised by the administrator, he continued to assist the food service workers because they were too short staffed without him. Even residents who were no longer able to verbalize or mobilize independently, there were acts of resistance that allowed them to exert power over what happened to their bodies.

When a family or resident placed high value on unrushed care they would have to pay a private caregiver to ensure that it happened. For example, there were a number of residents at both sites who had private HCW. In one meeting I observed, a family was told by the administrator that they would have to hire a private HCW because the facility was unable to provide sufficient one-to-one time for the resident. Here the ability to purchase extra staff time allowed for a more relational approach to care and, consequently, those residents without financial resources had to wait for ‘stolen moments’ with the facility’s staff. On the other hand, by supplementing the staffing, the more affluent residents were removed from the regular staff’s assignments making more time for the other residents. Yet the necessity of this flourishing system, at Site A nine percent of residents had private care providers, raises questions about the inequities in care provided to residents of different socioeconomic backgrounds.

As scholars such as Doane and Varcoe (2007) have suggested, providing relational care and enacting nursing values within the current context of health care is complex. Yet, they also challenge nurses to go beyond the superficial to authentically

engage in a relationship with those receiving care. In the current study, there was a definite tension for staff who, on the one hand, had a desire to have an authentic relationship with residents while, on the other, had to complete their work, which was defined as a series of tasks. Workload often interfered with the development of caring relationships between staff and residents. This contributed to a routinization of care where staff did not always have time to provide care in a way that recognized the unique identities and preferences of residents, with consequences for the residents' sense of identity. Greenwood (2007) describes the importance of understanding the other person and seeing them as an individual in order to provide a more relational type of care. Likewise, Arman and Rehnsfeldt (2007) explain, it's the 'little extras' that bridge gaps in the interactions between nurse and resident, helping to preserve dignity and validate identity. Thus despite contextual factors that may have created barriers to relational care, it did happen, but often behind closed doors.

The challenge of providing relational care in the current context of LTRC is also influenced by the hierarchical nature of nursing. Instances of connection often occurred with the sanction and support of one's coworkers. For example, when the HCW was persevering in bathing a resident, she had a colleague assist her; when the housekeeper was reading the resident's mail, the HCW found another task to busy himself with until she was done. Yet, this support often comes from one's horizontal colleagues, that is, a colleague in the same workgroup or categorization. For instance, it was rare for a RN to leave her paperwork to assist with residents' personal care so that a HCW could go slower and be less rushed when providing care.

Jervis (2002) described the strict hierarchy, or ‘chain of command’, in LTRC with the administrators at the top, then nurses, followed by HCWs. A similar hierarchy existed at both of the sites in this study. With the shrinking number of Registered Nurse (RN) positions and the shift towards Licensed Practical Nurses (LPNs), the delineation between the various ‘nurse’ groups – that is RNs, LPNs, and HCWs – is perhaps becoming even sharper. For example, there was the RN at Site A, who disdainfully spoke of the “dirty works” of personal care that are the responsibility of HCWs. She and other RNs and, to some extent LPNs, stressed the importance of their “paperwork” as the identifying marker of their work, separating themselves from hands on care of residents. The primacy of paperwork was also illustrated in the tension between RNs and LPNs at Site A, where LPNs had to do some personal care as part of their everyday work, whereas RNs were exempt from this. Rather than seeing personal care as an integral component of nursing, it was seen as a marker of low status. This low status provided support for withdrawing RNs from the point of care. The consequence of the erosion of clinical knowledge from the bedside however, is that acute health issues or even chronic issues may not be addressed in a timely way. The hierarchy that maintains distance between the work done by each group also limits communication and team work among the various groups, thereby contributing unnecessarily to the separation between expert gerontological nursing knowledge and the recipients of care.

The enduring hierarchical nature of nursing in LTRC illustrates the convergence of class and intra-gender oppression among those working in this setting. In describing their work, the mainly female staff in the study sites articulated their work according to their group membership, that is as administrators, RNs, LPNs, and HCWs. On occasions,

these groups worked in a cohesive manner, yet individuals largely relied on others within their group to complete their assignments. For RNs and LPNs, the focus on paperwork and contact with physicians meant that they could absent themselves from hands-on care, leaving it for the low-paid HCWs to complete, at times, unimaginable work assignments (as in the 1:24 ratio assignment).

As Black Feminist writers such as Brewer (1993) and Hill Collins (1989) suggested, it is in interlocking systems of oppression, characterized by intersectionalities that require further analysis to understand the experiences of Women of Colour. As in the hierarchy that exists within LTRC, Women of Colour often hold the lowest paying positions, with few opportunities to move into other roles. In this study, those in positions of power and authority, rather than exhibiting interest in this situation, played key roles in ensuring that it was maintained. This was exemplified in the silence among administrators at the staff meeting where the Housekeeper spoke about the verbal insults she received from residents, and in the strategic hiring practices of the same administrators to exclude Women of Colour from obtaining unionized positions that would provide job security and fair wages. The oppression of women by women was also demonstrated by the avoidance of certain types of work by RNs and LPNs, leaving the “dirty works” for the HCWs. In nursing, we have done little to address these informal structures of oppression that have previously been documented by scholars such as Berdes and Eckert (2001) and Das Gupta (1996). In order to create a sociopolitical milieu that fosters the Third Space between care providers and recipients of care, we must also confront and address these entrenched relations of oppression within nursing.

Chapter Summary

This discussion chapter began with an examination of the systematic decommissioning of citizenship of residents and staff in LTRC. Then, I discussed the impact of health policy in the everyday lives of residents and staff. The third section of this discussion focused on the ‘stolen moments’ of care that take place in LTRC. All of these issues are woven into discourses of ageism, corporatism, and efficiency, which foster the sociopolitical milieu in which they exist. As well, within this sociopolitical milieu, the historically situated intersections of race, gender, and class situate individuals into a hierarchical structure that persists through formal and informal processes. The legacy of postcolonialism is reflected in LTRC where there is a systematic decommissioning of citizenship for the largest populations – residents and Women of Colour who work there, by a small group in positions of power and authority. Yet, as suggested by Foucauldian epistemology, within this system, power was not static, and there were acts of resistance in which power relations shifted. These acts provided opportunities to open up and create a new culture, a new, shared identity, in the Third Space. Although the sections of this chapter are laid out consecutively to consider key themes that arose in the study, the real complexity of LTRC is that they need to be considered as simultaneous, intersecting, and compounding forces that ultimately shape how care is organized moment to moment and day to day. As I turn to the conclusions and recommendations in the final chapter, we are drawn to the question of what the future holds for LTRC in the Canadian health care system and the broader sociopolitical context of aging.

CHAPTER 9

DISRUPTING ROUTINES IN LTRC:

SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

This final chapter is organized into three main sections. First, I summarize the dissertation. Next, I draw conclusions based on the findings and discussion. Lastly, I make recommendations for the continuing evolution of the organization of care in long-term residential care (LTRC).

Summary of the Dissertation

Long-term residential care (LTRC) is a microcosm of our larger society – albeit intensified, where people from disparate backgrounds come together to live and work. Currently, there are multiple, demographic factors impacting upon LTRC. These demographic factors include: the aging population, the growing ethnic diversity of Canada's aging population, and ethnocultural diversity among LTRC staff. Alongside these factors is the ongoing restructuring of the health care system in British Columbia. Several restructuring changes have had particular impact on LTRC over the past decade, including: the closure of many LTRC beds and facilities, the introduction of the First Available Bed policy, and legislation allowing contracting of services (i.e. staff) by private companies. Together, these issues comprise the sociopolitical milieu in which day to day care is organized in LTRC.

The aim of this study was to improve care for residents living in LTRC by:

i) gaining a greater understanding of how care is organized in LTRC within a complex sociopolitical milieu, and ii) considering the potential consequences of how care is

organized in LTRC for the larger health care system. The study was guided by five objectives:

Objective 1: To examine the everyday encounters between residents living in long-term residential care and those involved in providing their day-to-day care;

Objective 2: To examine staff members' perceptions of how different roles contribute to the organization of resident care;

Objective 3: To examine social relations in the complex, institutional context of long-term residential care;

Objective 4: To examine how acute care services are utilized by residents of LTRC;

Objective 5: To examine the organization of care for residents living in LTRC within a broader sociopolitical milieu, and specifically within the context of the health care system in British Columbia.

To critically examine the issues influencing the organization of care in LTRC, this study was guided by a theoretical perspective that was informed by postcolonialism, postcolonial feminism, intersectionalities, and Foucauldian epistemology around discourse, subjugated knowledges, and power. The method of inquiry was critical ethnography, which allowed me to engage in a critical analysis of the 'taken for granted' assumptions in the organization of care in LTRC. Throughout the study, I was challenged to listen to, and observe the many players in this setting, in particular the residents, family members, staff, and administrators. This approach also challenged me to be reflexive about my positions of power within this context, where I have been situated in privileged positions as a White nurse and a manager at various points in my nursing career. As well, within the explicitly political nature of postcolonial work, the

recommendations of this research point towards revolutionizing health care policy and nursing approaches to care for adults living and working in LTRC.

Ethical approval for the study was obtained from the University of British Columbia Behavioural Review Board. The study took place at two LTRC facilities in the Lower Mainland of British Columbia. I was immersed in the main study site for ten months and the secondary study site for four months. My field work consisted of participant observation of day to day activities, which amounted to approximately 218 hours of field work over the ten months. I conducted 51 in-depth interviews with administrators, family members, residents, and staff. As data collection progressed, I began a review of relevant documents, such as the First Available Bed policy, Complex Care policy, licensing guidelines and internal policies and procedures to assist with the interpretation of data from field work and interviews. I also collected selected quantitative data from 2000 and 2005 related to transitions in care that reflected the facility's residents' utilization of health care services, and staffing levels.

The study findings were organized into three chapters. The first chapter focused on the voices of residents. The residents spoke about what it is like to live in LTRC and how they pass the time. The second chapter presented findings related to working in LTRC and the interactions between those living and working in LTRC during day to day care. The third chapter of findings focused on LTRC within the larger health care system. Throughout these chapters, I relied heavily on the voices of the residents and staff, who were primarily women, in keeping with the theoretical perspective of this study and "the need for knowledge construction from the perspective of the marginalized

female subject whose voice has been muted in the knowledge production process”
(Anderson, 2002, p.10).

Findings from the study illustrated the complexity of care in LTRC within the broader sociopolitical milieu. The voices of residents shared the frustrations of living in LTRC. Many had experienced constraints on choice in this institutional setting. They found ways to pass the time by keeping busy and connecting with others. The resident population also reflected the changing ethnocultural diversity of the general population. These residents, particularly when they did not speak or understand English, experienced isolation when the facilities depended on staff who spoke the same language to communicate with residents as they did not have funding for formal interpreter services. There was also an increasing presence of younger residents at the facilities, particularly adults with addiction and mental health issues, and individuals who had previously been homeless. The experiences of residents illustrated a systematic erosion of identity over time, characterized by many losses. As well, those residents who were problematized as being ‘different’ were at risk for receiving less care than residents who fit into the typical resident population.

The interpersonal aspects of care reflected the dynamics of bringing together people from various backgrounds and placing them together in a hierarchical system. Among the staff, there were a number of groups present in LTRC, including Registered Nurses, Licensed Practical Nurses, and Health Care Workers. These groups tended to work alongside each other, though, rather than together. Reflected in the relations of these groups were intersections of race, gender, class, and age. Women of Colour in

particular were positioned in low-paying, low-status positions, often with few opportunities to move into other roles.

Family members had a cautious presence in LTRC. Some were active contributors to care, either by providing hands on care, offering emotional support, or paying for additional services to supplement what was provided. Family members tended to rely on direct care staff to exchange information about residents, but they also, at times, had antagonistic relationships, particularly when family members requested a level of care that the staff were unable to provide. Moreover, the findings illustrated the Foucauldian notion of dynamic power relations in the social relations of those living and working in LTRC, which often involved acts of resistance.

Health care restructuring, underscored by discourses of ageism and corporatism, also influenced the organization of care and day-to-day interactions in LTRC. Specifically, policy changes such as the First Available Bed policy fostered anxiety and anger among residents and family members. It also strained the capabilities of facilities to admit very complex residents in a short turnover period. Pressure to adapt to these changes was largely driven by the acute care system, and the need to discharge older patients awaiting placement in LTRC. Another area of health care restructuring that influenced everyday care was the introduction of contracting of services, including staff, from private companies. A consequence of this change was that at one of the study sites, there was a continuous turnover of staff, which impacted on continuity of care for the residents. Within LTRC, there was an erosion of clinical knowledge and leadership, which meant that there were few voices to protest the impact of these changes. The culmination of these changes – heightened resident needs, frequent staff turnover, and the

erosion of clinical knowledge and leadership had implications for the quality of care that was possible within this setting.

In the discussion of these findings, I examined several key themes. The first area was the systematic decommissioning of citizenship that occurred for those who live in LTRC as well as for those who worked there. For residents, there were concomitant losses of identity and independence that occurred along with an erosion of their abilities to make choices and be autonomous. For staff, a decommissioning of citizenship often accompanied working in LTRC where they were viewed as easily replaceable. A second area was the impact of health policy on the everyday. Over the past decade there have been a number of restructuring changes in LTRC. The stories of residents and staff illustrated how these restructuring changes, made with good intentions, have had negative consequences for relationships between those who live and work in facilities. Some changes, such as the First Available Bed policy, have contributed to anxiety and anger among new residents and families, which creates a barrier to developing relationships. A third key theme related to the restrictions of relational care to ‘stolen moments’ rather than being a standard component of care. While there were moments when care flourished, these moments were often witnessed behind closed doors.

Although sometimes considered a place where mundane, institutional routines dominate, this analysis and discussion of the findings illustrates that LTRC is a dynamic site of intersecting forces and power relations. The study’s theoretical perspective provided the opportunity to “move beyond a single axis framework of analysis...to overcome the limitations of the oppressor/victim binary, in which individuals are characterized monolithically as one or the other” (Alcoff, 1998, p.484). Unlike some

previous ethnographic work in LTRC (for example see Foner 1994a, 1994b), there were no absolute angels or demons in this research. Rather, the ways in which individuals were socially constructed and positioned were often historically-situated in the intersections of race, class, and gender, the relations of power, and examples of resistance, all reflected the complex dynamics of bringing together people from different backgrounds, sometimes unwillingly, to live and work together in the same space. Thus, in this study, the legacy of postcolonialism resonated in LTRC - a microcosm of the organization of Canadian society. In the following sections, I present conclusions based on these findings and, finally, recommendations from the study.

Conclusions

From this study, I have drawn a number of conclusions. First, the organization of care in LTRC is largely shaped by the discourse of ageism that permeates our broader societal constructions of aging and care of the aged. Over time, this discourse supports a systematic decommissioning of citizenship for residents through the erosion of choice, identity, and civil rights. Within this context, though, some residents continued to assert their individuality, whether by disrupting care when it was not respecting their rights, or through acts of independence despite physical restrictions, or by mobilizing their resources of family advocates. As the Canadian population ages and more adults will require supportive care with increasing age and frailty, the power relations within LTRC may begin to shift to authentically reflect the rights of those for whom it exists.

Second, LTRC continues to be a woman's world, despite the presence of a handful of male residents, staff, and administrators. Within this gendered context, residents who are Women of Colour and have a language barrier tend to experience

isolation unless they passively join in with the dominant population of White, English-speaking women and men. This negating of their identities in order to assimilate into the dominant culture has resonance with the loss of nationhood of past colonial legacies. The experience of these women reflect the broader intolerance for difference in LTRC, and the unwillingness of those in positions of power to interrogate the entrenched routines of this setting. These routines that provide structure for day to day activities also prevent integration of new members and, at a broader level, diversity, into the LTRC community.

LTRC is also a racialized workplace for immigrant Women of Colour. Many are employed in low paying, low status jobs that require them to work across several sites. Despite their desire to continue their educations, there are few supports for these pursuits within the system. These staff often play a surrogate family role in the lives of residents, who may have absent biological families and depend on the staff to provide emotional, not just physical, care. Within the hierarchical class structure of nursing in LTRC, the upper class of RNs are able to pick and choose when they become involved in hands on care, leaving the 'dirty work' of personal engagement with residents to the HCW. These relations of power reflect oppressive intra-gender politics that continue to construct relations within the nursing community.

Third, under the guise of restructuring, privatization has become a normal component of the LTRC sector of the health care system. Public money from the provincial government is being paid to private, for-profit facilities through contracts with the health authorities. Even within non-profit facilities, if they have contracted services to a private company, public funding is still going into private coffers. Although Canadians loudly protest the shift towards privatization in the acute care sector, it has

gone largely unchallenged in LTRC. Again, this reflects the influence of ageism in fostering a system in which a different type of health care is acceptable for older adults than for the rest of the population.

Recommendations

- Critical analysis of the organization of care in LTRC needs to continue in order to further examine the issues raised in this research. Scholars in the field of gerontology, particularly critical gerontology, are positioned to continue to interrogate the disparities in care that are fostered through health care policy and service delivery for older adults. Greater integration of intersectionalities perspectives could provide a framework for critically examining the complexities and conundrums of multiple axes of oppression that operate simultaneously both within the aging population and between the aged and other groups.
- There is also a need to continue challenging discourses of ageism on the part of those who work in LTRC and society more generally. Fostering critical consciousness about these discourses requires fundamental changes in the way that aging is viewed in Western culture. In nursing, it has implications for the way that gerontological nursing is taught, for the way that care of older adults is constructed in clinical placements, and for the responsibility of educators to avoid re-inscribing ageism through their words and actions.
- The discipline of nursing should engage in collective critical reflexivity with regards to the enduring hierarchies within our discipline that foster a system of intra-gender oppression. As this study demonstrated, there are clear ‘territories’ of work, for the different groups engaged in nursing care. At a time when much

focus is being placed on interprofessional collaboration, we need to step back and critically consider the issues that impede intraprofessional collaboration. Nursing needs to advocate not just for our resident/patient populations, but also for our colleagues. For example, nurse leaders should be at the forefront to advocate for fair wages, job security, and benefits across all sites where nursing care is provided with public money. Registered Nurses in particular are in positions of privilege, largely because of the huge shortages being experienced and, thus, our voices should lend support to those we practice alongside everyday. Further research is needed into the experiences of Internationally Educated Nurses in Canada, particularly the interplay between this group and care of older adults and how they become mutually constructed as less privileged parts of the health care system. As well, policies need to be developed to assist Internationally Educated Nurses to reenter the nursing workforce when they immigrate to Canada.

- Nursing needs to reorient towards relational care. In a setting such as LTRC, it is perplexing that relational care occurs in ‘stolen moments’ rather than being the accepted approach and overarching philosophy to working with residents. The moments of the ‘Third Space’ that are fostered in these interactions provide opportunities for the development of inclusive communities for the diverse populations that live and work in LTRC. The ingrained daily routines aimed at providing care to a large number of complex residents by a small group of dedicated staff, should be held up for further questioning. Residents who participated in this study clearly indicated that the most valued part of their day

was when they had opportunities to participate in self-enriching activities such as music, art, and the simple act of unrushed conversation.

- To achieve revolutionary changes in the way that care is organized in LTRC, there need to be avenues for educating the next generation of leaders. In this study, there were many Health Care Workers and Licensed Practical Nurses, many of whom were recent immigrants, who were passionate about working with Canada's aging population. Yet, many of them experienced barriers, particularly time and money, to pursue further education. At a time when current leaders are retiring, it is imperative that LTRC look within and cultivate a new generation of leaders who understand and will advocate for this area of care.
- The flow of public funding into private, for-profit facilities and private companies that provide contracted staff for facilities needs ongoing examination. This situation is unlikely to be reversed and with the influential discourses of corporatism and privatization driving this process, health care administrators will continue to be pressured to find ways of generating 'revenue' in this sector. Great concern should be focused on where the revenues go – in non-profits, such as Site A, they are usually reinvested in resident care, however, in for-profits, such as Site B, they go to owners and shareholders. As one of the first areas of the health care system to enter this public-private arena, there are many lessons to be learned. The current situation also calls for greater accountability for where public money is being directed – whether to the recipients of care or for corporate gain. Systems of accountability, such as accreditation and licensing are in place, though they are not systematically applied, and may not address these financial

issues. In 2006, a special report to the Premier's Council on Aging and Seniors' Issues (Baird, 2006) was compiled which called for, among other recommendations, the appointment of a Minister of State and secretariat to address issues of the aging population. This recommendation should be taken up with calls to create an independent Ombudsperson to systematically review the LTRC system and to be a vigilant champion for high quality, standardized care for those who live in institutional settings.

- A related recommendation is for all Canadians, regardless of age, to be attentive to, and respond to, the encroachment of a multi-tiered system of public and private care in LTRC. While Canadians tend to be very vocal about this issue in relation to acute care services, there has been relative silence as private models of care have increasingly become the norm in LTRC. Informed groups need to mobilize the aging population, particularly the large cohort of Baby Boomers, to begin to shape the future of LTRC, because all too soon these individuals will be on the doorstep of the system that currently houses their parents. Collective political action will be necessary to engage with policy makers and health care decision makers over the future of LTRC in Canada.

Table 4.1:
Overview of Data Collection

Type of Data	Site A	Site B	Regional	Total
Interviews				51
Administrators	5	2	3	10
Family Members	5	6	n/a	11
Residents	6	2	n/a	8
Staff	12	10	n/a	22
Meeting Fieldnotes (# of meetings attended)	6	6	n/a	12
Informal Field Work (hours)	138	80	n/a	218

Table 4.2:
Facility Demographics

Study site	Site A	Site B
Information about facility		
Type of facility	Non-profit	Privately owned, for profit
Age of facility (years)	Approximately 30	Approximately 40
Differential charge for private/semi-private rooms	n/a (all private rooms)	Yes
Information about residents at study site		
Residents' age		
Range	39 – 102	49 – 106
mean	84	84
percent with private paid caregiver	9	2
percent non-English speaking		
General population	4	8
Special care unit population	35	n/a
Preferred language of non-English speaking residents	Cantonese (3) Croatian (2) Farsi (1) French (1) Greek (1) Korean (4) Polish (1) Punjabi (1) Sudanese (1) Ukrainian (1)	Cantonese (1) Dutch (1) German (1) Italian (1) Japanese (1) Mandarin (1) Portuguese (1) Punjabi (1)

*the exact number of beds is not provided in order to protect the identity of the study sites

Table 4.3:
Administrator Demographics (N=10)

Current Employer		
	Non-profit	5
	Private, for-profit	2
	Health Authority	3
Length of time in current position (years)		
	range	<1 – 10
	mean	4
Length of time with current employer (years)		
	range	<1 – 16
	mean	9
Length of time working in residential care (years)		
	range	8 – 17
	mean	12
Current Employment Status		
	Full-time	10
	Part-time	0
Healthcare Professional Designation		
	RN	7
	RSW	1
	None	2
Highest Level of Education		
	College Diploma	1
	Baccalaureate Degree	6
	Masters Degree	3
Gender		
	female	9
	male	1
Age		
	range	38 - 63
	mean	47
Country of Birth		
	Canada	8
	Germany	1
	India	1

Table 4.4:
Family Member (FM) Demographics (N=11)

Resident's age (years)		
	range	62 – 98
	mean	84
Resident's gender		
	female	10
	male	1
FM relationship to resident		
	child	6
	extended family	1
	spouse	4
Length of time resident has been in LTRC		
	range	6 weeks – 5 yrs
	mean	3 years
Resident waitlisted for different facility		
	yes	1
	no	10
Resident previously lived in different facility		
	yes	1
	no	10
Frequency of visits		
	daily	4
	> once per week	6
	monthly	1
Age (years)		
	range	49 – 84
	mean	67
Gender		
	female	7
	male	4
Employment status		
	full time	3
	part time	1
	retired	7
Education level		
	less than high school	3
	high school diploma	3
	college diploma	3
	bachelors degree	0
	masters degree	2
Country of birth		
	Austria	1
	Canada	8
	Czechoslovakia	1
	Poland	1

Table 4.5:
Resident Demographics (N=8)

Length of time resident has lived at current facility		
	range	6 weeks – 17 yrs
	mean	3
Currently waitlisted for different facility		
	yes	0
	no	8
Previously lived in different facility		
	yes	4
	no	4
Reason for leaving previous facility		
	previous facility was decommissioned	3
	current facility was preferred (waitlisted) site	1
Age (years)		
	range	48 – 99
	mean	79
Gender		
	female	5
	male	3
Education level		
	less than high school	3
	high school diploma	3
	college diploma	2
Main source of employment		
	educator	1
	homemaker	1
	housekeeper	1
	labourer	1
	self-employed	2
	various	2
Country of birth		
	Canada	4
	Canada (First Nations)	1
	England	1
	Poland	1
	Scotland	1

Table 4.6:
Staff Demographics (N=22)

Job Title		
Reception/Office Assistant		1
Chaplain		1
Dietician		1
Health Care Worker		7
Licensed Practical Nurse		6
Recreation/Therapy Staff		2
Registered Nurse		3
Social Worker		1
Length of time in current position (years)		
	range	0 – 19
	mean	6
Length of time working in residential care (years)		
	Range	0 – 31
	mean	11
Employer		
	Facility	12
	Company contracting services	10
Current Employment Status		
	Full-time	6
	Part-time	13
	Casual	2
Highest Level of Education		
	College Diploma	16
	Baccalaureate Degree	4
	Masters Degree	2
Gender		
	female	16
	male	6
Age		
	range	
	mean	
Country of Birth		
	Canada	10
	China	1
	Nigeria	1
	Philippines	9
	Russia	1

Table 4.7:
Care Transitions for Residents across the Health Care System

Study Site	Site A		Site B	
Year	2000	2005	2000	2005
# new admissions	72	70	55	58
# emergency department visits by residents	103	198	n/a	n/a
# hospital admissions	60	78	50	93
# of discharges	72	72	57	57
# of deaths	43	46	37	37
# of transfers to other LTRC facilities	13	13	20	20
# of transfers back to independent living in the community	3	4	0	0

Table 4.8:
Staffing Levels at Study Sites in 2000 and 2005

Study Site	Site A		Site B	
	2000	2005	2000	2005
Dietician	0.63	0.63	1PT	1PT
Food Service Worker	23.87	23.1	9FT	? Contracted to private company
Health Care Worker	49.55	46.47	34FT; 17PT	12FT; 24PT
Housekeeper/Janitor	15.73	13.47	7FT	5FT
Laundry	4.86	4.75	1FT	1FT
Licensed Practical Nurse	15.8	16.86	0	6FT; 3PT
Recreation	5.82	4.82 + music & art therapy	3FT	3FT
Registered Nurse	21.84	22.45***	12FT	3FT; 2PT
Social Work	1.0	1.0	0	0

*Site A responded to this questionnaire by providing the overall full time equivalents.

**Site B responded to this questionnaire by providing the number of full time (FT) and part time (PT) positions at each point in time.

***Although the absolute amount of RN FTEs increased, in reality, there were 18.45FTE direct care nurses, and 3.0FTE nurse coordinators, thus the amount of time RNs were involved in direct care had actually gone down and their management duties had increased.

Table 4.9: Timeline

Date	Activity	
December 2005	Successful oral candidacy exam	
Spring/Summer 2006	Negotiated access to study sites	
July 2006	Obtained ethics approval from UBC Behavioural Research Ethics Board	
October 2006 – August 2007	Site A data collection	Concurrent data analysis: coding of data, retrieval of relevant documents
May 2007 – August 2007	Site B data collection	
September – December 2007	Revision of Chapters 1 – 4; initial drafts of Chapters 5 – 9	Continue data analysis and interpretation
January – February 2008	Refined dissertation chapters	
February 2008	Submitted complete dissertation to UBC Graduate Studies	

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Appendix A:
Demographic Forms

Demographic Form for Administrators

The Organization of Care for Elders Living in Long-term Residential Care

Interview #: _____

Site Code: _____

Date: _____

1. What is your job title? (e.g. administrator, Director of Care, manager)

2. What are your primary areas of responsibility?

3. Number of years working in this role: _____

4. Number of years working at this site: _____

5. Do you have a health care professional designation (e.g. RN, RDN, SW, PT)?

If so, what is it? _____

6. Employment: (circle)

Full time

Part time

Other _____

7. Education level: (circle)

PhD

Masters

Degree

Diploma

High School Graduation

Other _____

8. Gender: (circle)

Male

Female

9. Country of birth _____

10. If not born in Canada, length of time (years) in Canada _____
11. Language(s) spoken _____

Demographic Form for Family Caregivers

The Organization of Care for Elders Living in Long-term Residential Care

Interview #: _____

Site Code: _____

Date: _____

5. How long has your family member been a resident of this facility?

6. Are they on a waitlist for another facility?

3. How often do you visit your family member at the facility (per week)?

4. How long do visits typically last? _____

5. Briefly describe the activities you do when you visit:

6. Are you employed?

Full time

Part time

Not at all

Other _____

7. What is your occupation? _____

8. Education level: (circle)

PhD

Masters

Degree

Diploma

High School Graduation

Other _____

9. Gender: (circle)
Male
Female
10. Country of birth _____
11. If not born in Canada, length of time (years) in Canada _____
12. Language(s) spoken _____

Demographic Form for Residents

The Organization of Care for Elders Living in Long-term Residential Care

Interview #: _____

Site Code: _____

Date: _____

7. How long have you lived here?

2. Are you on a waitlist to move to another facility (circle)?

Yes

No

3. Education level: (circle)

PhD

Masters

Degree

Diploma

High School Graduation

Other _____

4. Gender: (circle)

Male

Female

5. Year of birth: _____

6. Country of birth _____

7. If not born in Canada, length of time (years) in Canada _____

8. Language(s) spoken _____

Demographic Form for Staff

The Organization of Care for Elders Living in Long-term Residential Care

Interview #: _____

Site Code: _____

Date: _____

8. What is your job title? (e.g. nurse, LPN, care aide, care coordinator)

9. Number of years working in this role: _____

10. Number of years working in this role at this site: _____

11. Have you worked in any other roles in long-term residential care? If so what and for how long?

5. Do you have a health care professional designation (e.g. RN, LPN)?

If so, what is it? _____

6. Employment: (circle)

Full time

Part time

Casual

Other _____

7. Education level obtained in Canada: (circle)

PhD

Masters

Degree

Refresher

Diploma

High School Graduation

Other _____

8. Gender: (circle)

Male

Female

9. Country of birth _____

10. If not born in Canada, length of time (years) in Canada _____
11. Language(s) spoken _____
12. If not born in Canada, did you do any postsecondary education in your country of origin? (yes/no)
13. If so, what is your education level?: (circle)
- PhD
 - Masters
 - Degree
 - Diploma

Appendix B

Quantitative Data from Participating Facilities

The Organization of Care for Elders Living in Long-term Residential Care

Between January 1, 2000 and June 30, 2000

1. How many new admissions to facility were there?

2. How many discharges from facility were there?

 - a. Of these discharges how many were due to:
_____ residents' death
_____ transfer to other long-term residential care facilities
_____ discharge to the community
_____ other (please specify): _____
3. How many visits to the Emergency Department by residents of this facility were there?

4. How many admissions to hospitals by residents of this facility were there (i.e. residents were in hospital overnight)?

5. How many Added Care hours were used by the facility?

6. How many funded beds did the facility have?

7. How many staff full time equivalents (FTEs) were there at the facility?
_____ Care Aide (e.g. care aides, resident care attendants, etc.)
_____ Dietician
_____ Housekeeper
_____ Licensed Practical Nurse
_____ Registered Nurse (includes all DC1 & DC 2 positions)
_____ DC1 RN
_____ DC2 RN
_____ Rehabilitation Assistant
_____ Social Worker
_____ Other (please specify): _____

Between January 1, 2005 and June 30, 2005

8. How many new admissions to facility were there?

9. How many discharges from facility were there?

a. Of these discharges how many were due to:

_____ residents' death

_____ transfer to other long-term residential care facilities

_____ discharge to the community

_____ other (please specify): _____

10. How many visits to the Emergency Department by residents of this facility were there?

11. How many admissions to hospitals by residents of this facility were there (i.e. residents were in hospital overnight)?

12. How many Added Care hours were used by the facility?

13. How many funded beds did the facility have?

14. How many staff full time equivalents (FTEs) were there at the facility?

_____ Care Aide (e.g. care aides, resident care attendants, etc.)

_____ Dietician

_____ Housekeeper

_____ Licensed Practical Nurse

_____ Registered Nurse (includes all DC1 & DC 2 positions)

_____ DC1 RN

_____ DC2 RN

_____ Rehabilitation Assistant

_____ Social Worker

_____ Other (please specify): _____

15. Between 2000 and 2005 were any staff positions contracted out?

_____ Yes

_____ No

If yes, what type of positions were contracted out (please ✓ all that apply):

_____ Care Aide (e.g. care aides, resident care attendants, etc.)

_____ Dietician

_____ Housekeeper

_____ Licensed Practical Nurse

_____ Registered Nurse (includes all DC1 & DC 2 positions)

_____ DC1 RN

_____ DC2 RN


_____ Rehabilitation Assistant

_____ Social Worker

_____ Other (please specify): _____



Certificate of Approval

PRINCIPAL INVESTIGATOR Phinney, A.	DEPARTMENT Nursing	NUMBER B06-0438
INSTITUTION(S) WHERE RESEARCH WILL BE CARRIED OUT UBC Campus ,		
CO-INVESTIGATORS Anderson, Joan, Nursing; Baumbusch, Jennifer, Nursing; Reimer-Kirkham, Sheryl, Nursing		
SPONSORING AGENCIES		
TITLE: The Organization of Care for Elders Living in Long-term Residential Care		
APPROVAL DATE JUL 20 2006	TERM (YEARS) 1	DOCUMENTS INCLUDED IN THIS APPROVAL: June 30, 2006, Advertisement / Consent form / Apr. 3, 2006, Contact letter / Assent forms / Cover letter / Questionnaires
CERTIFICATION: <p>The application for ethical review of the above-named project has been reviewed and the procedures were found to be acceptable on ethical grounds for research involving human subjects.</p> <div style="text-align: center;"> <hr/><i>Approved on behalf of the Behavioural Research Ethics Board</i> <i>by one of the following:</i> Dr. Peter Suedfeld, Chair, Dr. Susan Rowley, Associate Chair Dr. Jim Rupert, Associate Chair Dr. Arminee Kazanjian, Associate Chair</div> <p>This Certificate of Approval is valid for the above term provided there is no change in the experimental procedures</p>		

THE UNIVERSITY OF BRITISH COLUMBIA

Appendix D: Letter of Initial Contact



School of Nursing

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Vancouver, B.C. Canada V6T 2B5
Tel: (604) 822-7417
Fax: (604) 822-7466

The Organization of Care for Elders Living in Long-term Residential Care

Long-term residential care is becoming more complex in British Columbia. People who live and work in residential care come from diverse backgrounds. They come from different ethnocultural backgrounds and, sometimes, do not speak the same language as other people living and working in the facility. Reforms in the health care system have meant that people being admitted to residential care are becoming more medically complex. At the same time, other factors, such as changes in the nursing workforce, are affecting the roles and responsibilities of those who care for residents. Through this study, we will learn more about how care for elders is organized in long-term residential care and how this is affecting the larger health care system, such as the use of emergency and in-patient services. Information from this study will provide valuable insight that will be shared with policy makers and health care decision makers in order to inform health care planning.

You are being invited to learn more about this study because you are the identified contact person for a resident living in a facility where this study is taking place. This study is being conducted as part of the degree requirements for Jennifer Baumbusch's doctoral degree in nursing.

Jennifer will be spending time at the facility to learn more about what it is like to live and work in long-term residential care. She will be doing observations of day to day care. She will spend up to 4 hours at a time with staff and residents. These observations will not affect daily routines. Jennifer will also be interviewing residents, staff, administrators, and family members to learn more about what it is like to live and work in long-term residential care. Interviews will take place at a convenient time and location and will last between ½ hour to one hour. Participation in all aspects of the study is voluntary. You may refuse to participate, refuse to be observed, refuse to answer any questions during an interview, and/or withdraw from the study at any time.

Doctoral Candidate

Jennifer Baumbusch, RN, MSN, GNC(C)
UBC School of Nursing

Dissertation Committee Supervisor

Joan Anderson, RN, PhD
Professor Emeritus
UBC School of Nursing

Co-Supervisor

Alison Phinney, RN, PhD
Assistant Professor
UBC School of Nursing

Committee Member

Sheryl Reimer Kirkham, RN, PhD
Associate Professor
Nursing Department, Trinity Western University

**If you would like to learn more about the study,
please contact Jennifer Baumbusch at xxx-xxx-xxxx or xxxxxx@xxxxxx
or Dr. Alison Phinney at xxx-xxx-xxxx**

THE UNIVERSITY OF BRITISH COLUMBIA

Appendix E: Letters of Consent



School of Nursing

T201- 2211 Wesbrook Mall
Vancouver, B.C. Canada V6T 2B5

Tel: (604) 822-7417

Fax: (604) 822-7466

The Organization of Care for Elders Living in Long-term Residential Care

Letter of Consent for Interviews (Residents & Family Caregivers)

Doctoral Candidate

Jennifer Baumbusch, RN, MSN, GNC(C)
UBC School of Nursing

Dissertation Committee Supervisor

Joan Anderson, RN, PhD
Professor Emeritus
UBC School of Nursing

Co-Supervisor

Alison Phinney, RN, PhD
Assistant Professor
UBC School of Nursing

Committee Member

Sheryl Reimer Kirkham, RN, PhD
Associate Professor
Nursing Department, Trinity Western University

You have been asked to participate in this interview because you live/have a family member living at a facility where this study is taking place. This research is being conducted as part of the nursing doctoral degree requirements for Jennifer Baumbusch.

Background

Long-term residential care is becoming more complex in British Columbia. People who live and work in residential care come from diverse backgrounds. They come from different ethnocultural backgrounds and, sometimes, do not speak the same language as

other people living and working in the facility. Reforms in the health care system have meant that people being admitted to residential care are becoming more medically complex. At the same time, other factors, such as changes in the nursing workforce, are affecting the roles and responsibilities of those who care for residents. Through this study, we will learn more about how care for elders is organized in long-term residential care and how this is affecting the larger health care system, such as the use of emergency and in-patient services. Information from this study will provide valuable insight that will be shared with policy makers and health care decision makers in order to inform health care planning.

Participation and Reporting

During the interview Jennifer will talk with you about what it is like to live/have a family member living in a long-term residential care facility. She will record the interview so that she can remember what you said. A transcript will be made, with all identifying information removed. The interview will take place at a time and location that is convenient for you. The interview will last about ½ hour to 1 hour. Information from the interviews will provide insight into what it is like to work in long-term residential care.

Confidentiality

Because this research is taking place in a residential environment and interviews may occur on site, it will be difficult to maintain complete anonymity about participation. In order to maintain confidentiality no names will appear in the transcripts and all identifying information will be removed. Copies of the transcripts will be kept in locked cabinets in the office of the Doctoral Candidate and data will be kept on computers that are password protected. Only Jennifer, her doctoral committee, and analysis group will have access to the data.

The data from the observation (with no identifying information from any of the participants) will be kept for a minimum of five years in accordance with the University of British Columbia research policy. The data will also be used for future analysis and educational purposes by Jennifer and all copies will be destroyed after such usage. Results of the study will be reported in Jennifer's dissertation report, presented at conferences, published in academic journals,

and reports written for policy makers and health care decision makers.

For Further Information

If you have any questions or concerns about the interview, please contact the Doctoral Candidate, Jennifer Baumbusch at xxx-xxx-xxxx or xxxxxx@xxxxxxxxx. If you have any concerns about your rights or treatment while participating in the interview, please contact the Research Subject Information Line in the UBC Office of Research Services at the University of British Columbia at 604-822-8598.

Consent

Your participation in this project is voluntary. YOUR DECISION TO PARTICIPATE OR NOT PARTICIPATE WILL IN NO WAY INFLUENCE YOUR CARE. IF YOU DECIDE TO PARTICIPATE AND THEN CHANGE YOUR MIND, YOU ARE FREE TO WITHDRAW FROM THE PROJECT AT ANY TIME. THIS WILL IN NO WAY INFLUENCE YOUR CARE.

Your signature below indicates that you have received a copy of this consent form for your own records.

Your signature indicates that you consent to participate in this study.

Signature

Date

Please print name _____

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Vancouver, B.C. Canada V6T 2B5
Tel: (604) 822-7417
Fax: (604) 822-7466

The Organization of Care for Elders Living in Long-term Residential Care

Letter of Consent for Interviews (Staff & Administrators)

Doctoral Candidate

Jennifer Baumbusch, RN, MSN, GNC(C)
UBC School of Nursing

Dissertation Committee Supervisor

Joan Anderson, RN, PhD
Professor Emeritus
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Co-Supervisor

Alison Phinney, RN, PhD
Assistant Professor
UBC School of Nursing

Committee Member

Sheryl Reimer Kirkham, RN, PhD
Associate Professor
Nursing Department, Trinity Western University

You have been asked to participate in this interview because you work at a facility where this study is taking place. This research is being conducted as part of the nursing doctoral degree requirements for Jennifer Baumbusch.

Background

Long-term residential care is becoming more complex in British Columbia. People who live and work in residential care come from diverse backgrounds. They come from different ethnocultural backgrounds and, sometimes, do not speak the same language as other people living and working in the facility. Reforms in the health care system have meant that people being admitted to residential care are becoming more medically complex. At the same time, other factors, such as changes in the nursing workforce, are affecting the roles and responsibilities of those who care for residents. Through this study, we will learn more about how care for elders is organized in long-term residential care and how this is affecting the larger health care system, such as the use of emergency and in-patient services. Information from this study will provide valuable insight that will be shared with policy makers and health care decision makers in order to inform health care planning.

Participation and Reporting

During the interview Jennifer will talk with you about what it is like to work in a long-term residential care facility and issues that you think impact how you do your work. She will record the interview so that she can remember what you said. A transcript will be made, with all identifying information removed. The interview will take place at a time and location that is convenient for you. The interview will last about ½ hour to 1 hour. Information from the interviews will provide insight into what it is like to work in long-term residential care.

Confidentiality

Because this research is taking place in a residential environment and interviews may occur on site, it will be difficult to maintain complete anonymity about participation. In order to maintain confidentiality no names will appear in the transcripts and all identifying information will be removed. Copies of the transcripts will be kept in locked cabinets in the office of the Doctoral Candidate and data will be kept on computers that are password protected. Only Jennifer, her doctoral committee, and analysis group will have access to the data.

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For Further Information

If you have any questions or concerns about the interview, please contact the Doctoral Candidate, Jennifer Baumbusch at xxx-xxx-xxxx or xxxxxx@xxxxxxx. If you have any concerns about your rights or treatment while participating in the interview, please contact the Research Subject Information Line in the UBC Office of Research Services at the University of British Columbia at 604-822-8598.

Consent

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Your signature indicates that you consent to participate in this study.

Signature

Date

Please print name _____

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Tel: (604) 822-7417
Fax: (604) 822-7466

**The Organization of Care for Elders
Living in Long-term Residential Care**

**Letter of Consent for Participant Observation
(Residents & Family Caregivers)**

Doctoral Candidate

Jennifer Baumbusch, RN, MSN, GNC(C)
UBC School of Nursing

Dissertation Committee Supervisor

Joan Anderson, RN, PhD
Professor Emeritus
UBC School of Nursing

Co-Supervisor

Alison Phinney, RN, PhD
Assistant Professor
UBC School of Nursing

Committee Member

Sheryl Reimer Kirkham, RN, PhD
Associate Professor
Nursing Department, Trinity Western University

You have been asked to participate in this observation because you live/have a family member living at a facility where this study is taking place. This research is being conducted as part of the nursing doctoral degree requirements for Jennifer Baumbusch.

Background

Long-term residential care is becoming more complex in British Columbia. People who live and work in residential care come from diverse backgrounds. They come from different ethnocultural backgrounds and, sometimes, do not speak the same language as

other people living and working in the facility. Reforms in the health care system have meant that people being admitted to residential care are becoming more medically complex. At the same time, other factors, such as changes in the nursing workforce, are affecting the roles and responsibilities of those who care for residents. Through this study, we will learn more about how care for elders is organized in long-term residential care and how this is affecting the larger health care system, such as the use of emergency and in-patient services. Information from this study will provide valuable insight that will be shared with policy makers and health care decision makers in order to inform health care planning.

Participation and Reporting

In order to learn more about what it is like to live in residential care, Jennifer will spend time with you, for as long as four hours at a time, as you do different things throughout the day. She will write down what she sees and hears so that she doesn't forget. She may also sit in on your care conference. As Jennifer will be spending several months at the facility, she may observe you a few times. The information that she collects will provide insight into what it is like to live in long-term residential care.

Confidentiality

Because this research is taking place in a residential environment and observations will be made during daily life, there is a risk to privacy. Jennifer will be with you for long stretches. She will leave at those times when you don't feel comfortable having her present, such as when you need privacy around your care. She will check with you to make sure that she is not intruding when you need your privacy. As well, there is a risk to maintaining confidentiality. Because Jennifer may be observing you in common areas, such as the dining room other people at the facility may know that you are taking part in the study. In order to maintain confidentiality of the data no names will appear in the notes and all identifying information will be removed. Copies of the notes will be kept in locked cabinets in the office of the Doctoral Candidate and data will be kept on computers that are password protected. Only Jennifer and her doctoral committee and analysis group will have access to the data.

The data from the observation (with no identifying information from any of the participants) will be kept for a minimum of five years in accordance with the University of British Columbia research policy. The data will also be used for future analysis and educational purposes by Jennifer and all copies will be destroyed after such usage. Results of the study will be reported in Jennifer's dissertation report, presented at conferences, published in academic journals, and reports written for policy makers and health care decision makers.

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The Organization of Care for Elders Living in Long-term Residential Care

Letter of Consent for Participant Observation (Staff & Administrators)

Doctoral Candidate

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Sheryl Reimer Kirkham, RN, PhD
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Confidentiality

Because this research is taking place in a residential environment and observations will be made during daily life, there is a risk to privacy. At any time during the observation you may ask Jennifer leave the immediate area. As well, there is a risk to maintaining confidentiality. Because Jennifer may be observing you in common areas, such as the dining room other people at the facility may know that you are taking part in the study. In order to maintain confidentiality of the data no names will appear in the notes and all identifying information will be removed. Copies of the notes will be kept in locked cabinets in the office of the Doctoral Candidate and data will be kept on computers that are password protected. Only Jennifer and her doctoral committee and analysis group will have access to the data.

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Signature _____ Date _____
Please print name _____