THE INFLUENCE OF INFORMATION EXCHANGE PROCESSES ON THE PROVISION OF PERSON-CENTRED CARE IN RESIDENTIAL CARE FACILITIES

by

Sienna Caspar

BSc, University of South Alabama, 1990
MA, Simon Fraser University, 2008

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Abstract

*Purpose:* The movement away from task-oriented care toward the consistent provision of person-centred care (i.e., care based on residents’ needs and preferences) is widely recognized as the goal of the residential care culture change movement. The purpose of this study was to explore why the attainment of this goal has remained elusive for many residential care facilities (RCFs), despite significant effort to alter practice.

*Methods:* I conducted an institutional ethnography to explore the textually mediated work processes that influence the day-to-day work practices of front-line care staff in RCFs. The social organization of RCFs was explored through the observation of resident care attendants’ (RCAs’) practices and the interaction of those practices with institutional texts. The data were derived from three RCFs and included 104 hours of naturalistic observation, 76 in-depth interviews, and document analysis.

*Results:* Practical access to institutional texts containing care-related information was dependent on job classification. Regulated healthcare professionals (e.g., RNs) frequently accessed these texts to exchange information. Although RCAs provided 80% of the care to residents, in all sites studied, they lacked practical access to the institutional texts that contained important information relevant to the residents’ individualized care needs and preferences (e.g., assessments, care plans, social histories). The RCAs primarily received and shared information orally; however, the organizational systems in the facilities studied mandated the written exchange of information and did not formally support an oral exchange. Consequently, the oral exchange of care information was largely dependent upon the quality of the RCAs' working relationships with one another and especially with management.
Implications: Access to detailed knowledge of residents’ needs and preferences is fundamental to the provision of person-centred care. The transfer of this knowledge to and between front-line care staff is dependent upon the quality of the relationships managers develop with and among RCAs. Initiatives aimed at building supportive and collaborative work teams are essential to the inclusion of RCAs in the care planning process and to the attainment of the goal of person-centred care.
Preface

This dissertation is original, unpublished, independent work by the author, S. Caspar. The fieldwork reported in Chapters 5-8 was covered by UBC Research Ethics Board—Certificate number H11-03536 and Vancouver Island Health Authority Health Research Ethics Board—Certificate number H2012-16.
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Dedication

To the women and men who care for people living in residential care facilities.
Chapter 1: Introduction

Canada, along with most of the Western world, is experiencing the effects of population aging, defined as the extent to which a population’s age structure is distributed in the older cohorts as a consequence of longer life expectancy and lower fertility rates (McPherson, 2004). According to Statistics Canada (2012), it is expected that by the year 2031 the number of people over 64 years of age in Canada will increase from 13% to 25% of the population. Given this rapid increase, the number of older adults living in residential care facilities (RCFs) can also be expected to rise dramatically. This is especially likely since the population over 84 years is the fastest growing age group in Canada (see Table 1.1) and it is this group that is most likely to require long-term, residential care.

Table 1.1: Population Aged 85 Years or Older as a Percentage of All Individuals Over the Age of 65. Data Source: Statistics Canada, 2006.

The prevalence of living in RCFs increases with age. Among the age group of 65 to 69 years, about 1% lived in RCFs in 2011; among the age group of 85 years or older, the percentage was 29.6% (Statistics Canada, 2012).
It is estimated that approximately 25% of elderly individuals in Canada will reside in an RCF at some point during their lives (Conn, 2002). According to the Rising Tide report (Alzheimer Society, 2010), the demand for RCF beds is based on the projected prevalence and severity of dementia. These projections suggest that the number of people who will require care in an RCF could quadruple, to 690,000 by the year 2038 (Alzheimer Society, 2010). It is widely recognized that the care of older adults who have dementia can be especially challenging to RCF staff members due to the behavioural and psychological symptoms of dementia (Cassidy & Sheikh, 2002). Consequently, not only is the number of people who require care going to increase, but the complexity of the care they require is likely to increase dramatically as well.

Concurrent with these trends, projections suggest that there will be a significant reduction in the number of available formal care providers (i.e., registered nurses, licensed practical nurses, and resident care attendants) for RCFs (Stone, 2001). This is further compounded by high turnover rates caused by resident care attendants’ (RCAs) dissatisfaction with the workplace (Bowers, Esmond, & Jacobson, 2003) and high levels of stress and burnout due to the physical and emotional demands of their work (Cohen-Mansfield, 1997). The combination of higher prevalence rates of dementia and diminishing availability of formal caregivers is likely to cause the work within RCFs to become even more physically and emotional demanding.

Within this context of diminishing and strained resources, there is, simultaneously, increasing importance being placed upon the provision of "person-centred care" in RCFs. A

2 Demand for nurses is much higher than nursing schools can accommodate and is expected to increase by 2 to 3 percent each year through at least to 2025. It is proposed that this increase in demand is mainly due to the aging baby boomer population (Stone, 2001).
central tenet of person-centred care is that it is individualized, based on the care recipient’s unique needs, preferences, and life history (Fazio, 2008). Accordingly, the provision of this type of care is largely dependent upon caregivers' access to individualized information about the person to whom they are providing care. The attainment of the goal of increasing the provision of person-centred care is considered by many to be essential to both the quality of care and quality of life of people residing in RCFs, especially those who have Alzheimer disease or a related dementia (Brooker, 2007; Fazio, 2008; Kitwood, 1997; Talerico, O'Brien, & Swafford, 2003). Unfortunately, a review of the literature indicates that meaningful improvements in the provision of person-centred care in RCFs have been largely unrealized, despite significant effort (Doty, Koren, & Sturla, 2008; Miller, Miller, Jung, Sterns, Clark, 2010). In light of these developments, there is a need for a better understanding of how the social organization of care in RCFs may facilitate or hinder the delivery of high quality, person-centred care.

**Discovering a Problematic**

Dorothy Smith (1987), a Canadian sociologist who is widely recognized as a pioneer of institutional ethnography (IE), described a “problematic” as a place to begin an investigation. She said that a problematic develops from a sense that something troublesome, interesting, and worthy of study is going on. Thus, every IE investigation begins with issues, concerns, or problems that are real for people and that are situated in their relationships with an institutional order. My experiences and observations (on both a professional and personal level) of what happens to the individualized information required for person-centred care in institutional healthcare settings led to my sense that something troublesome and interesting was going on. I entered into this study with three distinct, yet intertwined, experiences that shaped my research questions as well as the lens through which I approached this study—these include my
experiences and observations as: a professional, a researcher, and a family caregiver. My exploration of these experiences also serves as an acknowledgement of both my motivations and my assumptions as I entered into this research.

Professional. I have worked as a certified therapeutic recreation specialist (CTRS) in RCFs for over 20 years. During my first position as a CTRS in a RCF, I witnessed physical and psychological abuse of residents with dementia (e.g., a resident being tied to her chair because she was damaging the newly installed wallpaper due her attempts to “pick” the pretty flowers in the design, a resident being yelled at and vigorously shaken because she had spilled juice on newly install carpet). Although I reported what I had witnessed to the State regulatory agency, I found that very little was actually done to ensure that instances such as these would no longer occur in this RCF. It was this experience that created the foundation for my passionate determination to make changes to the quality of care provided for, and quality of life of, residents in RCFs.

After 12 years of clinical experience in RCFs, I furthered my education and became a dementia care specialist and consultant. In this role, I trained staff members in RCFs about the best practices in dementia care. These trainings were based on the care philosophy of person-centred care. Subsequent to these trainings, I returned to the RCFs to assist care staff members in implementing what they had learned. What I found was that very little, if any, of the information I had imparted resulted in practice changes within the facilities. I ultimately came to believe that it was not the individuals within the facilities that resisted the change; instead, I felt it was the organizational systems within which they worked that prevented the change from occurring. I viewed these organizational systems as being based primarily on the medical model, which
places inordinate emphasis on the timely completion of tasks, adherence to routines, and objective medical outcomes.

It is noteworthy that the field of therapeutic recreation is based on a holistic approach to wellness and asserts that “health” is significantly more than the absence of illness (Stumbo & Peterson, 2004). As a CTRS, I believe that a person’s spiritual, emotional, cognitive and physical needs must all be met for an individual to be deemed “healthy.” I have never believed that I “fit” well in healthcare settings wherein the medical model is firmly established. My views and values as a CTRS, combined with my experience as a consultant, have made me very aware of the limitations of the medical model.

**Researcher.** For my master’s thesis, I examined the relationship between RCAs’ access to structural empowerment (i.e., support, information, formal power, informal power, and resources) and their reported ability to provide individualized, person-centred care to residents in RCFs. My findings suggested that support, especially in the form of rewards and recognition for a job well done, seemed to be particularly salient to RCAs. In addition, access to informal power, as measured by the quality of relationships in the workplace, appeared directly related to both RCAs’ quality of work life and the quality of the care they provided (Caspar & O’Rourke, 2008). Thus, I entered into this current study with the supposition that feeling appreciated and recognized for their work, combined with the quality of their workplace relationships, were two factors that determined whether RCAs felt able to provide person-centred care in RCFs.

Prior to conducting this study, my assumptions and values as a researcher were fairly entrenched in a quantitative inquiry paradigm. Consequently, making the decision to conduct a qualitative research study was not an easy one. I often felt as though I was learning a new language in a foreign land. As a researcher, I am committed to ensuring that my work is relevant
and applicable to the “real world,” for “real people,” doing “real work.” I am less interested in examining how and why we come to know things and more concerned about determining whether what we claim to know (i.e., research findings) is helpful to people. When choosing my research method, I admittedly spent little time deciphering and exploring the ontological and epistemological aspects of my selected method; instead, my primary focus was on whether this method could produce evidence that would be useful to the people that I am trying to serve as a researcher (i.e., the residents and staff of RCFs).

**Family caregiver.** My personal experience as a family caregiver of a terminally ill spouse with dementia was extremely influential in the development of my research questions. It is for this reason that it is important to introduce this study with an account of that experience.

**The story behind this study.** When I admitted my husband, John, to a palliative care unit, I believed that he had weeks, perhaps days, to live. The idea that he might have months to live had never crossed my mind. Yet, his body seemed unwilling to succumb to the cancer that was prematurely ending his life. Believing that he had little time left to live, it seemed reasonable and appropriate (and even just) that I be the one to provide most of his care. For the previous six weeks, I had been available 22 hours a day—stealing just two hours each day, during the evening meal, so that I could be with my children and thank my mother again and again for “being there” for them.

During those six weeks, I watched John’s dementia set in as a result of the cancer having spread to his brain via his cerebral spinal fluid. Because I was there, and knew him so well, I was able to make subtle, yet important, adaptations in my caregiving, which were required because of his ever-changing needs. These were the adaptations that enabled him to take his pills orally, even when he could no longer understand what they were for or why he needed to take them—
even when he had trouble seeing them or picking them up and putting them into his mouth. His vision was impaired because of the cancer, so he needed an overhead light to see the pills; he needed the pills put into a cardboard bowl so that he could scoop them up because his fine motor skills were also impaired; he needed no more than three pills at a time placed into the bowl; he needed a cup of water with a lid and a straw; he needed step-by-step directions to take them; he needed to be reminded to swallow after taking each of his 12 pills. Based on these needs, our “pill taking ritual” was developed; it was repeated four times a day and it enabled John to take his pills orally. This was an important ability because his skin integrity was poor and his shoulders and thighs had several injections sites that had formed lumps; it was, therefore, preferable to administer his medications orally rather than by injection. I knew this, so I ensured that I was always present when John took his medications.

This was my role and my routine for six weeks. It worked well until my children’s school year began—causing me to be pulled between my responsibilities as John’s caregiver and my responsibilities as a mother. There were now going to be times when it would be impossible for me to be there when John was given his medications. In anticipation of this, I talked to his nurse and discussed with her, in detail, what John needed to take his medications. She watched as I demonstrated our routine and assured me that all would be fine when I was not there. The next day I had to be away and I returned to his room to find his medications in a small paper cup on his bedside table, their delivery had occurred two hours before my return. I found his assigned nurse. She was not the one I had talked with the day before; this nurse had no awareness that John needed any assistance in taking his medications. The knowledge and information that I had shared had not been transferred to the nurse who was next assigned to John’s care. My heart sank and my anger rose. I knew of this problem, referred to as “inter-shift communication
breakdown,” for I had watched it occur over and over again during the 21 years I had worked as a recreation therapist in RCFs. Until that moment, however, I had never experienced it from the vantage point of a family member.

Determined to ensure that this situation did not occur again, I sat down and thought of all that I knew about providing care to John, which now needed to be known, understood and replicated by the nursing staff when I was not there. I prioritized it by importance and recorded it in point form so that it would be relatively easy to read. I then discussed it with his nurse and had it posted in his room, on his medication sheet, and in his chart. On this one-page note, I described how to help John with his toileting and his medications and, most important, about the fact that he was lactose intolerant. I had already discussed this with the dietician and he was on a special diet. Still, there were snacks on the unit and to be extra cautious I wrote in capital letters that he had to be given a lactose pill immediately before eating anything that had lactose in it.

Having worked in RCFs, I knew what to write and I knew where to put it to ensure that it would be read by the staff. I believed I had covered all the bases and that things would now go more smoothly when I could not be on the unit. Three days later, I had to attend an evening school function for my oldest son and my communication plan was put to the test. After having been away from the unit for four hours, I returned to find John eating custard. I immediately asked for his nurse. She was on a break. I asked for her to be interrupted so that I could find out if John had been given a lactose pill. The answer was “No,” the nurse had not given it to him. She said she was sorry, but was unaware that he was lactose intolerant.

“Perhaps I should write it in his chart,” said the nurse.

“It is written there,” I said.

“Perhaps we should post it in his room?” said the nurse.
“It is posted in his room,” I said.

The information was available; still it had not been read nor applied. The result was seven hours of uncontrolled and painful diarrhoea. I cleaned him, I had always been the one to clean him…. he preferred it that way, and because he did, so did I. We both preferred it because I knew him, I understood him, and I knew how to make his experience of being cared for the best that it could possibly be. It was because of this that, even though the dementia caused him not to know who I was, he trusted me and he knew that it was simply “better” when I was there.

To me, this is what person-centred care is about. It is about knowing a person such that trust is established between the caregiver and the care recipient. The ultimate result of this care is safety, security, and comfort for both the care recipient and the care giver. Consequently, I believe that the provision of person-centred care is impossible without an understanding of the unique needs, wishes, and routines of the care recipient. Furthermore, if this information is not available, gets lost, or is not applied, the goal of providing person-centred care cannot be realized. My experiences on the palliative care unit combined with my observations as both a CTRS and a consultant in RCFs affirmed my belief that we are a long way from being able to ensure that person-centred care is consistently provided in the majority of institutional healthcare environments.

I do not share this story or this belief as a condemnation of the nursing profession or of the quality of care provided to John while he was on the palliative care unit—far from it. The nurses were dedicated, caring, thoughtful, and skilled. I often referred to them as “angels walking on this earth.” None of these nurses purposefully neglected or harmed John, yet, more than once during the three months that John and I were on the palliative care unit, instances occurred that put him at risk. Each of these instances occurred because the staff did not access or apply
information that would have enabled them to provide the individualized care that he required. I had watched this type of breakdown in communication occur in RCFs and I had always believed that it was due to one of two problems—lack of adequate staffing or lack of adequately trained staff.

However, these hypotheses did not hold in the palliative care unit. These were skilled, educated registered nurses (RNs) with specialized training in palliative care. These were nurses working on a unit with enviable staffing ratios—4 to 5 patients to 1 RN, whereas in RCFs, the ratios are often closer to 100 residents to 1 RN. And yet, what I was experiencing as a family member was what I had watched occur over and over again while I was a CTRS working in RCFs. Family members would inform care staff members of the individualized needs and wishes of their loved one…

“My mother needs her feet elevated whenever she is sitting otherwise her feet swell and it is very painful for her.”

“My husband was poor when he was growing up. They only took sponge baths with a bucket in the backyard. Now that he has Alzheimer’s disease he doesn’t recognize what a shower is and he is afraid of it. He needs to have a bath basin and a sponge and then he won’t fight with you over bathing.”

“My mother will not eat her food if you serve her too much. She is afraid if she touches it no one will eat the leftovers, so she will not eat anything unless you serve her a smaller portion.”

“If you distract my sister by singing to her she will let you give her the insulin shot. That is the only way I could do it while I was caring for her.”

I believe the transfer and application of this personal information is what enables the provision of person-centred care in healthcare settings of any kind, but most especially, in RCFs.
Yet, my experience indicates that this information most often does not get transferred or it is inconsistently applied to the benefit of the residents living in RCFs.

Some may question my introduction of a study based in RCFs with the story of an experience that occurred in a palliative care unit. It is important to note that the similarities between RCFs and palliative care units are many (e.g., family involvement, a holistic approach to care, admissions with the understanding that discharge is unlikely, and attempts at creating a ‘homelike’ environment). In fact, due to the recent changes to admission policies to RCFs within British Columbia, which require newly admitted residents to have highly acute and complex care needs (British Columbia Ministry of Health, [BCMOH], 2009), some have recently asserted that RCFs may soon need to be re-classified as “Palliative Care Units for the Aged” (Schulz, 2011). This is the effect of a significant increase in the acuity of residents’ care needs, which has led to a reduction in their length of stay as the result of higher mortality rates (Canadian Healthcare Association, 2009). Furthermore, and perhaps most important, palliative care units and RCFs have a goal of providing person-centred care that includes family members as part of the care team, and both institutions continue to fall short of attaining that goal.

**The Problematic and My Standpoint**

My experiences on the palliative care unit with John combined with my years of experience working in RCFs create a strong foundation from which to develop my problematic for this study. Smith (2006) asserts that the problematic forms the foundation for research questions that cannot be fully explained by studying experiences. The questions I pondered as I developed the problematic related to person-centred care in RCFs, included the following:

1. How is information pertaining to the personal needs, wishes and routines of residents in RCFs obtained?
2. Where is this information stored and how is it transferred between care staff members?

3. What are care staff members’ beliefs about this information?

4. How and why does this information get lost, when it does?

5. Why is personalized information not consistently applied so as to enable person-centred care?

6. What processes in RCFs enable or impede the translation and application of this information?

Smith (2006) argued that before researchers attempt to explore a problematic, they must take a “standpoint.” Consistent with institutional ethnography, a standpoint is considered to be the sum of experiences of everyday practice embedded in an institutional order. Accordingly, the taking of a standpoint anchors one’s research in the experiences and concerns of a particular group of people. In this study, I took the standpoint of RCAs—the front-line formal, unregulated caregivers in RCFs. RCAs (also referred to as nursing assistants, nurses’ aides, health care assistants, care aides, healthcare aides, and personal support workers) provide the majority of direct resident care and thus play a central role in determining whether person-centred care is provided in RCFs (Kane, 1994).

**Purpose and Significance of This Study**

A review of the literature revealed that, compared with other healthcare services, research about residential care services, processes, and outcomes is sparse. In addition, of the research that is conducted in healthcare institutions, very little focuses on, or includes, unregulated healthcare staff members. For example, when I reviewed the literature about interdisciplinary collaboration, team decision making, team building, and communication in healthcare
institutions, I found that the studies focused almost exclusively on regulated healthcare professionals (e.g., registered nurses, licensed practical nurses), with little or no mention of attendants, assistants, or aides as members of the healthcare team (e.g., Lemieux-Charles & McGuire, 2006; Manser, 2009). Thus, a purpose of this study was to give voice to unregulated care staff members and to recognize them as members of the healthcare team in RCFs.

It is my hope that this study will contribute to the advancement of knowledge by developing a more complex understanding of how institutional processes and social relations shape RCAs' experiences and influence their access to information and their ability to provide person-centred care. More than that, however, I hope that this study produces knowledge that can be applied to generate a much needed culture change in RCFs.

**Overview of the Chapters**

The subsequent chapter, a review of the literature, explores how person-centred care has been conceptualized, experienced, and studied. This chapter attempts to review what we know about person-centred care from the perspectives of both the providers and the recipients of care in RCFs.

The third chapter provides an overview of the conceptual framework for the study and introduces the reader to institutional ethnography as a method for scientific enquiry. In this chapter, I describe the study setting and sample and detail the specific investigative and analytic methods I used to study the social organization of care in RCFs.

The fourth chapter, "The Context of Living or Working in a Residential Care Facility," describes the complex regulatory framework that governs RCFs in British Columbia (BC). I first discuss macro-level contextual factors by providing an historical overview of residential care regulations in Canada. At the meso-level, I explore current provincial and regional regulations
that govern the three study RCFs (Facilities #1, #2, and #3). Finally, at the micro-level, I discuss the regulations that determine who lives and works in these institutions.

The fifth chapter, "The Influence of Everyday Texts on the Provision of Person-Centred Care: Exploring the Embodied Work Experience of RCAs," describes the embodied work experience of RCAs with a specific emphasis on the exchange of information that occurs during three phases of a work shift: at the beginning of the shift (i.e., before the provision of care commences), during the shift (i.e., while care is provided), and at the end of the shift (i.e., after the provision of care).

Chapter Six, "The Influence of Institutional-Level Texts on the Provision of Person-Centred Care in Residential Care Facilities," introduces information exchange “maps” that I created to represent the flow of residents’ care information between RCAs and the other members of the healthcare team. The maps, specific to each facility, include “every day” texts and institutional-level texts and demonstrate the interconnectedness and directionality of the information flow between them.

Chapter Seven, "The Influence of Information Exchange between Management and the Care Team: Essential Gates of Communication," breaks from the original trajectory laid out for this institutional ethnography. In this chapter, I first explore the use of written versus oral information exchange between management and the care staff members. Next, I discuss how informal, open communication influences organizational trust in the workplace. Finally, I close the chapter by examining the differences found between successful and unsuccessful formal, two-way communication exchanges between management and the RCAs.

Chapter Eight, "Boss Texts: Explicating the Ruling Relations that Influence the Provision of Person-Centred Care in Residential Care Facilities," examines the boss texts that influence
RCAs’ access to information and that directly or indirectly influence their ability to provide person-centred care. In an attempt to present a balanced perspective, I discuss both the positive outcomes as well as some of the unintended consequences that result from the activation of selected boss texts.

The concluding chapter presents a synthesis of the research findings followed by a discussion of the link discovered between the presence of empowered leaders in RCFs and RCAs' quality of work-life and care—a link that is essential to the provision of person-centred care. I examine both the theoretical and policy implications of the findings, and conclude by addressing the study’s limitations and considering some future directions and research.
Chapter 2: Review of the Literature

The purpose of this study was to develop a more comprehensive understanding of how institutional processes and social relations shape resident care attendants’ (RCAs’) experiences and influence their ability to provide person-centred care. It was deemed essential to begin with a review of what is known about person-centred care. In this chapter, I first explore how person-centred care has been conceptualized and implemented. Next I discuss the small body of literature examining how person-centred care has been experienced by both the recipients and providers of care. I conclude the chapter with an examination of the ways in which person-centred care has been studied and present the systematic literature review I conducted of intervention studies aimed at increasing the provision of person-centred care practices in residential care facilities (RCFs).

How Has Person-Centred Care Been Conceptualized?

Person-centred care has been described as a care philosophy in which a positive relationship is established that respects care recipients’ preferences and life histories, honours their identities, enables their engagement in meaningful activities, and encourages an overall sense of well-being (Fazio, 2008). The person-centred care approach originated from the work of Carl Rogers, a psychotherapist who developed the "client-centred approach" to psychotherapy in the 1950s (Kirschenbaum, 2004). An important aspect of the client-centred approach is the therapeutic benefit of positive interpersonal interactions. The conditions that influence positive change include having a therapist who provides unconditional positive regard, is empathetic, and is genuine or congruent within the client-therapist relationship. The term person-centred evolved from the work of Rogers and his colleagues at the Center for Studies of the Person in the 1970s (Kirschenbaum, 2004).
The person-centred approach was later adopted and applied to dementia care in RCFs as described in *Dementia Reconsidered: The Person Comes First* by Tom Kitwood (1997). In his book, Kitwood discussed a philosophical approach to formal caregiving that uses residents’ unique personal preferences and needs to guide their care practices, thus enabling the individualization of care plans and care routines (Boise & White, 2004). A central feature of person-centred care is the recognition that all human life, including people with dementia, is grounded in relationships, and that people with dementia need an enriched social environment that fosters opportunities for personal growth while compensating for their impairment (Brooker, 2007).

By adopting the term "person-centred", Kitwood (1997) forced the discussion of who or what is a "person" into the context of dementia care. This was critical with respect to Western societal values that imply that to be a person is to be capable of conscious thought, and to possess autonomy, agency, rationality, and self-awareness (Brooker, 2007), which results in the pervasive assumption that a loss of self and personhood occurs for all persons with advanced dementia (Kontos & Naglie, 2007). Kitwood (1997) challenged these assumptions by viewing personhood as a status (or standing) that could be bestowed upon one human being by others in the context of social relationships. Central to this idea is that these social relationships are based on recognition, respect, and trust and that all human beings have value as "persons" regardless of their cognitive abilities.

In emphasizing the value of all persons, person-centred care also acknowledges the personhood of direct care staff, the respect for whom is believed to be as crucial as for those with dementia (Kitwood, 1995). Although Kitwood’s (1997) book focused primarily on persons with
dementia, it is important to note that person-centred care is a model that is assumed to benefit RCF residents who do not have cognitive deficits.

**What's in a Name?**

Attempting to conduct a thorough search for literature about person-centred care proved to be somewhat challenging because the key elements and philosophy of person-centred care have been described with the application of a broad-spectrum of terms (e.g., individualized care, resident-directed care, consumer-directed care, patient-centred care, relationship-centred care, self-directed care). Some authors have asserted that these terms share connotations and definitions that are philosophically congruent with the term person-centred care and that the variance merely depends upon the context in which care is provided (e.g., hospitals and acute care settings tend to use the term patient-centred care, whereas RCFs tend to use resident-centred or resident-focused care) (see Morgan & Yoder, 2012). Others have argued that there exist subtle but important conceptual differences in the terms (Edvarsson, Winblad, & Sandman, 2008; Talerico, O'Brien, & Swafford, 2003). Specifically, some researchers have contended that using such terms as patient-centred or resident-centred results in the individual with dementia continuing to be defined in terms of their status within a healthcare institution (i.e., patient or resident), as opposed to being a unique person (Brooker, 2007; Talerico et al., 2003).

Similarly, it is argued that use of the term "individualized care" as opposed to person-centred care narrows the frame of reference such that care needs are determined and met with potentially little attention to the lived experience of the care recipient (Brooker, 2004). For example, Brooker (2004) maintained that it is possible to conduct a detailed assessment and to develop an individualized care plan based solely on goals determined from the care providers' perspective, without prioritizing preferences and routines that the care recipient considers
important. She provided an example of a resident in a long-term care facility with an individualized care plan that detailed how frequently the resident was required to use the toilet so as to remain continent. Yet the fact that the resident was someone who believed that her quality of life was largely dependent upon the ability to make and drink a cup of tea every afternoon may not have been considered in the plan of care. Consequently, the resident remained defined by her status as a patient with continence needs, while the need to continue a life-long activity of making and drinking afternoon tea was disregarded (Brooker, 2007). Brooker contended that a person-centred care approach ensures that care is individualized, whereas care that is individualized does not necessarily translate into person-centred care.

Another important distinction deserving mention is found with the term “patient-focused care.” The similarity between this term and those used to describe a person-centred care philosophy has produced some confusion and even inappropriate interchange of the terms; therefore, it is important to differentiate this term from the rest. Briefly, patient-focused care originated in acute care hospital settings in an effort to improve the efficiency and effectiveness of service delivery while being more responsive to patients’ concerns. It is a model of care delivery established for self-contained units staffed by multi-disciplinary caregivers who are supposed to be trained to provide up to 80% of what patients need while in their rooms. The key components of patient-focused care are consistent with the initiatives implemented for continuous quality improvement—these being interdisciplinary teams working together to accomplish needed changes in care delivery with a primary focus on the elimination of any care delivery process that is deemed unnecessary, redundant, or does not add “value to the end-product” of patient care (Kerfoot & LeClair, 1991).
In British Columbia, patient-focused care has been used as a model for reforming staffing ratios through changing job descriptions and care routines, and has been referred to as a “hospital staffing redesign or reengineering model” (Talerico, O’Brien & Swafford, 2003). The difference here is that patient-focused care is based on care recipients’ needs as well as cost containment and organizational reforms, whereas person-centred care is almost solely focused on the care recipients’ needs.

**Attempts at Clarifying the Meaning of the Concept “Person-Centred”**

The use of "person-centred" terminology is frequent in both the literature and in practice and has come to denote quality care; however, consensus has yet to be achieved on the exact meaning of the concept (Edvarsson, Winblad, & Sandman, 2008; Passalacqua & Harwood, 2012; Packer, 2000; Talerico, O’Brien, & Swafford, 2003). Literature reviews and concept analyses have been conducted to clarify the meaning of person-centred care (Hughes, Bagley, Reilly, Burns, & Challis, 2008; McCormack, 2004). Many assert, however, that the concept of person-centred care remains vague and abstract, is viewed through various lenses, and means different things to different people in different contexts (Brooker, 2004; Edvardsson, Fetherstonhaugh, & Nay, 2010; Hughes et al., 2008; Nolan, Ryan, Enderby, & Reid, 2002). This is likely the result of person-centred care being viewed as both a value-based philosophical approach as well as a practice-based framework.

Rockwell (2012) asserted that person-centred care "best describes a practice philosophy, rather than a practice model—it suggests values and best practices to employ when working with residents of care facilities, but it does not provide prescriptive techniques or problem-solving procedures" (p. 234). Entwistle and Watt (2013) concurred with Rockwell and emphasized that even subtle differences in the ways in which care providers think about "person-centred care"
have important implications for how they understand the value and ethical significance of their interactions with the people for whom they provide care.

Other authors have been more pragmatic and view person-centred care primarily as a set of caregiving techniques focused on individualized care approaches. According to Boise and White (2004), RCFs that profess to deliver person-centred care should be implementing nursing routines and care practices that are individualized to each resident’s unique preferences. These include enabling residents to prepare for sleep when they like, eat what and when they prefer, bathe or shower according to their personal needs and preferences, celebrate life events consistent with their personal lifelong traditions, and interact with friends and family members in ways that are meaningful and important (Boise & White, 2004).

Walker, Porter, and Gruman (1999) argued that individualized care plans developed on the basis of person-centred care should focus on the specific needs of the individual by: (a) ensuring that each resident is treated as an autonomous adult; (b) encouraging independence; (c) enabling freedom of movement; and (d) giving residents the right to make decisions regarding their daily lives. Some authors have published frameworks that detail the care approaches considered to be consistent with the person-centred care philosophy. For example, Brooker (2004) reviewed the existing literature about person-centred dementia care and identified four essential elements of a person-centred care approach: (a) valuing and respecting people with dementia and those who care for them; (b) regarding individuals with dementia as complete people; (c) looking at the world from the perspective of the person with dementia; and (d) creating a positive social environment.

Talerico, O’Brien, and Swafford (2003) presented seven key components of person-centred care: (a) knowing the person as an individual; (b) providing care that is meaningful to the person
in ways that respect his/her values, preferences, and needs; (c) viewing residents as bio-psycho-social beings; (d) enabling the development of consistent and trusting caregiving relationships; (e) emphasizing freedom of choice and individually-defined risk taking; (f) promoting emotional and physical comfort; and (g) involving residents’ families, friends, and social networks in care decisions. McCormack (2004) used a relational perspective and defined person-centred care as an approach to practice that is established through the formation and fostering of therapeutic relationships. According to McCormack, this approach is based on three key values: (a) respect for persons; (b) the individual right to self-determination; and (c) mutual respect and understanding.

A criticism of person-centred care is the tendency to focus only on the person with dementia and to neglect the experiences of the family and formal care providers (Nolan, Davis, Brown, Keady, & Nolan, 2004; Nolan, Ryan, Enderby, & Reid, 2002). Nolan et al. (2002) argued that person-centred care fails to "fully capture the interdependencies and reciprocities that underpin caring relationships" (p. 203). This criticism led to the emergence of a relationship-centred model of dementia care based on the "Senses Framework" (Nolan et al., 2004; Ryan, Nolan, Reid, & Enderby, 2008). This approach is guided by the belief that all parties involved in care (i.e., the person with dementia as well as the family members and care staff) should experience relationships that promote a sense of security, belonging, continuity, purpose, achievement, and significance.

More recently, other authors have claimed that person-centred care is shrouded in well-intended but often paternalistic approaches that place "patients" or "clients" at the centre of care decisions, but rarely, if ever, actively involve them in decision making (Dupuis et al., 2012). These criticisms have resulted in a more recent movement focusing on "authentic-partnerships."
Dupuis et al. (2012) supported the socio-critical or partnership approach in dementia care, which views all knowledge perspectives as equally valued, including the expertise of persons with dementia (Clarke, 1999). Thus, they have challenged researchers and practitioners alike to consistently and actively include persons with dementia in any attempt to improve the quality of their care or life.

This review demonstrates the challenges inherent in attempting to achieve a universally agreed upon operational definition of person-centred care. It also underscores why it is important to continue the dialogue on this complex topic, which is important to both the quality of care and life of individuals who reside in RCFs, the vast majority of whom have dementia.

Although the complexity of the topic needs to be appreciated, a pragmatic approach, aimed at simplifying the term, may be useful. Based on this review, I offer that person-centred care can be said to have three components——each of equal importance. First, care providers must know and value the needs, concerns, and preferences of their care recipients. Second, care providers must be able (based on their skills, abilities, and experiences) and enabled (based on their access to information, resources, and support) to adjust their care practices so as to meet the care recipients’ needs, address their concerns, and honour their preferences as consistently as possible. Third, a reciprocal relationship between care givers and care recipients (based on mutual trust and respect) must be formed, acknowledged, and supported. Simplifying the concept to these three components may make it more useful for caregivers attempting to implement it in the everyday practice of care and more measureable for researchers attempting to study it.

**How Has Person-Centred Care Been Implemented?**

The movement away from care that is provider driven and task oriented (i.e., care that is based on consistent adherence to care providers’ routines and focused on cost effectiveness and
the timely completion of tasks) to the consistent provision of person-centred care within RCFs is widely recognized as the universal goal of a “culture change movement” in the developed world. According to Rahman and Schnelle (2008), "culture change" is a process associated with the transformation of RCFs that goes "beyond superficial changes to an inevitable re-examination of attitudes and behaviour, and a slow and comprehensive set of fundamental reforms" (p. 142). Culture includes both implicit and explicit contracts that dictate what is expected of members and defines the rewards or sanctions associated with compliance or non-compliance (del Bueno & Vincent, 1986). Cultural norms have been found to be more effective in influencing behaviour than are formal control systems, such as written policies and procedures or supervisory monitoring (Gibson & Barsade, 2003). Thus, culture change encompasses system-wide changes in practice that occur as a result of both intrinsic and extrinsic motivation.

The culture change movement began in earnest in North America following the first Institute of Medicine (IOM) (1986) report on improving the quality of care in nursing homes. The authors of the IOM report wrote that “whenever possible, facility staff and management should honour consumer preferences” (p. 172). A year later, the US Omnibus Budget Reconciliation Act (OBRA) of 1987 introduced numerous changes to USA federal nursing home regulations, requiring nursing homes to adopt a more social-behavioural treatment model for residents (Morford, 1988).

However, ten years after those regulatory changes were implemented in the US, it was clear that they had not led to a more humanistic culture in RCFs (Flesner, 2009). Subsequent to the regulatory changes, grassroots organizations were formed, such as the Pioneer Network (a national group formed to serve as an umbrella organization for the culture change movement) and numerous models of care were developed and implemented across North America (e.g.,
Eden Alternative (Thomas, 2003), Gentle Care (Jones, 1995), and Wellspring (Stone et al., 2002)—each with the primary purpose of facilitating the provision of person-centred care in RCFs.

Unfortunately, the empirical base for this movement has been weak and the goals have, for the most part, continued to be largely unrealized (Rahman & Schnell, 2008). For example, in 2007, a survey of nursing homes in the US was conducted to examine the penetration of the culture change movement at the national level, and to measure the extent to which nursing homes had adopted culture change principles and practised resident-centred care (Doty, Koren, & Sturla, 2008). A representative sample of 1,435 nursing homes was surveyed between February and June 2007. For the survey, the phrase “culture change for resident-directed care” was defined as occurring in an organization that had home or work environments in which: (a) care and all resident-related activities were decided by the resident; (b) the living environment was designed to be a home, rather than an institution; (c) close relationships existed between residents, family members, and the community; (d) work was organized to support and allow all staff members to respond to residents’ needs and desires; (e) management allowed collaborative and group decision making; and (f) processes and measures were used for continuous quality improvement.

The survey examined whether the sampled nursing homes had adopted practices that made care provision more “resident directed,” that engendered a work environment that fostered staff autonomy and decentralized decision making, and that altered the physical environment to make their facilities look and function like a home, rather than a hospital. The researchers found that only 5% of the sampled nursing homes reported that the definition of culture change for resident-directed care “completely” described their facility. Forty-three percent of the facilities (categorized as “traditional nursing homes”) stated that their respective nursing homes met the
“culture change” criteria “not at all” or only “in a few respects,” and that their leadership was only “somewhat,” “not very,” or “not at all” committed to the adoption of culture change. The results of this survey indicated that, although some improvements had been realized, most of the culture change initiatives had yet to penetrate the culture and care of the sampled RCFs.

Unfortunately, the literature is fraught with examples of failed attempts at successful implementation and sustained person-centred care delivery. Possible reasons for the failures have included observations that the concept of person-centred care is ill-defined (Brooker, 2004; Nolan, Davies, & Brown, 2006), is too idealistic and thus unworkable on a day-to-day basis (Packer, 2000), conflicts with practice and process realities, which tend to deny the diversity of residents (Ray, 1999), contradicts traditional models of service delivery, and is unsustainable because of issues related to staffing levels and resources (Dowling, Manthorpe, & Crowley, 2007). The failure to implement person-centred care has been found repeatedly in facilities that have not successfully redressed pre-existing organizational and staffing problems (Hagenow, 2003; Scalzi, Evans, Barstow, & Hostvedt, 2006; Talerico, O'Brien, & Swafford, 2003).

Studies that have examined the factors that support the successful implementation of culture change models indicate that good leadership, stable management, strong teamwork, efficient communication systems, and an investment in staff training and education about culture change are requisites for change (Barba, Tesh, & Courts, 2002; Steiner, Eppelheimer, & De Vries, 2004). Resistance from senior leadership is the most frequently cited barrier to adopting culture change, followed by the perceived cost and concerns about compliance with regulatory requirements, which often demand increased conformity to prescribed routines rather than flexible care practices (Miller, Miller, Jung, Sterns, Clark, & Mor, 2010).
Crandall, White, Schuldheis, and Talerico (2007) and Rosemond (2009) explored factors that helped or hindered the implementation of person-centred care in RCFs. Of interest, contrary to commonly held beliefs and her hypotheses, Rosemond (2009) found that implementation effectiveness was not associated with the presence of financial resources, management support, organizational stability, or the amount of time and training offered to workers to learn about person-centred care. Instead, she found that the factors positively associated with implementation effectiveness included the way in which leaders communicated with RCAs about the intervention and whether the intervention fostered smooth operations in the daily routines of the RCAs.

Crandall, White, Schuldheis, and Talerico (2007) reported that the most striking differences between facilities that were most successful in implementing person-centred care and those that were unsuccessful were related to institutionalized practice changes. More specifically, those facilities that made changes to the institutional documents and texts associated with care delivery (e.g., changes in mission statements, policies and procedures, job descriptions, and training materials) were the most successful in implementing and sustaining person-centred care. This finding was replicated by Hill (2004), who identified procedural barriers within an institution itself and governmental policies and regulations as two major barriers in the implementation of person-centred care.

Examples of regulations that can be barriers to the implementation of person-centred care include, but are not limited to, the following: (a) fire safety regulations that promote uncluttered spaces yet counter efforts to create homelike environments (e.g., not allowing art created on paper to be placed on the walls); (b) regulations that specify that every resident must have a private room and do not allow RCFs to accommodate residents who, because of the opportunity for socialization and a sense of security, prefer to have a roommate; and (c) regulations that
require a defined breakfast and lunch schedule throughout the week do not allow RCFs to accommodate residents who prefer to eat brunch *except* on weekends or holidays (Residential Care Regulation, 2012).

**How is Person-Centred Care Experienced?**

Edvardsson, Fetherstonhaugh, and Nay (2010) conducted one of the few studies aimed at exploring person-centred care as it is understood by people with dementia, family members, and RCF staff. Their findings indicated that these stakeholders viewed the core feature of person-centred care to be the promotion of a continuation of self and normality. Five content categories emerged as contributing to the promotion of a continuation of self and normality: knowing the person, welcoming the family, providing meaningful activities, being in a personalized environment, and experiencing flexibility and continuity.

There is a dearth of studies aimed at evaluating person-centred care as experienced by residents in RCFs—the majority of whom have dementia (Rosenzweir, 2010), their family members, or RCF care staff members. Researchers have focussed on more generalized issues, such as the "quality of care." When questioned about the quality of the care provided, RCAs tend to focus on the quality of the relationships formed between residents and themselves and on *how* care is delivered, rather than on specific clinical outcomes (i.e., outcomes primarily associated with residents’ physical health) (Bowers, Esmond, & Jacobson, 2000). Furthermore, they deem relationships to be the central determinant of both quality of life and quality of care (Deutschman, 2001; McGilton, 2002; Schirm, Albanese, & Garland, 1999; Wagner & Colling, 1993). Finally, they recognize that the indicators of quality of care include positive outcomes for the residents as well as for themselves (Deutschman, 2001), and often state that providing person-centred care by being able to do the “extras” (e.g., sitting and talking with a resident
about his or her past, taking extra time to put makeup on a resident) is what “really” matters (Deutschman, 2001; Schirm et al., 1999).

From the residents’ perspective, high quality care is based almost exclusively on having considerate, respectful RCAs with supportive attitudes, who are kind and “nice” while providing care (Deutschman, 1999; Grau, Chandler, & Saunders, 1995; Tellis-Nayak & Tellis-Nayak, 1989). Residents also deem the relationship between themselves and the care staff to be a central determinant of high quality care and life. According to Grau et al. (1995), the greater their perception of having a positive relationship with staff members, the less residents view themselves as objects receiving care. Thus, an important determinant of residents’ quality of life is their interpersonal relationships, yet their relationships are often neglected as a significant assessment element. An exception to this was a recent study of Coleman and Medvene (2013) that found the strongest effect of a person-centred care intervention to be an improvement in residents’ reported “relationship closeness” with the RCAs.

How Have Person-Centred Care Interventions Been Studied?

The majority of published articles related to person-centred care are descriptive or anecdotal in nature; however, a review of the literature demonstrates a continued effort by researchers to find ways to rigorously study person-centred care interventions. The lack of a universally accepted operational definition of person-centred care is likely associated with the struggles researchers have experienced in studying the outcomes associated with its implementation. For example, Brownie and Nancarrow (2013) recently conducted a systematic review of the effects of person-centred care on residents and staff in RCFs and concluded that the complexity of the interventions and range of outcomes examined made it difficult to form accurate conclusions about the impact of person-centred care interventions.
Given these complexities, I conducted a comprehensive review of the literature to gain insight into how person-centred care has been studied and to understand more fully the factors that influence the effectiveness of interventions aimed at improving the provision of person-centred care practices in RCFs. My aim was to describe interventions targeting both residents’ and care staff’s behaviour and to assess their effectiveness. The strategy to identify relevant studies included searching the following electronic indexes and databases: Academic Search Complete, AgeLine, CINAHL, MEDLINE, PsycINFO, PubMED, and SocINDEX; undertaking manual searches of journals and the bibliographies of retrieved articles; and acquiring information from experts in the field. Key words used in the search included long-term care, nursing home, outcomes, quality of care, quality of life, intervention, person centred care, resident centred care. Articles meeting the following criteria were chosen for inclusion:

1. The setting was in a nursing home, long-term care (LTC) facility, RCF, or special care unit,
2. The population of interest was RCF care staff members or residents of RCFs,
3. A primary focus of the intervention was aimed at improving the provision of person-centred care practices,
4. There was evident evaluation of the intervention with empirical data provided,
5. The study was published in an English-language journal, and
6. The publication date was between 1985 and 2013.

For example, MEDLINE, Academic Search Complete, CINAHL, and PsycINFO were first searched with the key words, person-centred care, nursing home, AND intervention; limitations of publications dated between 1985 and 2013 and those published in English were placed on the search. This search yielded 11 citations. Three duplicated citations were removed. The abstracts
of the remaining eight references were reviewed for relevance. Of these, four were excluded because they provided only preliminary results, did not provide empirical data relevant to an intervention designed to increase the provision of person-centred care practices in RCFs, or were reviews of previously published intervention studies. The remaining four studies received a full review. In addition, a subsequent search of each retained article’s reference list was conducted. This process was repeated several times with different databases and different key words until 38 studies were found that met the inclusion criteria set out for this review.

Table 2.1 presents the selected studies summarized by intervention focus, study (author and country), the goal or intended outcomes, intervention format, sample, implementation factors, the outcomes or impact, follow-up, level of evidence, risk of bias, and effectiveness rating. The stated goals and intended outcomes of the selected studies were stratified by target population: residents or staff. The residents’ outcomes were classified into three categories:

1. Behaviour (e.g., decreased agitation, decreased physical aggression),
2. Health status (e.g., functional status, infection rate, fall rates), and
3. Quality of Life—outcomes based on residents’ perceived sense of emotional, social, and spiritual wellbeing, including safety, physical comfort, enjoyment, meaningful activity, relationships, and dignity.

The staff outcomes were classified into five categories:

1. Attitudes (e.g., beliefs and values regarding person-centred care practices, aging, or dementia-related behaviour),
2. Knowledge (e.g., increased knowledge of Alzheimer’s disease and related disorders and person-centred care practices),
3. Quality of Care—change in actual care practices related to physical and cognitive health and well-being of the residents,

4. Quality of Life—changes in actual care practices related to the social, emotional, and spiritual health or well-being of the residents (e.g., providing choices, improved communication, or developing relationships), and

5. Quality of Work Life—changes in the quality of work life (e.g., team building, leadership, support, empowerment/autonomy, overall quality of work-life, safety and security, or reward and recognition).

The format of the program or intervention (e.g., lecture, group discussions, practice sessions, videos, on-site consultation, or written materials) was described to better understand the types of formats frequently used in practice change interventions in RCFs and to determine whether specific formats are associated with intervention effectiveness. The intervention factors (i.e., the features within the intervention developed specifically to produce, enable and reinforce changes in behaviour related to care practices) were categorized with the classification system developed by Green and Krueter (2005), and included the following:

1. **Predisposing factors**: The creation of a shared vision that provides the foundation for change in practice. Effectively communicating and disseminating information designed to modify staff members’ knowledge, beliefs or attitudes (e.g., lectures, written information, group work, didactic training, experiential learning, video presentations, role-playing, or computerized learning).

2. **Enabling factors**: Conditions and resources within the environment developed to allow or enable staff members to implement new skills (e.g., modified work
schedules, practice opportunities, changes to policy or treatment guidelines, development of new treatment protocols, or access to appropriate resources), and

3. **Reinforcing factors**: Mechanisms that reinforce the implementation of new skills or practices (e.g., providing cues or reminders, improved peer support, timely and appropriate feedback, timely and consistent follow-up, and rewards and recognition for a job well done).

The interventions were then further classified into types: Type I = predisposing factors only, Type II = predisposing plus enabling factors, Type III = predisposing plus reinforcing factors, and Type IV = predisposing, enabling, and reinforcing factors (Davis, O'Brien, Freemantle, Wolf, Mazmanian & Taylor-Vaisey, 1992).

The quality of the published evidence was categorized as evidence generated from properly randomized control trials (RCT), quasi-experimental designs (i.e., well-designed controlled trials without randomization) (QE), and descriptive case studies or case reports (DCS).

The Cochrane Collaboration’s tool for assessing risk of bias (Higgins et al., 2011) was used to evaluate risks related to five key domains (i.e., selection, performance, detection, attrition, and reporting bias) for each of the studies. Risk of bias was classified as follows: 1 = low risk of bias in all key domains with plausible bias unlikely to seriously alter the results; 2 = unclear risk of bias for one or more key domains with plausible bias that raises some doubt about the results; 3 = high risk of bias for one or more key domains with plausible bias that seriously weakens confidence in the results.

Finally, the effectiveness of each study was evaluated based on a combined overview of the sample size, effect size, outcomes and impact, level of evidence, and the risk of bias. The effectiveness was rated based on the following descriptions: A = good evidence to support
recommendations of effectiveness, B = fair evidence to support recommendation of
effectiveness, C = insufficient evidence to recommend for or against the effectiveness, D = fair
evidence to support recommendation of ineffectiveness, and E = good evidence to support
recommendation of ineffectiveness.
Table 2.1: Review of Person-Centred Care Practice Intervention Studies

<table>
<thead>
<tr>
<th>Intervention Focus</th>
<th>Study (Country)</th>
<th>Goals/Intended Outcomes</th>
<th>Implementation factors</th>
<th>Outcomes and Impact</th>
</tr>
</thead>
<tbody>
<tr>
<td>Person-centred Care</td>
<td>Ashburner at al., 2004 (UK)</td>
<td>X X X</td>
<td>TYPE IV Unspecified format</td>
<td>46 nursing staff, 21 residents Information sharing, collecting and sharing residents' life histories with care staff Weekly team supervision meeting with staff Action learning set for managers</td>
</tr>
<tr>
<td>QOL and psychosocial</td>
<td>Beck et al., 2002 (USA)</td>
<td>X X</td>
<td>TYPE I Specific staff were hired and trained as 'Project Nurse Assistants' Time and length of training unspecified</td>
<td>143 residents Care staff unspecified Information sharing</td>
</tr>
<tr>
<td>Eden Alternatives</td>
<td>Bergman-Evens 2004 (USA)</td>
<td>X</td>
<td>TYPE IV unspecified Assumed Standardized Eden training provided to care staff members with managerial support</td>
<td>33 residents Unspecified Information Sharing Unspecified Managerial Support Unspecified Follow-up team meetings</td>
</tr>
<tr>
<td>RELATE</td>
<td>Bechtcher et al., 2004 (USA)</td>
<td>X X X</td>
<td>TYPE III 9 sessions (unspecified length) Lecture with experiential techniques and practice homework between sessions Information sharing</td>
<td>50 Residents 38 RNs, 46 Nursing assistants, On the job coaching &amp; supportive mentoring</td>
</tr>
<tr>
<td>Study (Country)</td>
<td>Intervention Focus</td>
<td>Goals/Intended Outcomes</td>
<td>Implementation factors</td>
<td>Outcomes and Impact</td>
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</tr>
<tr>
<td>Leadership vs. Renovation Bond &amp; Fiedler, 1999 (USA)</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>TYPE I</td>
</tr>
<tr>
<td>Integrated Care Boumans, et al., 2008 (Netherlands)</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>TYPE II</td>
</tr>
<tr>
<td>Perfecting Patient Care (PPC) Castle &amp; Bost, 2009 (USA)</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>TYPE IV</td>
</tr>
<tr>
<td>Beliefs and values re: aging Chandler et al., 1986 (USA)</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>TYPE I</td>
</tr>
<tr>
<td>Intervention Focus</td>
<td>Study (Country)</td>
<td>Goals/Intended Outcomes</td>
<td>Implementation factors</td>
<td>Outcomes and Impact</td>
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</tr>
<tr>
<td>resident-centred care Vs. DCMap</td>
<td>Chenoweth et al., 2009 (AUS) AND Jeon, et al., 2012.</td>
<td>X X X</td>
<td>TYPE IV</td>
<td>2-day training on PCC Vs. 2-day training on dementia care mapping: Lecture</td>
</tr>
<tr>
<td>ERIC Emotional Response</td>
<td>Chrzescijan-ski et al., 2010 (AUS)</td>
<td>X X</td>
<td>TYPE I</td>
<td>One 40-min video Hands-On skill application</td>
</tr>
<tr>
<td>Eden Alternative</td>
<td>Coleman et al. 2002 (USA)</td>
<td>X</td>
<td>TYPE IV</td>
<td>unspecified Assumed Standardized Eden training provided to care staff members with managerial support</td>
</tr>
<tr>
<td>Person-centred Care</td>
<td>Coogle et al., 2006 (USA)</td>
<td>X</td>
<td>TYPE I</td>
<td>Six 8-hr Train the trainer sessions for selected staff: Lecture One 12-hr and one 5-hr workshop for all staff: Lecture</td>
</tr>
<tr>
<td>Intervention Focus</td>
<td>Study (Country)</td>
<td>Goals/Intended Outcomes</td>
<td>Implementation factors</td>
<td>Outcomes and Impact</td>
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<tr>
<td>Individual care plans &amp; clinical care</td>
<td>Edberg &amp; Halberg, 2001 (Sweden)</td>
<td>Resident</td>
<td>Quality of Life</td>
<td>Knowledge</td>
</tr>
<tr>
<td>Emotion-oriented care</td>
<td>Finnema et al., 2005 (Netherlands)</td>
<td>Resident</td>
<td>Quality of Life</td>
<td>Knowledge</td>
</tr>
<tr>
<td>Person-centred care</td>
<td>Fossey et al., 2006 (UK)</td>
<td>Resident</td>
<td>Quality of Life</td>
<td>Knowledge</td>
</tr>
<tr>
<td>Caring Journey</td>
<td>Gaspard et al., 2009 (Canada)</td>
<td>Resident</td>
<td>Quality of Life</td>
<td>Knowledge</td>
</tr>
<tr>
<td>Intervention Focus</td>
<td>Goals/Intended Outcomes</td>
<td>Implementation factors</td>
<td>Outcomes and Impact</td>
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<tr>
<td>Study (Country)</td>
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<tr>
<td></td>
<td>Resident</td>
<td>Staff</td>
<td>Behaviour</td>
<td>Goal/Intended Outcomes</td>
</tr>
<tr>
<td>Greenhouse model</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>R.E.A.L.T.E.A. Ao training</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>The use of drama to improve PCC</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Best Practice Dementia Care</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Intervention Focus</td>
<td>Study (Country)</td>
<td>Goals/Intended Outcomes</td>
<td>Implementation factors</td>
<td>Outcomes and Impact</td>
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<tr>
<td>Person-centred care</td>
<td>Linn et al., Linn et al., 1989 (USA)</td>
<td>Resident</td>
<td>Behaviour</td>
<td>Health</td>
</tr>
<tr>
<td>Best practice in Dementia Care</td>
<td>Lintern et al., 2000 (UK)</td>
<td>X X X X</td>
<td>TYPE IV</td>
<td>2-day training for management</td>
</tr>
<tr>
<td>Emotional Communication</td>
<td>Magai et al., 2002 (USA)</td>
<td>X X X</td>
<td>TYPE I</td>
<td>Ten 1-hr sessions over 2 weeks: lecture and experiential sessions</td>
</tr>
<tr>
<td>REPC: Relationship Enhancing program</td>
<td>McGilton et al., 2003 (Canada)</td>
<td>X X X</td>
<td>TYPE IV</td>
<td>Eight 20 min sessions over 7 months: Lecture and experiential Learning</td>
</tr>
<tr>
<td>Dementia Care</td>
<td>Peterson, et al., 2002, USA</td>
<td>X</td>
<td>TYPE I</td>
<td>Length and time not specified: Lecture, video, role-play.</td>
</tr>
<tr>
<td>Intervention Focus</td>
<td>Study (Country)</td>
<td>Goals/Intended Outcomes</td>
<td>Implementation factors</td>
<td>Outcomes and Impact</td>
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<tr>
<td></td>
<td></td>
<td>Resident</td>
<td>Staff</td>
<td>Behaviour</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Quality of Life</td>
<td>Attitude</td>
<td>Knowledge</td>
</tr>
<tr>
<td>Partners in Caregiving</td>
<td>Pillmer et al., 2003 (USA)</td>
<td>X</td>
<td>X</td>
<td>TYPE I</td>
</tr>
<tr>
<td>FOCUSED Dementia Care</td>
<td>Ripich et al., 1995 (USA)</td>
<td>X</td>
<td>X</td>
<td>TYPE III</td>
</tr>
<tr>
<td>Eden Alternative</td>
<td>Robinson &amp; Rosher 2005 (USA)</td>
<td>X</td>
<td>X</td>
<td>Type IV</td>
</tr>
<tr>
<td>Best Practice Dementia care</td>
<td>Schonfeld et al., 1999 (USA)</td>
<td>X</td>
<td>X</td>
<td>TYPE I</td>
</tr>
<tr>
<td>Emotion-Oriented care (Validation)</td>
<td>Schrijnemakers et al., 2002 Netherlands</td>
<td>X</td>
<td>X</td>
<td>TYPE II</td>
</tr>
<tr>
<td>Intervention Focus</td>
<td>Study (Country)</td>
<td>Goals/Intended Outcomes</td>
<td>Implementation factors</td>
<td>Outcomes and Impact</td>
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<tr>
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<td>---------------------</td>
</tr>
<tr>
<td>Resident</td>
<td>Health</td>
<td>Quality of Life</td>
<td>Knowledge</td>
<td>Quality of Care</td>
</tr>
<tr>
<td>Resident</td>
<td>Health</td>
<td>Quality of Life</td>
<td>Knowledge</td>
<td>Quality of Care</td>
</tr>
<tr>
<td>Resident</td>
<td>Health</td>
<td>Quality of Life</td>
<td>Knowledge</td>
<td>Quality of Care</td>
</tr>
<tr>
<td>Resident</td>
<td>Health</td>
<td>Quality of Life</td>
<td>Knowledge</td>
<td>Quality of Care</td>
</tr>
<tr>
<td>Resident</td>
<td>Health</td>
<td>Quality of Life</td>
<td>Knowledge</td>
<td>Quality of Care</td>
</tr>
</tbody>
</table>

**Intervention Focus:**
- Bathing without a Battle
  - Sloane et al., 2004 (USA)
  - TYPE II
  - Didactic training with hands-on supervision
  - Sample: 73 Residents, 37 nursing assistants
  - Implementation factors: Information sharing
  - Outcomes: Changed bathing routines
  - Follow-Up: No follow-up
  - Level of Evidence: RCT (1)
  - Risk of Bias: (A)
  - Effectiveness Rating: #1 sustained at 6 months, #3 not sustained at 6 or 12 months

- Testad et al., 2010 (Norway)
  - TYPE III
  - 2-day education session and monthly group guidance for 6 months
  - Sample: 145 Residents, 197 RNs, LPNs, and Care Assistants
  - Implementation factors: Information Sharing
  - Outcomes: Monthly Group guidance sessions for 6 months
  - Follow-Up: #1 sustained at 6 months, #3 not sustained at 6 or 12 months
  - Level of Evidence: RCT (2)
  - Risk of Bias: (B)
  - Effectiveness Rating: #1,2,3,4,5 not reported

- Wells et al., 2000 (Canada)
  - TYPE IV
  - Five 20-30 min education sessions: Lecture, role play, games
  - Sample: 40 residents, 44 care staff
  - Implementation factors: Information sharing
  - Outcomes: Random observations of care staff to ensure and reinforce use of newly learned skills
  - Follow-Up: #1,2,3,4,5 not reported
  - Level of Evidence: QE (1)
  - Risk of Bias: (A)
  - Effectiveness Rating: #1 sustained at 6 months, #3 not sustained at 6 or 12 months

- Wilkinson, 1999 (USA)
  - TYPE IV
  - 1-day workshop: lecture, role play, and exercises
  - Sample: 40 residents, 32 RNs, LPNs, nursing assistants
  - Implementation factors: Information sharing
  - Outcomes: Hired an advanced practice psychiatric nurse to work 10-hr shifts to teach and role model
  - Follow-Up: #1,2,3,4,5 not reported
  - Level of Evidence: DCS (2)
  - Risk of Bias: (E)
  - Effectiveness Rating: #1 sustained at 11 months

- Zimmerman et al., 2010 (USA)
  - TYPE I
  - 6-sessions Unspecified length
  - Sample: 491 direct care staff, 171 supervisors
  - Implementation factors: Information Sharing
  - Outcomes: Did follow-up training based on unit needs assessment
  - Follow-Up: #1,2,3,4,5 not reported
  - Level of Evidence: RCT (2)
  - Risk of Bias: (E)
  - Effectiveness Rating: #3 partially sustained at 3 months, #5 sustained at 3 months
Thirty-eight studies met the selection criteria. Studies from eight countries were included in this review and the majority of the studies were conducted in the USA (see Table 2.2). More than one half of the studies (n = 22, 58%) were published in the last ten years (between 2003 and 2013); the remaining were published during the 17-year period between 1985 and 2002.

Table 2.2: Number and Frequency of Included Studies by Country (N = 38)

<table>
<thead>
<tr>
<th>Country</th>
<th>n</th>
<th>Relative frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>United States of America</td>
<td>22</td>
<td>58%</td>
</tr>
<tr>
<td>Canada</td>
<td>5</td>
<td>11%</td>
</tr>
<tr>
<td>United Kingdom</td>
<td>3</td>
<td>8%</td>
</tr>
<tr>
<td>Netherlands</td>
<td>3</td>
<td>8%</td>
</tr>
<tr>
<td>Australia</td>
<td>2</td>
<td>5%</td>
</tr>
<tr>
<td>Sweden</td>
<td>1</td>
<td>.03%</td>
</tr>
<tr>
<td>Norway</td>
<td>1</td>
<td>.03%</td>
</tr>
<tr>
<td>Germany</td>
<td>1</td>
<td>.03%</td>
</tr>
</tbody>
</table>

Intervention Format and Duration

Previous reviews of education initiatives in RCFs have found that lecture or didactic methods of instruction alone are unlikely to be successful in producing the desired changes in behaviour (Aylward, Stolee, Keat, & Johncox, 2003; Kuske, Hanns, Luck, Angermeyer, Behrens, & Riedel-Heller, 2007; Nolan et al., 2008). The majority of the studies in this review used multiple teaching methods for their interventions. The most common was lecture in combination with role-play, group work, experiential learning, and written material offered as a supplementary resource. One group of researchers reported specifically on staff members’ learning preferences and styles (Kemeny, Boetther, DeShon, & Stevens, 2006). According to Kemeny et al. (2006), RCAs often have impoverished educational experiences leading to a lack of confidence with traditional passive approaches to learning such as class-room style teaching (Bova and Kroth (2001) as cited in Kemeny et al. (2006)). Thus, Kemeny et al. (2006)
emphasized the importance of creative, experiential learning for RCAs. Smith, Buckwalter, Garand, Mitchell, Albanese, and Kreiter (1994) made a similar argument when they suggested that how an educational initiative is delivered is as, if not more, important than the content.

Several published accounts did not report the duration of the intervention or the exact duration of each aspect of the intervention (i.e., education sessions vs. hands-on follow up and support). Of those that did, the duration of the interventions ranged from one 40-minute session to a 48-hour training initiative. An overview of the studies indicated that the duration of the educational portion of the interventions was not predictive of their effectiveness (i.e., one intervention provided 42 hours of staff training and received an effectiveness rating of “E” while another provided only 12 hours of training and received an effectiveness rating of “A”). The reported duration of ongoing support following the initial training intervention ranged from a 3-week hands-on phase to 24 months of follow-up support. Unlike the duration of the initial training session, the duration and depth of follow-up support seemed to be predictive of effectiveness. This observation is discussed in more detail within the review of the intervention factors, set out below.

**Intervention Factors**

According to the literature, it is essential to involve staff members as fully as possible in the design, content, delivery, and evaluation of practice change initiatives and to create a consensus among them as to the need for education, practice change, and the desired goals and outcomes (Burgio, Stevens, Burgio, Roth, Paul, & Gerstle, 2002; Nolan et al., 2008). The practice of including staff members in the development stage of an intervention is said to improve their sense of ownership and to help to establish the appropriateness and relevance of the intended program (Nolan et al., 2008). Of interest, this review of the literature found that this
practice is not the norm in intervention studies conducted in RCFs. Of the studies reviewed, only four indicated that they sought input from staff members and administrators about their training needs and the appropriate focus and content of the intervention (Castle & Bost, 2009; Kemeny, Boetther, DeShon, & Stevens, 2006; McGilton, O'Brien-Pallas, Darlington, Evans, Wynn, & Pringle, 2003; Wilkinson, 1999).

**Predisposing factors.** One half of the studies, 19 in total, were classified as Type I; they evaluated predisposing intervention factors alone. Each of these studies relied solely on information sharing as their implementation strategy to produce change. It is widely recognized that providing education alone is rarely effective in producing actual change in practice (Aylward, Stolee, Keat, & Johncox, 2003; Kuske, Hanns, Luck, Angermeyer, Behrens, & Riedel-Heller, 2007; Nolan et al., 2008). One of the studies demonstrated that improvements in staff knowledge or attitudes did not lead to improvements in care practices (Lintern, 2000). Of the studies classified as Type I, only two received an effectiveness rating of A (Linn & Stein, 1989; Pillemer et al., 2008) and none received a rating of B. Thus, the results of this review lend further support to the assertion that educational interventions classified as Type I are largely ineffective in producing change in the care practices provided in RCFs. According to Green and Kreuter (2005), the creation of a shared vision is included as a predisposing factor. Only one of the studies indicated that they incorporated vision setting as part of their initiative (Boumans, Berkhout, Vijgen, Nijhuis, & Vasse, 2008).

**Enabling factors.** Eight of the studies were classified as Type II (interventions that included both predisposing and enabling factors for implementation). Of these, only one received an effectiveness rating of A (Sloane et al., 2004) and none received an effectiveness rating of B. Over one half of the studies (n = 23) did not include any enabling factors within their
interventions. This finding is consistent with previous reviews of continuing education studies in RCFs. For instance, Aylward, Stolee, Keat, and Johncox (2003) found that in nearly three quarters of the 48 studies they reviewed,\(^3\) new information was presented to staff members with no strategies in place to support the transfer of new knowledge into practice.

Enabling factors include conditions and resources within the environment that are developed to allow or enable staff members to implement new skills. Thus, administrative commitment to assist and enable the translation of learning into practice would be considered an important enabling factor. Of the studies reviewed, only three discussed the ways in which they addressed, ensured, and measured administrative support for the initiative (Lintern, 2000; McGilton, O'Brien-Pallas, Darlington, Evans, Wynn, & Pringle, 2003; Wilkinson, 1999). This is an interesting finding because the literature consistently notes that lack of administrative support likely explains the failure of education, training, and practice change initiatives (Aylward, Stolee, Keat, & Johncox, 2003; Campbell & Knight, 1991; McCabe, Davison, & George, 2007; Nolan et al., 2008). Of note, only one study provided a two-day training course that specifically targeted leadership skills and support from management and senior staff, and subsequently created a development plan to address enabling factors prior to providing education to the direct care staff (Lintern, 2000).

The most common enabling factor examined in the relevant studies was the development and implementation of care plans for residents (n = 5). It should be noted that individualized care plans are now considered a basic standard of practice in RCFs; however, the creation of care

\(^3\) The large number of studies reviewed by these authors relative to those reviewed here resulted from their review not being limited to intervention studies specifically aimed at increasing the provision of person-centred care.
plans does not necessarily ensure that they will be used or implemented in day-to-day practice. This may be why so many of the studies that used this as the primary enabling factor did not produce observable change in behaviour or outcomes. Thus, unless other enabling and reinforcing factors are in place, the development of care plans is not sufficient in creating sustained changes in RCF care practices.

It is noteworthy that care staff members’ access to the care plans was not addressed in any of these studies. Rather, they seemed to assume that the information contained within the residents’ care plans would be accessed and applied in the day-to-day care practices of the healthcare staff. This presumption, and the consequent lack of attention to how residents’ individualized care information is accessed and exchanged among professional care staff members, is pervasive in the literature.

**Reinforcing factors.** Reinforcing factors are the mechanisms that reinforce and encourage the implementation of new skills and care practices. In total, 16 (42%) of the studies included reinforcing factors as part of their interventions. Of these, three were classified as Type III (predisposing and reinforcing only) and 13 were classified as Type IV (predisposing, enabling, and reinforcing factors). A review of these studies indicated that the presence of reinforcing factors is significantly related to the effectiveness of the intervention. For example, 11 of the 14 studies that received an effectiveness rating of A (good evidence to support recommendation of effectiveness) or B (fair evidence to support recommendation of effectiveness) included reinforcing factors as part of the intervention.

The reinforcing factors described in these interventions included such things as "on the job coaching," "hands-on practice," "supportive mentoring," "increased supervision," and "team meetings." These factors all indicate that resources in the form of direct human involvement and
interaction were provided to the RCAs as they worked to implement the newly learned skills and care practices. Given the influence that reinforcing factors exert on the success of care practice interventions, the importance of these types of supports for RCAs should not be underestimated.

Of interest, staff motivation systems via rewards or recognition for intervention implementation were not used in any of the studies. This finding is noteworthy because motivational factors, such as recognition and a sense of achievement, have been found to be important to RCAs’ perceived empowerment and quality of work life (Caspar & O’Rourke, 2008; Pennington, Scott, & Magilvy, 2003). Further to this, Scalzi, Evans, Barstow, and Hostvedt (2006), who reviewed barriers and enablers to changing organizational culture in nursing homes, found that few, if any, incentives and rewards were linked to the implementation of quality of life or person-centred care practices. Rather, incentives in RCFs were often linked to competing or conflicting goals, such as performance-based outcomes related to the medical model—which places more emphasis on regulatory compliance than on meeting residents’ individualized needs. Regulatory compliance can cause residents to be treated according to their diagnostic or functional status, with funding and staffing determined in relation to such status (as opposed to their individualized needs) (Ronch, 2004). Thus, regulatory compliance can reinforce the continued dominance of the acute care medical model in RCFs. As a result, the staffing remains hierarchically organized, highly scheduled, and predominantly focused on clinical tasks and the documentation of medically related objectives (e.g., medications, task completion, illness, and disease) (Diamond, 2009; Gnaedinger, 2003). Unless reinforcing factors such as motivation, recognition, and incentives are part of the intervention, the highly structured day-to-day care practices and routines may be in direct conflict with the successful implementation of any intervention aimed at increasing the provision of person-centred care.
**Goals and Outcomes**

The majority of the studies (77%) had multiple goals and intended outcomes related to the interventions. Only five of the studies had goals that focussed solely on residents’ outcomes and 14 of the studies focussed solely on staff outcomes. The remaining 19 studies focussed on outcomes for both residents and care staff. It is noteworthy that the outcomes of interventions associated with person-centred care are typically evaluated using criteria based on caregivers’ or researchers’ perspectives and not the care recipients’. Thus, there is growing concern that standardized measures for assessing outcomes may not address those that are significant for the person with dementia (Bamford & Bruce, 2000; O'Connor et al., 2007). The outcomes of these intervention studies should be viewed with this caveat in mind.

Of the studies reviewed, 13 had goals related to changes in residents’ behaviour, five of which (38%) reported significant improvement following the intervention. The most common goals were related to residents’ behaviour, particularly decreased agitation or aggression. Only eight of the studies had goals related to changes in the residents’ health status; of these, four reported significant improvements following the intervention, indicating a 50% success rate. A total of 13 studies had goals related to the residents’ quality of life, and about one half of them (n = 7) reported improvements.

When reviewing the goals of the care staff, 13 studies examined care staff members’ attitudes and only four of them reported significant improvements following the intervention. Staff attitudes were most often measured using instruments designed by the researchers and specifically focussed on the intervention goals. Changes in care staff members’ knowledge was a cited goal in 15 of the studies reviewed and nine (60%) of these studies reported improvements.
as outcomes. The most frequent method used to measure changes in the care staff’s knowledge was a simple pre- and post- pen and pencil test.

Twelve of the studies included goals pertaining to the care staff’s behaviour related to the residents’ quality of life, seven of which reported improvements as outcomes. All of the studies that reported improvements in the care staff’s behaviour related to the residents’ quality of life also reported that the improvements were sustained for two months or more following the intervention. Of interest, only 11 studies included improvements in the care staff’s provision of quality care. Of these studies, seven reported improvements in the quality of care as an outcome.

Finally, 17 of the studies indicated that improvement in the quality of the work life of the care staff was a goal of the intervention. Of these, only two studies indicated that improvements were successfully realized as a result of the intervention. Quality of work life was most often measured in relation to absenteeism, intent to leave, and turnover rates (a significant consideration in most RCFs in the USA). In addition, some studies included measures related to care staff members’ experiences of physical and verbal assault while on the job. Others measured quality of work life via questionnaires related to perceptions of job satisfaction. Thus, it is important to note that this outcome was measured in a variety of ways, some being highly objective while others being primarily subjective in nature.

It should be noted that many studies reported intervention goals that were not evaluated or not reported. For instance, in five of the 13 studies that specified improved quality of life as a goal of the intervention, the authors did not measure or report any outcomes related to quality of life (Bond & Fiedler, 1999; Gaspard, Garm, Harriman, & Scheffler, 2009; Goodridge et al., 1997; Kuske et al., 2009; Zimmerman et al., 2010). Other authors evaluated interventions designed to address residents’ behaviour, such as agitation and aggression and reported
significant improvements in the staff’s attitudes and knowledge related to these issues, but they did not measure actual change in the residents’ behaviour (Kemeny, Boetther, DeShon, & Stevens, 2006; Schonfeld et al., 1999). It is unclear why these goals were not measured or reported as outcomes by the authors of these studies. Methodological issues such as these may be due to the unique challenges presented to researchers conducting studies in RCFs; however, they also raise questions about the possibility of bias due to incomplete or selective reporting.

Methodological Quality: Sample Size, Follow-Up, Level of Evidence, and Risk of Bias

Other reviewers of the literature about interventions conducted in RCFs designed to improve care practices have noted serious weaknesses in the methodological approaches of the research (Aylward, Stolee, Keat, & Johncox, 2003; Kuske, Hanns, Luck, Angermeyer, Behrens, & Riedel-Heller, 2007; Nolan et al., 2008). These have included concerns regarding small sample sizes, lack of control groups, lack of randomization, low response rates, high attrition rates, and other threats to validity such as the use of self-reports. Because of these concerns, the reviewers have concluded that the reported impact of the various interventions needs to be interpreted with caution. Thus, previous reviews have led to calls for more scientifically rigorous methodology to evaluate interventions (Aylward et al., 2003; Kuske et al., 2007; Nolan et al., 2008).

The sample sizes of the studies included in this review ranged from 8 to 662 in the care staff samples and from 19 to 346 in the resident samples. However, it should be noted that the majority of the publications that reported their sample size had generally small samples of fewer than 150 staff and residents.

Most of studies included in this review conducted a follow-up evaluation (n = 29). The majority of those (n = 19) conducted follow-up evaluations at six months or more after the
completion of the intervention. The remaining studies (n = 9) conducted follow-up evaluations between one and five months after the intervention. Of the studies that reported follow-up evaluations, the majority (n = 21) reported some aspect of the outcomes being sustained. Thirteen of these studies reported sustained changes to residents’ outcomes. It should also be noted that previous reviews of intervention studies in RCFs have found that close to two thirds of the studies did not conduct follow-up evaluations and only one study was found that reported sustained changes to residents’ behaviour (Aylward, Stolee, Keat, & Johncox, 2003). Thus, findings from this review indicate a significant and positive trend in the use of follow-up evaluations in intervention research in RCFs as well as a significant trend in sustained positive outcomes for residents.

Within this current review, 13 (34%) of the studies applied a randomized controlled trial (RCT) methodology, eight (21%) used a quasi-experimental design, and 17 (44%) used a descriptive case study design. Positive trends in methodology were also found when evaluating the risk of bias. Sixty-six percent of the studies that received a rating of “1” (indicating a low risk of bias) were conducted between 2003 and 2013. Despite this pattern, however, there is still a need for significant improvement in this area. Of the studies reviewed, only nine (23%) were evaluated as having a low risk of bias, whereas 21 (54%) were evaluated as having a plausible risk of bias, which was high enough to raise doubts about the reported results. Finally, eight (21%) of the studies were assessed as having a high enough risk of bias to seriously weaken confidence in the reported results.

The current review found that most intervention studies conducted in RCFs have relied on the same person or persons to lead the intervention and to collect the data. When this was not the case, the studies relied on the often under-trained and overworked staff members to collect the
relevant data, many of whom participated in the intervention. This practice leads to serious concerns regarding the risk of bias. Of the studies reviewed, only four ensured that the individuals who collected the data were blind to the intervention (Chenoweth et al., 2009; Fossey et al., 2006; McGilton, O'Brien-Pallas, Darlington, Evans, Wynn, & Pringle, 2003; Sloane et al., 2004; Testad, Ballard, Brønnick, & Aarsland, 2010). Thus, lack of blinding of outcome assessors was a major source of potential bias in the studies reviewed. Two other sources of potential bias were related to incomplete outcome data or selective outcome reporting. Of the studies reviewed, six did not report findings related to variables that were stated to be outcome goals of the intervention. Minimizing the risk of bias is an area in need of significant improvement in intervention research conducted in RCFs. Without this, the ability to truly claim the effectiveness of an intervention is seriously weakened.

**Intervention Effectiveness**

In all, nine (23%) studies in this review received an effectiveness rating of “A” (i.e., good evidence to support recommendations of effectiveness), six of which were published between 2003 and 2013. In addition, five (13%) studies received an effectiveness rating of “B” (i.e., fair evidence to support a recommendation of effectiveness), three of which were published between 2003 and 2013. Thus, although there are some positive signs in intervention effectiveness, many published studies reported outcomes with either insufficient evidence to recommend for or against effectiveness (n = 10; 26%) or fair (n = 6; 15%) or good (n = 8; 21%) evidence to support a recommendation of ineffectiveness.

There were two primary features of the interventions that significantly affected their effectiveness ratings. One was a methodological feature, which affected the measure of the effectiveness, while the other was a substantive feature, which affected the actual intervention
effectiveness. The methodological feature was an increased risk of bias due to the study designs. Specifically, researchers who relied upon care staff members to obtain the data for their studies should have taken additional measures to ensure that the practice did not confound the outcomes. For example, Wilkinson (1999), who conducted a study about an intervention to reduce residents’ agitation and aggression, used staff members who participated in the intervention to obtain the outcome data. Part of the intervention was increasing the staff members’ awareness of agitation and aggression and to encourage the documentation of the presence of this behaviour. Thus, after the intervention, the researchers found an increase in the very behaviours they were attempting to decrease. They noted that this increase was likely the result of staff members’ increased awareness and reporting of the behaviours after the intervention. There were significant threats to the validity of the baseline measures, which in turn rendered the outcome assessments unreliable, thus making it impossible to accurately rate the effectiveness of the intervention.

The second feature that significantly affected the effectiveness rating of an intervention was the presence of reinforcing factors. This is perhaps one of the most noteworthy findings of this review because it indicates that, with the presence of effective enabling and reinforcing factors, interventions aimed at improving the provision of person-centred care in RCFs are, in fact, both feasible and sustainable.

Summary and Reflections

The literature is fraught with examples of failed attempts at successful implementation and sustained person-centred care delivery on RCFs. This review provides some explanation as to why meaningful improvements in the provision of these care practices in RCFs have been largely unrealized, despite significant effort.
There are three key factors that need to be addressed for changes to occur in the care practices in RCFs related to quality of life and quality of care. First, information designed to modify care staff members' knowledge, skills, beliefs or attitudes must be effectively communicated and disseminated (i.e., predisposing factors). Second, conditions and resources must be developed within the RCFs to enable staff members to implement new skills (i.e., enabling factors). Third, mechanisms must be in place to support the implementation of new skills or practices (i.e., reinforcing factors). Unfortunately, the majority of researchers attempting to change practice have not ensured that all of these factors were addressed. This is an important consideration given the amount of research published regarding the lack of change to care practices during the course of the last decade (Commonwealth Fund, 2007; Corazzini et al., 2010; Hill, Kolanowski, Milone-Nuzzo, & Yevchak, 2011).

Before practice can be changed or innovative approaches implemented, the institution must be able to support the changes with sufficient resources. For example, care plans developed based on person-centred care practices are believed to produce positive results for the recipients of care. However, to consistently implement the highly individualized care prescribed in these care plans, RCFs must have sufficient resources. These resources could include such things as: (a) appropriate staffing levels, (b) appropriate levels of staff education and training, (c) appropriate access to individualized information regarding each resident’s history, needs, strengths, and interests, and (d) the ability to schedule staff so as to create and maintain consistent, trusting caregiving relationships.

It would be beyond the scope of a single doctoral study to attempt to address all of the resources required to provide person-centred care. The aim in this study was to focus on care staff members' access to individualized information regarding each resident's history, needs,
strengths, and interests. Studies that take into account care staff members' access to residents’
individualized care information have not been undertaken. I aimed to address this gap by
exploring how the social organization of care enables or impedes care-related information
exchange within RCFs.
Chapter 3: Methodology

Nadler and Tushman’s (1988) congruence model indicates that the most important determinant of successful implementation of practice changes in institutions is achieving the correct balance between the desired change and the environmental and social realities. Organizations will be effective only to the degree that their "internal components"—the way tasks are organized, the informal ways that people relate to each other, the formal structure, policies, and procedures, and the characteristics of an organization’s employees—are congruent (Nadler & Tushman, 1988).

Institutional ethnography (IE), as a method of inquiry, provides a practical and effective means by which to examine the congruence (or lack thereof) of the "internal components" in an institution. According to Smith (1987), institutional standardizing tools, which she referred to as replicable texts (i.e., any document, record, form, report, or page that is written, drawn, or otherwise reproducible) provide the visible representations of the "internal components" of an institution. Smith (1987) asserted that workers in any institution are organized—through institutional standardizing tools—to treat similar situations in the same way. A powerful way in which the organizational culture of RCFs either supports or hinders the implementation of person-centred care is through these institutional standardizing tools. Thus, I selected the methods described within an IE to provide a conceptual framework for this study.

Describing the methodological and analytical processes of IE is not a simple endeavour. According to Smith (2005), the emphasis of IE "is always on research as discovery rather than, say, the testing of hypotheses or the exploration of theory as analysis of the empirical" (p. 2). It is for this reason that Smith (2005) referred to IE as a "method of inquiry" rather than a "methodology." DeVault and McCoy (2002) acknowledged that it is difficult to fully explain the
methodological and analytical processes of IE because investigations themselves are rarely planned completely in advance and the steps of the researcher are dependent on the nature of the inquiry. According to Smith (2005), “Each next step builds from what has been discovered and invades more extended dimensions of the institutional regime. The mapping of social relations expands from and includes the original site so that the larger organization that enters into and shapes it become visible” (p. 35). Thus, in following IE as a method of inquiry, I began with the particular experiences of the resident care attendants (RCAs) working in residential care facilities (RCFs) and then proceeded inductively to explore the social relations that governed them.

In this chapter, I present the research design, process, and methods. I begin with a description of the conceptual framework of IE and describe how I applied this method of inquiry to the investigation of the social processes that influence care provision in RCFs. I then present my research objectives, questions, and aims, followed by the study rationale. Following this, I detail the data collection and investigative methods. I conclude the chapter with a description of some ethical considerations.

**Conceptual Framework: Institutional Ethnography**

IE was developed by Canadian sociologist, Dorothy Smith (1977) in response to her experiences as a woman in academia in the 1950s. Smith’s method has its roots in both Marxism and feminism. That people are driven and affected by powers above them, and of import, that these dynamics are usually invisible to them are key concepts in Marxist theory. Marx emphasized the importance of understanding the experiences of “real people” to understand the “whole picture” of what is happening from a sociological perspective (Smith, 1977). IE also draws from feminist perspectives in its concern with the ways in which the social category of gender exploits, oppresses, or marginalizes women and their experiences (Smith, 1977).
As a young academic in the 1950s, Smith found that the theories and abstractions within the sociological literature and research did not capture nor accurately represent her experiences as a working, single mother of two young children. In response to this lack of representation, Smith concluded that human experience needed to be examined in a new way—by talking about and examining everyday experiences rather than by examining abstract theories. She emphasized that IE is not a qualitative research methodology, but an alternative sociology that serves exploration and discovery, rather than theorizing. Accordingly, IE researchers learn from people’s everyday knowledge of their lives and doings; they do not impose pre-formulated interpretations (Smith, 2005). According to Smith, discussing everyday experiences becomes a means of discovering new knowledge. She described this new form of knowledge as “embodied knowing”—the knowledge that comes from the expert, who is the person living the experience.

In the text *The Everyday World as Problematic: A Feminist Sociology*, Smith (1987) articulated a new way of doing sociological research. Her new perspectives allowed her to see that many social relations, and, in particular, people’s formal roles, are mediated by texts, forms and reports (Campbell & Gregor, 2008). A concrete example of this was how her mothering was affected by professors’ tenure track requirements outlined in university policies. The discovery that texts and power relations profoundly affected people’s everyday experiences formed the foundation for Smith’s future work.

**Institutional Ethnography: Central Concepts**

IE begins with an exploration of the lived experiences of people directly involved in an institutional setting; however, the individuals are not the direct objects of investigation. Rather, it is the organizational processes that have generalizing effects on the people’s activities and
experiences that are under examination. The researcher’s purpose in an IE is not to generalize about the participants, but to discover and describe the social processes that shape their activities.

Several key concepts within IE require both a definition and a description of how they relate to one another. The researcher begins an IE by identifying an experience worthy of investigation and then selects a "standpoint" from which to observe the "social relations" that permeate and influence the identified experience. The social relations are explored through a detailed examination of the study participants' embodied experiences. The focus of this exploration is to uncover the "textually-mediated work practices" that occur in response to the activation of "replicable texts" that coordinate their activities. The ultimate purpose of IE is to discover "disjunctures" and to subsequently explicate the "ruling relations" that influence the day-to-day practices of the study participants. Each of the key terms presented in the above description of IE is defined below.

**Standpoint.** Taking a standpoint explicitly notes the place from which an IE researcher “looks out” and acknowledges the way that an inquiry is “situated” vis-à-vis other “knowers” and other “ways of knowing” (Cambell & Gregor, 2008). It anchors the research to the concerns and experiences of a particular group of people (DeVault & McCoy, 2002).

**Social relations.** According to Smith (2005), social relations are activities and practices through which people’s lives are socially organized. It is within social relations that we find the interplay of people’s ordinary activities being concerted and coordinated purposefully by something beyond their own motivations and intentions. These social relations occur as people carry out their activities within a social organization (Cambell & Gregor, 2008). Furthermore, one’s activity or work is said to affect the experience of another and it is this flow of activity or work that further constitutes the social relations. Thus, within IE, the term social relations is
often used as a technical term to describe the complex practices that coordinate people’s actions, often without their conscious knowledge.

**Replicable texts.** Smith (personal communication, May 3, 2011) described replicable texts as concrete forms of works, numbers, or images that exist in a materially replicable form. She said that it is the “activation” of these texts by people that enables the texts to coordinate the social organization of institutions. Thus, within IE, a social organization is explored through the actual practices of individuals and the interaction of those practices with material objects, particularly replicable texts. Smith declared that it is not sufficient to use texts as sources of information about organizations; rather, they are to be observed and gathered as they enter into people’s local practices and to be examined as they co-ordinate people’s activities.

**Textually mediated work practices.** According to Campbell and Gregor (2008), a text has the power to hold people to acting in particular ways, although they may not recognize how their actions are being shaped by the texts when they meet face-to-face and relate to each other as individuals. In this way, the texts "mediate" the actual work practices. It is the relatively fixed and replicable character of texts "that can be stored, transferred, copied, produced in bulk, and distributed widely, allowing them to be activated by users at different times and in different places” (Smith, 2006, p. 34) that enables them to influence the social organization of individuals and groups within an institution.

**Disjuncture.** A disjuncture has been described as that moment of disquiet between the actuality of a person’s experience and the actionable institutional realities (Smith, 2005). Within an IE investigation, a disjuncture is believed to be imposed by regulatory frames, such as laws, policies, and other regulatory forms, that govern the structure or organization of the replicable texts used by the workers within an institution. The aim of IE investigations is not to study or
map out an institution in its totality; rather, it is to explicate pieces of actual work practices within a specific institution in ways that reveal points of disjuncture with governing processes and practices (Cambell & Gregor, 2008). Of significance, this mode of inquiry enables researchers and study participants to not only discover disjunctures, but to uncover solutions to address them (Pence, 2001).

**Ruling relations.** The ruling relations, determined by the distribution of power within a social structure, are the complex set of rules by which society is organized (Smith, 1990). These formal rules may or may not be fully known by the individuals within a local setting (or institution), but they ultimately affect their work activities or experiences. The rules are “translocal” in that they are developed outside the local setting. Smith (1990) maintained that, in contemporary society, ruling is organized through a construction of knowledge that relies on the complex forms of reporting, noting, accounting, and recording particular aspects of people’s work and lives.

**Objectives, Research Questions, and Aims**

The objective of this study was to improve our understanding of how the social organization of residential care within RCFs supports or inhibits the exchange of residents’ care information and thus, the provision of person-centred care. Following the framework of an IE investigation, it was assumed that, to achieve the objective, an understanding was required of the ruling relations that guided the everyday care practices of the RCAs in relation to organizational demands and priorities, as reflected in the institutional texts found within the RCFs.

Methodologically, IE proceeds inductively, moving from the particular experiences of workers in their everyday work to the general analysis of the social relations that govern them. Hence, this study was divided into two phases: Phase 1, in which I explored how RCAs
experienced working in RCFs and Phase 2, in which I explored the social and institutional processes that shaped the RCAs’ experiences and how these processes affected their access to information and their ability to provide person-centred care (see Figure 3.1, p. Error!).

**Bookmark not defined.**

RCAs need to be in compliance with multiple regulations, guidelines, policies, and expectations while simultaneously considering the dynamic and unique needs of their residents. Thus, the provision of person-centred care must be accomplished within a highly regulated and complex healthcare system. In this study, I investigated the textually-mediated work processes within selected RCFs, thereby revealing points of disjuncture between the actual, embodied work practices of the RCAs and the governing processes that influenced them. I accomplished this through an exploration of the actual day-to-day care practices of selected RCAs and a detailed analysis of the influence that the replicable texts exerted on those care practices.

The research questions that guided this study were:

1. What are the primary institutional texts that influence RCAs in their day-to-day work?
2. How do textually mediated work processes influence the provision of person-centred care in RCFs? And
3. How is the work of RCAs socially organized in RCFs?

The specific aims of the study were to:

- Systematically gather and analyze the replicable texts that influenced the day-to-day care practices within the study RCFs. This analysis included those texts that were actually used in the day-to-day care practices (e.g., daily flow sheets) and extended to texts that regulated or influenced the standards of care at the facility from the provincial and
national levels (e.g., care plans at the facility level, laws at the provincial level, accreditation standards at the national level).

- Create a map that details how replicable texts containing residents’ care information are made actionable by RCAs in RCFs.

- Assess the relationship between the replicable texts in the RCFs and the provision of person-centred care to determine the following:
  
  o How is information pertaining to the provision of person-centred care obtained in the RCFs (e.g., personal histories, needs, preferences, and routines of residents)?
  
  o Where is this information stored? On what texts, if any, is it stored?
  
  o Who has consistent and practical access to this information?
  
  o How is this information transferred between care staff members?
  
  o What organizational processes within the RCFs enable or impede both the translation and application of this information in day-to-day care practices?

- Develop specific knowledge that could be used to make recommendations for change and that could be linked directly to the creation of new standardizing practices, such as new rules, policies, procedures, forms, and training.

**Study Rationale**

The rationale for this study was based, in part, on my personal experience with replicable texts that contained language and information supportive of person-centred care within RCFs yet which remained largely inaccessible to the RCAs. For example, language explicitly supportive of person-centred care was most often found in institutional-level texts and boss texts (e.g., mission statements, public relations brochures, the Resident’s Bill of Rights). Yet, these texts were rarely, if ever, referred to during the course of the day-to-day work of RCAs. Instead, they were created,
reviewed, and revised by personnel who were often furthest away from the provision of direct care (e.g., policy makers, administrators). Another grouping of texts, which were specifically associated with the provision of person-centred care, were texts that contained residents’ personalized information (e.g., social histories, care plans). However, my experiences led me to believe that these texts were often found only in the residents’ charts, which were also rarely, if ever, referred to during the course of the day-to-day care practices of the RCAs.

**Investigative Methods**

DeVault and McCoy (2002) described the procedures of research within IE as: (a) identifying an experience, (b) examining the processes or texts that affect the experience, and (c) investigating how those processes affect the activities within the experience. To accomplish these procedures, IE researchers are encouraged to draw on a variety of investigative and analytic methods. These include, but are not limited to, classic ethnographic field techniques, such as interviewing key informants, undertaking observations, and writing detailed field notes (Campbell & Gregor, 2008). It is important to note that within IE, these interviews and observations are specifically focused on how the experience of the subject is socially organized by institutional processes, rather than the customary sociological interest in studying groups of people (MacKinnon, 2005). Thus, a unique feature of IE is the exploration of what is referred to as the "translocal" level (i.e., what is beyond everyday experiences and not necessarily visible to the individual).

I began with “local” observations and interviews of the RCAs. During my observation periods, I focused intently on the RCAs' observable activities with replicable texts during a regular work-shift. Once I was confident that I had achieved an understanding of the everyday practice of residential care provided in the RCFs, I shifted my focus to the “translocal” level by
examining which and how institutional texts and, subsequently, boss texts affected the actual
everyday provision of the residents’ care (see Figure 3.1). Everyday experiences and interactions
within the RCFs were captured using three primary investigative methods: (a) naturalistic
observations, (b) in-depth interviews, and (c) textual analysis. As expected in an IE investigation,
these primary methods of data collection were interconnected, and the data collected from one
source informed the data collected from the others (Townsend, 1996).
Figure 3.1: Research Process Map

Phase 1: How do RCAs experience work in RCFs?

- Naturalistic Observation in RCFs-field notes
  - Observe documentary practices and collect forms
  - In-depth Interviews

- Data Analysis
  - Describe RCAs' everyday work experiences
  - Create information access and exchange map

Phase 2: What social and institutional practices shape the RCA’s experiences? How do institutional and social practices affect RCAs' access to information and ability to provide person-centred care?

- Interviews with RNs, LPNs, and team leaders
- Interviews with management & support staff
- Interviews with residents and family members

Expand the information access and exchange map by “tracing up” the institutional-level and boss texts. Analyse how these factors influence information exchange and the provision of person-centred care within RCFs.

- Interviews with regional and provincial-level senior administrators and regulators.
  - How do these factors structure RCAs' work and what are the possibilities for change?
Phase One

**Naturalistic observations.** The majority of the RCAs recruited for this study were first “shadowed” or followed as they performed their daily work routines within the RCFs. Each observation began at the start of the RCA’s work-shift and concluded at the next team’s start-of-shift meeting following the end of the participating RCA’s shift. Each RCA was observed only during the course of one of her regular work-shifts. Observations in IE are not treated as sources of data about the object being observed, but as a point of entry into the working of the institution of interest (Hammersley & Atkinson, 1995). Thus, the focus of these observations was to create a chronological account of the work of RCAs within their “everyday, every shift” work. This chronological account created a story of what they did via a detailed description of the particulars of their work. It informed my understanding of the RCAs’ work practices in their lived, embodied work-life. Specific emphasis was placed on information exchanges and on detailing all the texts that were used, or referred to, during the course of the RCAs’ work-shifts.

To respect the rights and privacy of the residents, no residents were observed when personal care was provided behind a privacy screen (e.g., bathing, toileting). However, notes were taken during those times regarding the activities that the RCAs were engaged in. Thus, although I did not observe the RCAs actually bathe the residents, I was able to take notes about the work that was occurring. For example, I was able to note that the RCA was providing a resident a bath, how long it took to accomplish the activity, what preparation went into the work activity, what occurred following the activity, what texts, if any, influenced the activity (e.g., was there a text that detailed the resident’s preferences regarding whether she took a bath or a shower and what time of day she preferred to be bathed?), and if available, whether the RCA accessed that text. Detailed field notes were written for each of the naturalistic observations of the RCAs.
(Emmerson, Fretz, & Shaw, 1995) and included any questions that arose from the observations. Thus, my notes and observations guided the subsequent interviews and observations.

**In-depth interviews.** Following the naturalistic observations, each of the RCAs was asked to participate in an in-depth interview. Permission was sought from the participants to tape record and transcribe the interviews. The interviews lasted approximately one hour and took place in a private location in the facility where the RCAs worked. The focus of these interviews was to ask the RCAs to fill in the gaps of what was observed so that I could further learn about "how things worked" within an RCF. It was during these interviews that I was able to further explore what had occurred when the RCA provided personal care to a resident, which I did not observe out of respect for the resident’s rights and privacy.

It is important to note that within IE, interviews are not structured, rather they are said to be more like “talking to people” (DeVault & McCoy, 2002). According to Smith (2005), adhering strictly to an interview script limits the institutional ethnographer to what she or he has already anticipated and hence forestalls the process of discovery. Thus, the interviews all began with general questions such as, "With as much detail as you can, describe a regular work-day." "What makes a good day?" and "What makes a bad day?" The interviews then proceeded with questions specific to the exchange of information and the provision of person-centred care, such as: “When a resident is first admitted, how do you learn how to provide care to them?” Following the IE method of inquiry, all other questions evolved out of the course of the conversations and interviews as they would normally arise (Smith, 2006). Each interview informed the ones that followed; thus, the interviews and the subsequent interview questions were iterative in nature. The focus of these interviews was to identify the “institutional work process that shape[d] the informants’ everyday work” (DeVault & McCoy, 2002, p. 755).
**Textual analysis.** During Phase One of the study, blank copies of the texts that were used or referred to during the naturalistic observations and interviews were obtained and analyzed for content related to the individualized care preferences and needs of the residents. I grouped these texts into the category of “everyday texts”—those texts that were found in the everyday practice of the RCAs (e.g., residents’ bathing lists). During Phase Two, I categorized the texts into one of two groupings: (a) “institutional-level texts”—those texts that had the potential to mediate the work of the RCAs and were developed at the facility level (e.g., the residents’ assessments and care plans) and (b) “boss texts”—those texts that were translocal in that they were developed outside of the local institution and implemented across multiple healthcare institutions (e.g., laws, regulations, and standards of practice). All of these replicable texts were considered because they coordinated, or attempted to coordinate, the care staff members’ actions that were integral to the RCFs; thus, they were investigated as the visible traces of the institutionalized social relations that governed the actual work practices.

I identified the everyday texts during the observations and interviews completed during Phase One by taking note of the texts that guided and informed the RCAs’ daily care practices. The institutional-level texts and boss texts were identified through four sources: (a) observations of practice with the associated everyday texts, (b) my personal knowledge, (c) the search of web sites of relevant regulatory bodies with public domain search engines, and (d) the interviews conducted during Phases One and Two.

**Phase Two**

The focus of Phase Two was to explore and describe how social relations were organized within and beyond the local setting. Phase Two began with interviews of the facilities’ RNs and LPNs and then the support staff (e.g., maintenance, dietary staff, administrative assistants,
recreation staff), managers, residents, and residents' family members. The purpose of interviewing people other than the RCAs stimulated discovery of how what was done, in the context of the work, was guided or ruled by relations not always known or understood by the participants (Campbell & Gregor, 2008). Thus, the focus of these interviews was to understand how the organizational linkages and social relations between these groups supported or hindered the RCAs’ access to information and ability to provide person-centred care. The questions for these interviews were not pre-determined and were derived specifically from the previous observations and interviews conducted with the RCAs.

I concluded Phase Two by conducting interviews with the senior administrators and regulators at the regional level. The focus of these interviews was to address the development, implementation, and use of the institutional-level texts found within the RCFs and the boss texts that influenced the daily care practices. My intention was to inform the study participants of the findings and to engage in a discussion of the possibility for change in the institutional work processes and texts that could positively influence the RCAs’ access to information and ability to provide person-centred care.

Data Collection: Setting and Sample

Campbell and Gregor (2008) suggested that sample size be decided by the type of data to be gathered. Several criteria, namely, the methodology, the complexity of the phenomenon under study, and the experience of the researcher should guide the decision of sample size in qualitative research (Sandelowski, 1995). Because IE follows the natural shape of everyday practices, the number of data sources (e.g., informants, documents) should emerge out of the research process rather than be predetermined in an a priori research design. Streubert-Speziale and Carpenter
(2003) suggested that participants be selected on the basis of their in-depth and particular knowledge about the experience under study.

In an IE, data collection continues until sufficient data have been collected to record how everyday practice actually works within an institutional framework (Townsend, 1996). Thus, the data collection process for this study began broadly to describe accurately the everyday work world of RCAs and gradually narrowed until no new variations or contradictions emerged in the observed practice. Data were collected over seven months.

**Setting.** The study was conducted in three RCFs located in British Columbia (BC), Canada. These RCFs were selected based on several features: (a) the facilities were home to between 120 and 150 residents; thus, they were similar in size to many RCFs within BC; (b) the facilities were home to residents who were assessed as having complex care needs and thus required the presence of skilled nurses 24 hours a day, 7 days a week; (c) the facilities were similar to the majority of RCFs within BC in their staffing mix (e.g., a registered nurse (RN) oversaw a licensed practical nurse (LPN) who was a team leader who oversaw the resident care attendants (RCAs)); (d) similar to the vast majority of RCFs in BC, the care staff were members of a union; (e) the facilities had implemented an explicit person-centred model of care; and (f) the facilities were located within reasonable proximity so that they were readily accessible for observations to take place during all shifts and for extended periods.

A key-differentiating feature among the three facilities was their ownership status. A substantial body of research has assessed the relationship between ownership status and quality of care in RCFs. A recent systematic review and meta-analysis by Comondore et al. (2009) concluded that, on average, not-for-profit facilities provide higher quality of care compared with for-profit facilities. However, their findings also suggested that while a positive association is
evident, it likely varies across situations and is potentially mediated by management philosophies and related work organization systems. It is because of these equivocal findings that the study facilities were purposefully selected to vary by ownership status. Facility #1 was a private-for-profit facility, Facility #2 was a private not-for-profit facility, and Facility #3 was owned and operated by the government funded regional health authority. See Table 4.1 on page 106 for an overview of the contextual factors of the three participating RCFs.

**Facility #1.** Facility #1 was owned and operated by a private-for-profit provider of independent retirement living, long-term care, and home care in Canada and the United States. This firm was selected for two reasons. First, the site had recently developed a professional practice model based on their corporate mission of providing person-centred care. This practice model involved advocacy, empowerment, and respect for residents’ autonomy, self-determination, and participation in decision-making. Second, at a chance meeting at a national conference on aging, senior members of the organization expressed interest in this research. Consequently, senior administrators from this corporation were contacted to seek their endorsement of the study. After multiple e-mails and phone meetings, these administrators agreed to have one of their facilities in BC participate in the study. A subsequent interview with the corporation's Provincial Director of Long Term Care Services was held. During this meeting, Facility #1 was selected for inclusion in the study based on the above-mentioned criteria.

Facility #1 provided complex care services to 131 residents, of whom 101 resided in publically subsidized units and 30 resided in private-pay units.  

![image]

Facility #1 provided complex care services to 131 residents, of whom 101 resided in publically subsidized units and 30 resided in private-pay units. The building was "older" and

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4 The difference between private-pay and publically subsidized beds is described in detail in Chapter 4, which describes the context of living or working in RCFs.
lacked physical design features that many RCFs in BC offered to residents (e.g., all private rooms, mechanical ceiling lifts built into the ceiling of each room to assist in lifts and transfers of physically impaired residents, small "neighbourhood" gathering areas). It housed residents in rooms that were private (i.e., one resident per room), semi-private (i.e., two residents per room), and 4-bed wards (i.e., four residents per room). The majority of the residents lived in semi-private rooms or 4-bed wards located on the lower level. The private pay rooms were all single dwelling rooms located on the second level. In this facility, the care staff members rotated to a new resident assignment list (i.e., a new group of residents to whom they would provide care) every six weeks.

Facility #2. Facility #2 was a privately owned, not-for-profit facility. This facility was owned and operated by a well-known service organization. The goal of the service organization was to "support a culture of caring with compassion for the residents living in their facility." They also espoused a person-centred approach to care through the creation of "a warm, home-like atmosphere by grouping residents into small families of eight to twelve." Upon reading the research proposal, a senior administrator from the health authority recommended that I invite this facility to participate. I corresponded via e-mail with the executive director of the facility and then met with her to discuss the facility’s participation. She expressed interest in and support of the study and we subsequently pursued and obtained consent from the board of directors of the facility. This facility was home to about 125 residents, six of whom paid privately for their rooms. This facility was purpose built to provide specialized care to individuals with dementia who also had complex care needs. Every resident had a private room (i.e., one resident per room) and ceiling lifts were located in the rooms of those residents who required them. The care staff members were assigned to care for the same residents every shift they worked. This practice of
“permanent resident assignment” is recognized by many as a "best practice" in dementia care (Castle, 2011).

**Facility #3.** Facility #3 was owned and operated by the government funded regional health authority. It was home to approximately 150 residents and offered no private-pay rooms. The facility had several buildings, each of which was purposefully designed to meet particular care needs (e.g., small home-like units for ambulatory residents with dementia and larger hospital-like units for physically frail residents). Depending upon the building, the residents were housed in private, semi-private, and 4-bed wards. During my data collection, the care staff members in this facility were in the process of moving from permanent resident assignments to a rotation wherein they were assigned to different residents every three months.

**Sample.** The primary sampling strategy was purposive sampling. The study participants were composed of employees (i.e., RCAs, RNs, LPNs, support staff, and managers) who were employed on a casual or permanent, full- or part-time basis in one of the study RCFs, as well as family members, residents, and regional and provincial-level senior administrators, regulators, a member of a provincial advocacy group, and a researcher who utilized data from the Resident Assessment Instrument-Minimum Data Set (RAI-MDS) for research purposes.

The study RCAs were recruited during initial information meetings. Based on my past experience as an employee, consultant, and researcher in RCFs, I was acutely aware of how important issues related to trust in the researcher-participant relationship would be to this study. In acknowledging this, I gave much attention to how I would introduce this study to the staff during the recruitment meetings. I engaged a professional coach who assisted and challenged me as I explored this issue. As a result of this ongoing coaching, I developed an outline of my introduction to the study, which included messages of transparency and some vulnerability on
my part. This was important because, in effect, I was asking the RCAs to be transparent and vulnerable by participating. I believe my attention to these details was instrumental in recruiting sufficient numbers of participants.

In all, 14 RCAs agreed to be “shadowed” during their workday and to be subsequently interviewed; 4 RCAs agreed to be interviewed only. The 4 RCAs whom I interviewed, but did not shadow, were purposefully selected because they offered a unique perspective within their institution (i.e., they worked as casuals in multiple RCFs and in multiple units throughout RCFs, worked on units other than the ones in which I had conducted naturalistic observation, or actively participated in specific organizational programs such as a work-load committee). Attention was paid to recruiting RCAs who worked on all shifts during the 24-hour workday (e.g., day shift, evening shift, and night shift). At the completion of data collection, I had conducted 104 hours of naturalistic observation.

RNs, LPNs, support staff, managers, residents, family members, senior administrators, regulators, a researcher, and RCF advocates were also recruited for in-depth interviews. The focus of these interviews was to understand how the organizational linkages and social relations between these groups of employees supported or hindered the RCAs’ access to information and thus, their ability to provide person-centred care.

In all, I conducted 76 interviews. Following a description of the study requirements, informed and voluntary consent to be interviewed was obtained from each of the study participants. See Tables 3.1, 3.2, and 3.3 for details of the study participants stratified by study phase, facility, and sector.
Table 3.1: Phase One—The Number of Study Participants by Facility

<table>
<thead>
<tr>
<th>Facility #1</th>
<th>Facility #2</th>
<th>Facility #3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Resident Care Attendant</td>
<td>8</td>
<td>6</td>
</tr>
</tbody>
</table>

Table 3.2: Phase Two: Part A—The Number of Study Participants by Facility

<table>
<thead>
<tr>
<th>Participant Group</th>
<th>Facility #1</th>
<th>Facility #2</th>
<th>Facility #3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Executive Director</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Social Worker</td>
<td>2</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>RAI-MDS Coordinator</td>
<td>2</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Nursing Supervisor</td>
<td>1</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Registered Nurse</td>
<td>2</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>Licensed Practical Nurse</td>
<td>2</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>Resident</td>
<td>3</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Family Member</td>
<td>4</td>
<td>5</td>
<td>4</td>
</tr>
<tr>
<td>Maintenance Employee</td>
<td>0</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Administrative Assistant</td>
<td>1</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Food Services Employee</td>
<td>1</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Recreation Employee</td>
<td>1</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

Table 3.3: Phase Two: Part B—The Number of Study Participants by Sector

<table>
<thead>
<tr>
<th>Sector/Title</th>
<th>Number of participants</th>
</tr>
</thead>
<tbody>
<tr>
<td>Member of a provincial advocacy agency for RCFs</td>
<td>1</td>
</tr>
<tr>
<td>Union Representative</td>
<td>1</td>
</tr>
<tr>
<td>Senior Administrator</td>
<td>2</td>
</tr>
<tr>
<td>Regulator or Licensing Officer</td>
<td>3</td>
</tr>
<tr>
<td>Researcher</td>
<td>1</td>
</tr>
<tr>
<td>Retired Manager</td>
<td>1</td>
</tr>
</tbody>
</table>

Data Analysis

Data analysis in IE is not clearly prescribed in the works written about the methodology. However, consistent with all IE studies is the requirement to analyze not only the participants’ understandings and experiences, but to connect those experiences with a ruling system located outside the participants’ everyday world. According to Smith (2005), the purpose of the analysis is not seeking patterns; rather, the purpose is to explicate how the work is socially organized. Thus, the goal of my data analysis was to obtain an accurate understanding of the relationships
between the everyday practice of care giving in the RCFs and of how the institutional priorities and mandates, as reflected in the institutional texts, influenced the RCAs’ work. The data analysis began with the interviews that followed the observation periods; as each interview progressed I verified my understanding by reframing my questions and clarifying the responses (Campbell & Gregor, 2008; DeVault & McCoy, 2002).

Campbell and Gregor (2008) recommended using the following guiding query during the analysis phase of an IE study: “What does it tell me about how this setting or event happens as it does?” (p. 85). Correspondingly, DeVault and McCoy (2002) described the researcher as one who is to “find and describe social processes that have generalizing effects” (p. 753). They further proposed that selection of one strand is necessary because researchers often collect considerably more information than they can use in an analysis.

The data included in the analysis were derived from the field notes, recorded interviews, and documents obtained during Phases One and Two. Transcripts of the recorded interviews were produced verbatim. Microsoft Word® was used to manage and group the data from the interviews. The decisions regarding how the data were to be grouped were not predetermined. Rather, they evolved from a review of the observation notes, the transcribed interviews, and the process of creating information-exchange maps.

The goal of IE is not to explain people or their attitudes, but to explicate the social processes within which people find themselves and which they reproduce and alter through their participation. Thus, I was encouraged to focus on the actual work processes and the forms of knowledge and co-ordination that went into the care of the residents of the study RCFs. The constant focal point of my analysis was discovering any gaps between what the RCAs experienced as a result of the institutional processes and the institutional goal of providing
person-centred care. Because I selected the standpoint of the RCAs, I made every effort to see the gaps from the RCAs’ position and to see what parts of the gaps were produced by the institutional practices (i.e., a disjuncture).

Early on in the data analysis I created information-exchange "maps" that demonstrated the interconnectedness and directionality of the information flow between the RCAs and the other care staff. I conducted observations, interviews, and document reviews until I believed that I understood how the residents’ care information was obtained, where it was stored, how it was accessed and by whom, and how it was transferred or shared by the various staff members. Having the data analysis grounded in these information-exchange maps provided an essential foundation from which to determine when the data collection and analysis were "complete."

An IE study does not stop at the identification of issues that are problematic in the everyday work of people, but seeks to understand how these issues are governed by institutional priorities and mandates as reflected in the institutional texts. Accordingly, it is through the identification of the relationships between the texts and everyday practice that problems within the institution can be addressed with specific solutions for change. Consequently, I completed the analysis by creating a model that represented a conceptualized understanding of the factors that positively influenced the provision of person-centred care in the participating RCFs.

**Ensuring Scientific Quality**

Several scholars have articulated ways of ensuring the scientific quality or rigor of qualitative research (Lincoln & Guba, 1985; Maxwell, 2012; Onwuegbuzie & Leech, 2007). Two broad types of threats to validity are often raised in relation to qualitative studies: (a) researcher bias—how the researcher’s values and expectations influence the conduct and conclusion of the study and (b) reactivity—the influence of the researcher on the setting or individuals studied.
(Maxwell, 2012). According to Maxwell (2012), it is impossible to eliminate the influence of the researcher on the study and it is equally impossible to eliminate the researcher’s theories, beliefs, and perceptual “lens” during the research process.

Consequently, the goal of a qualitative researcher should not be to attempt to eliminate these influences, but instead to understand them and to use them productively. For this reason, it was important for me to reflect on my ontological and epistemological approach to the research. I believe that the attainment of "universal truth" is impossible and that truth is culturally or socially constructed. I believe that knowledge is contextual, is subject to multiple interpretations, and is constructed through social interaction (Gergen, 1999). I also believe that knowledge depends on decreasing the influence of ideological biases. Thus, as I engaged in this research, the quality of the work and the utility of the results were largely dependent upon my ability to remain open while being fully immersed and engaged. I recognized early that a significant challenge was finding a balance between honouring and applying my prior knowledge and experiences (both on a professional and personal level) to enhance the research while simultaneously not letting any preconceived ideas obstruct the opportunity to learn something new or see something that I had not seen before.

Once in the field, my aim was to put my preconceived ideas aside and be as open to learning from others who are positioned differently from myself as possible. Following the advice of Dorothy Smith (personal communication, May 3, 2011), I attempted to ensure a level of objectivity and openness by remaining steadfastly focused on the actual work that the RCAs did. During my interviews, I also worked diligently to ensure that it was the informants' ideas, thoughts, and experiences that guided the interviews and not my own.
Throughout this study, I reflected on what my possible biases were, how I should deal with them, and how I may have influenced what the participants said and did. I reflected on how these influences affected the validity of the conclusions I believed I could draw from the data. Hammersley and Atkinson (1995) called this process “reflexivity”—the ability of the researcher to reflect upon, examine, and explore the social process and contextual factors that influence the research relationship as well as the study participants’ lives. According to Etherington (2007), reflexivity allows researchers to include our "selves" in the research by making transparent our values and beliefs that influence the research process. In this study, my reflexive work was made transparent through field notes, the more extensive writing that I engaged in at the end of each observation period and interview, and monthly meetings I held with my research supervisors to discuss my ongoing data collection and field experiences.

In addition to reflexivity, the rigor of this study was assessed through the following validity tests: (a) the collection of “rich” data, (b) evidence of credibility, and (c) the search for discrepant evidence or negative cases (Becker, 1970; Emerson, Fretz, & Shaw, 1995; Fonow & Cook, 1991; Lincoln & Guba, 1985; Wolcott, 1990). According to Becker (1970), “rich” data are detailed and varied enough to provide a full and revealing picture of what is going on. This is clearly the goal of an IE investigation and was imperative to the rigor of this study.

To ensure that I obtained rich data, my observation periods included all of the shift types that the RCAs worked (e.g., day, afternoon, and night) and I observed the RCAs' shifts in their entirety, rather than observing a portion of them. Finally, I remained in the facilities and observed the start-of-shift reports and inter-shift communication immediately following each observation period. I interviewed each participant following the observation period so that I was able to clarify my observations and “fill in the gaps” of anything that I may have missed or
I repeated my shadowing of complete shifts and in-depth interviews until I believed that I had obtained a clear and detailed picture of what happened in the course of an RCA’s workday. In addition, I ensured “rich data” by taking detailed, descriptive notes of the specific events that I observed (Emerson, Fretz, & Shaw, 1995) and by transcribing the interviews verbatim (Maxwell, 2012).

The notion of credibility refers to ensuring that study findings reflect the realities of the participants (Streubert-Speziale & Carpenter, 1995). For this IE study, it was important to address how the participants’ realities were included and described accurately and thoroughly in the data. Thus, the credibility of the findings was sought in three ways: (a) through member checking—the process of ensuring that the participants had input into the interpretation of their experiences (Sandelowski, 1993), (b) auditability—the ability of others to trace the methods used in the study via a transparent “decision trail” (Sandelowski, 1986), and (c) triangulation—ensuring that I had multiple points of view when gathering the data (Sandelowski, 2000).

I addressed member checking by sharing the emerging findings with, and soliciting feedback about the data and conclusions from, the participants throughout the data gathering and analysis stages. Member checking occurred with each participant. I did this with the intention of ruling out the possibility of misinterpreting the meaning of what the participants said or did, and to include their perspective about what was going on. In addition, I used member checking as a means of identifying my own biases and possible misunderstandings of what I had observed or heard (Maxwell, 2012). As noted by Hammersley and Atkinson (1995), however, participants’ feedback is no more inherently valid than are their interview responses; therefore, both were taken as evidence of the validity of my accounts.
Auditability refers to the "decision trail" left by a researcher that allows others to trace the methods used (Sandelowski, 1986). A transparent decision trail was provided within my study design, my explanation of my methodological choices, and the information-exchange maps I created.

Triangulation refers to the use of a variety of methods to collect information from a diverse group of individuals. Triangulation is used to reduce the risk of systematic biases. In this study, I addressed this issue in several ways. First, I used multiple methods to obtain the data: observations, interviews, and textual analyses. Second, I gathered data from diverse participants: RCAs, RNs, LPNs, support staff, residents, family members, managers, and senior administrators. Finally, I gathered and analyzed documents and texts created at three distinct levels: the everyday or local work environment, the institutional-level, and the relevant boss texts.

According to Maxwell (2012), one way to test validity in qualitative research is by analyzing negative cases and discrepant data. He stressed that researchers “need to rigorously examine both the supporting and the discrepant data to assess whether it is more plausible to retain or modify the conclusion, being aware of all of the pressures to ignore data that do not fit your conclusions” (p.112). I actively worked to ensure that I included and addressed divergent data in my analyses and asked my key informants for ongoing feedback so as to check my own biases and assumptions and to challenge any flaws in my logic or methods.

Ethical Considerations

During the preliminary study information meetings (with small groups and one-to-one), all of the participants were informed that their participation was entirely voluntary. Before they decided whether they wished to participate, they were offered an information sheet that informed
them about the study, why the research was being done, and what was required of them, if they decided to participate (see Appendix A). They were also informed in writing and verbally that if they decided to take part in the study they were free to withdraw at any time without giving any reason for their decision. Furthermore, they were informed that if they did not wish to participate, they did not have to provide any reason for their decision, and their decision would in no way affect their employment status or relationship with management.

The confidentiality of the data collected during any research project is essential; therefore, numeric identifiers were used to replace the names of the participants and they were grouped into one of only six categories: RCA, Team Leader, Manager, Administrator (i.e., participants interviewed in Phase 2), Resident, and Family Member. In addition, all the participants were referred to as female (regardless of their gender) in the analysis and writing. All of the participants were asked to sign a consent form (see Appendix A). However, it is important to acknowledge that, as a result of spending considerable time in the three facilities, I engaged in informal discussions with RCAs who, although not active study participants, knew that I was a researcher and informally spoke with me (e.g., in the break room, while waiting for report, and in the hallways). I did not take notes of my conversations with, or observations of, these RCAs, who had not formally consented to participate. Consequently, although I acknowledge that the conversations I had with them informed my findings, I primarily relied on the data obtained from the study participants who had signed consent forms.

All of the RCAs’ interviews were scheduled during their regular workday. The interviews of all employees and residents of the three RCFs took place in private locations in their respective RCF. All other participants (e.g., family members, senior administrators, regulators) were contacted directly, and the times and locations of their interviews were set based on what
was most convenient to them. These interviews occurred in offices, coffee shops, and the participants' homes.

In designing this study, I was acutely aware that asking RCAs to leave their unit during their regular work-shift could result in negative consequences for the residents under their care and for their teammates who would have to "pick up the slack" and care for the residents in their absence. Thus, in an attempt to ensure the least amount of interference with the residents, families, and other care staff members, I paid the salaries of casual RCAs to cover the duties of the participating RCAs while they were engaged in the interviews. Because I could not afford to do the same for the participating regulated care staff, I scheduled their interviews to occur either immediately before or after a regularly scheduled work-shift; I gave them an honorarium for their participation equivalent to one and one half hours of work at their pay grade. The facility managers allowed the nursing leaders and other support staff to accommodate my interviews within their normal workday; thus, they were not given an honorarium nor replaced by a casual staff member. All of the RCAs who agreed to be observed during an entire work-shift and to participate in an interview were offered a $45 gift card as a "thank you" for their participation. Every study participant who agreed to participate in an interview alone was offered a $25 gift card.

The names of the residents of the facility and their identifying information (e.g., date of birth, room numbers) were not sought and no residents were selected for direct observation. Rather, my goal was to make general observations of "anonymous" residents during the RCA job shadowing. In addition, to respect the rights and privacy of the residents, I was not present when personal care was provided behind privacy curtains or closed doors (e.g., bathing rooms and toileting).
I recognized that it was important to ensure that, to the extent that they were able, residents with dementia understood that they were participating in research and were given the opportunity to agree or refuse to be observed. I accomplished this by obtaining signed consent from the resident (or designate) and also by seeking verbal assent—affirmative agreement to participate or, alternatively, respecting the resident’s expressed dissent or objection (Black, Rabins, Sugarman, & Karlawish, 2010). Recognizing the continual nature of naturalistic observation, obtaining assent was an ongoing process (Morse & Field, 1995). To address the ongoing nature of assent during the observation periods, I wore a nametag that identified my role as a researcher and I reminded the participants of who I was and why I was there. I spoke directly to the residents using language appropriate to their cognitive status while making observations of both their verbal and nonverbal responses to our conversations. I relied on my expertise as a dementia care specialist and recreation therapist to engage in these conversations and to assess the residents’ apparent assent or dissent.

**Ethics review.** I was required to obtain ethics approval for this study from four ethics review boards or committees (i.e., the health authority ethics review board, the university behavioural research ethics board, and two facility-specific ethics review committees). Because I intended to observe RCAs interacting with residents with dementia, one of the ethics review boards designated the study as "high risk." Regardless of my efforts to ensure that the study would have minimal impact on the residents, the ethics board required that I obtain signed, informed consent from all of the residents whom I might observe in the facility (or their representative family members) prior to commencing the study.

Obtaining signed consent from all residents or their family members was an arduous task. I accomplished this task by first mailing a study package, which I compiled and an administrative
assistant from the facilities addressed, to selected residents and all family members of the facility. This package contained the following items: (a) an information letter explaining the research aims and goals, (b) a detailed description of the data collection processes, (c) a consent form, and (d) a stamped self-addressed envelope to return the signed consent form (see Appendix B, C, D, and E). Following the mail out, I conducted several information meetings for the facility’s residents and their family members to recruit participants and to gain consent for the naturalistic observations.

The requirement of having to have informed, signed consent from every resident who may have been observed had the unintended consequence of placing a relatively heavy burden on the participating facilities. I required their assistance in determining which residents were cognitively able to provide informed consent and then in contacting the family members of the residents who were deemed not competent to sign their own consent forms.

The time consuming process of obtaining signed consent from all residents or their family members, in Facility #1, led to a change in the subsequent recruitment strategy. I obtained signed consent from only those residents whom I interviewed. To conduct my observations of the RCAs, I obtained ongoing verbal assent from every resident and requested signed consent only from family members.

In the second facility, I conducted naturalistic observations only of staff who worked in one small unit within the facility. I did so because I was then required to obtain signed consent from the family members of a limited number of residents who lived in the one unit (as opposed to the entire facility). In an attempt to address the possible bias that this recruitment strategy produced, I ensured that I interviewed an RCA who worked in another unit in this facility and also an RCA who worked on a casual basis on all units in the facility. Though this strategy
assisted in obtaining consent from family members, it was not until I had almost completed the data collection that I realized that the RCAs from this facility were at greater risk of being identified because the majority of the data obtained could have been traced to the one unit where they were permanently assigned. Thus, in Facility #3, I conducted naturalistic observations in two units. This approach better enabled me to protect the RCAs' anonymity, yet I was not required to obtain consent from 150 residents or family members.

The process of obtaining consent was the most challenging aspect of this study. The unintended outcomes of the ethics review process—a process that should have protected the study participants—was that some of them experienced unnecessary risks associated with the loss of anonymity. In an attempt to address this, I assigned some study participants more than one number (i.e., in the place of their name) when including their quotations. I was especially diligent in doing this when there was a possibility that a quotation could be traced to a particular facility.
Chapter 4: The Context of Living or Working in a Residential Care Facility

The simplified, but accurate, goal of this institutional ethnography was to understand how information exchange is influenced by the way in which care work is socially organized in residential care facilities (RCF). I accomplished this through observing and interacting with people engaging in their everyday activities, which, when taken together, helped me to understand more fully “how things work” in these institutions.

An understanding of “how things work,” however, must begin with an examination of the context within which the work occurs. Consequently, I begin by describing the complex regulatory framework that governs RCFs in British Columbia (BC). The information presented here is derived from an extensive review of governmental policies, an overview of the relevant research literature, an analysis of selected participant interviews, and my personal clinical experience. I first discuss some macro-level contextual factors by providing an historical overview of residential care regulations in Canada. At the meso-level, I explore the current provincial and regional regulations that govern the three study facilities (Facilities #1, #2, and #3). Finally, at the micro-level, I discuss the regulations that determine who lives and works in these institutions.

The Macro-Level Context: An Historical Overview of Residential Care Regulations in Canada

When attempting to better understand how the regulatory framework influences the quality of living or working in RCFs in BC, it is prudent to review the historical evolution of institutional living environments in Canada. Sadly, a review of this history reveals societal values that have been mostly oppressive and discriminatory against individuals who are unable to be productive members of the labour force.
Before the Great Depression, the only form of public support available to the destitute elderly was within institutional settings. The guiding principles of these institutions (called poor houses, work houses, or alms houses) were derived from the English Poor Laws—laws passed in the 1600s and later revised in the 1800s to ensure that conditions of life in these houses would be less pleasant than that experienced by the lowest working class citizens. Therefore, only the absolute essentials necessary for minimal maintenance of the individual were provided in any of these institutions (Forbes, Jackson, & Kraus, 1987). Unfortunately, until recently, it seems that the English Poor Law system exerted the greatest single influence on the evolution of residential care in Canada (Emodi, 1977).

The governmental systems that invented poor houses were also eager to discourage people from using them, and a stigmatization attached to admission was not only intended, but also encouraged. Fear of the poor houses (based on the substandard and inhumane conditions within which residents were forced to live) was a “pro-active” way to ensure that only those individuals who were truly incapable of labour were admitted. People in need were considered subjects of their own failure and were viewed as second-class citizens. The Puritan-based suspicion that moral degeneracy was the true cause of poverty enabled the grossly substandard living conditions experienced in these houses to remain for centuries (Forbes, Jackson, & Kraus, 1987). In Canada, the “general mix” poor houses and work houses (single dwellings in which up to 200 people lived, including the poor, unwed mothers, mentally ill individuals, mentally impaired individuals, delinquents, and the infirm elderly) existed well into the twentieth century (Forbes et al., 1987).

This historical review of institutional living environments provides an important foundation from which to understand how the first measures of the quality of care provided
within RCFs were defined, measured, and regulated. The original inspectors of the poor houses primarily ensured that the management and bookkeeping of these establishments were in order. They frequently reported that the living conditions were substandard, but, in keeping with the ideologies of the Poor Laws, they did little to rectify the situations (Emodi, 1977). In Ontario, inspections of the poor houses were originally the responsibility of the Inspector of Prisons and Public Charities; in other provinces, the inspections were conducted by physicians or governmentally appointed persons (Forbes, Jackson, & Kraus, 1987).

In 1918, the American College of Surgeons (ACS), of which Canada was an active member, developed the Minimum Standards for Hospitals. The document filled just one page, yet at the time only 89 of 692 hospitals surveyed (12.9%) met the requirements for the minimum standards of care (Accreditation Canada, 2013). It was in the 1920s that the first “private hospitals” were opened for the elderly. These facilities provided little more than food, shelter, and minimal nursing care and were often run by nurses forced to add to their income by opening their homes to patients (Forbes, Jackson, & Kraus, 1987). According to Emodi (1977), these hospitals provide the link between the earliest facilities and modern RCFs.

Between 1920 and 1970 much change occurred that would lead to significant improvements in the quality of care offered to Canadians living in RCFs. During this 50-year period, Canada opened long-term residential care public and private hospitals specifically for the elderly (1920s), implemented the Old Age Pension Act (1927), implemented the Homes for the Aged Act (1947), implemented the Canada Assistance Plan (1966) and, most important, implemented a national insurance program via the Hospital Insurance and Diagnostic Services Act (1957) and the Medical Care Act (1966). Each of these interventions had a dramatic impact on where, how, and how well the elderly were cared for (Forbes, Jackson, & Kraus, 1987).
However, it was not until 1978 that the accreditation of RCFs was implemented. Up to this time, no surveys specific to RCFs were developed; therefore, it may be safe to assume that residential care “hospitals” would have been surveyed under the same standards developed for acute care settings (Accreditation Canada, 2013). It is no wonder then that original standards of care in RCFs were primarily focused on meeting basic biological needs, were clearly task oriented, and were based almost exclusively on objective medical and clinical outcomes. Critics of the medical model state that it “justifies control as appropriate treatment for the good of the patient” (Lyman, 1989, p. 602). Furthermore, they contend that it creates a hierarchy of power within care environments and promotes care that is primarily custodial in nature (Lyman, 1989; Lyman, 1990).

**Meso-Level Context: How Quality is Regulated and Measured in Residential Care Facilities**

The BC Ministry of Health (BCMOH) establishes province-wide goals, standards, and expectations for the delivery of care and services for seniors. This ministry is responsible for ensuring good governance and the continuous monitoring and evaluation of service delivery in BC’s RCFs. Though the BCMOH sets the standards and expectations for care, the actual delivery of services for seniors is the responsibility of BC’s regional health authorities.  

5

5 In 2001, BCMOH restructured the administrative oversight of publicly-funded healthcare services by amalgamating the existing health authorities into six larger health authorities: five have geographic areas of responsibility (i.e., Vancouver Island, Fraser, Interior, Vancouver Coastal, and Northern) and one oversees specialized provincial health services (e.g., Children’s Hospital, Women's Hospital, Cancer care).
Throughout BC, residential care services are provided in publicly owned and operated (not-for-profit) facilities, privately owned not-for-profit facilities, and privately owned for-profit facilities. Each type of facility was purposefully represented in this study. Facility #1 was a privately owned for-profit RCF, Facility #2 was a privately owned not-for-profit RCF; and Facility #3 was a publicly owned and operated RCF (see Table 4.1).

Publicly subsidized residential care beds are funded, in part, by the BC Government and, in part, by the resident. According to the BCMOH, the cost of operating a RCF bed is about $6,000 per month, or $200 per day. Depending upon their incomes, subsidized residents contribute between $898 (15%) and $2,932 (49%) per month (BCMOH, 2013). This rate structure requires that people in subsidized beds pay up to 80% of their after-tax income, provided that they have at least $325 of their income remaining each month. Private for-profit and private not-for-profit facilities can offer both publicly subsidized as well as private-pay services. For example, in Facility #1, 29 of the 130 beds (22.3%) were private-pay beds, and in Facility #2, 6 of the 125 beds (4.8%) were private-pay.  

Accordingly, these privately owned facilities are referred to as "affiliated" or "contracted" facilities because they are contracted by the regional health authority to provide services to individuals entitled to publicly subsidized services. Regardless of the ownership status, all RCFs in BC are required to comply with the same standards of care.

Regulating quality in residential care. In BC, the RCFs that are located in the community are licensed and regulated under the Community Care and Assisted Living Act (CCALA). The residential care services that are provided in a public, extended care hospital or a private hospital are governed under the Hospital Act. Facilities that are licensed under either

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6 The total number of beds has been approximated to ensure anonymity of the participating RCFs.
legislative act may be publicly owned and operated or operated by private, non-profit or for-profit entities. Most RCFs (71%) in BC are licensed under the CCALA; however, over 100 RCFs (29%) continue to be regulated by the *Hospital Act*. Facilities #1 and #3 were governed under the *Hospital Act* and Facility #2 was governed under the CCALA.

According to the British Columbia Ombudsperson Public Report #47 (2012), the *Hospital Act* has changed very little in the past 50 years. At its inception, its principal focus was the regulation of public hospitals that provide acute care, rehabilitation and extended care services. Significantly, the *Hospital Act* has no mandatory standards of care or practice provisions for the operators who provide residential care services.

The CCALA, on the other hand, was created in 2002 to replace the *Community Care Facility Act*, and outlines extensive care standards specific to both residential care service provision and the physical environment within which it occurs. The CCALA also determines the responsibilities of the medical health officers, who are appointed under the *Public Health Act* and employed by the regional health authorities. Medical health officers are responsible for issuing licences, conducting routine inspections, investigating complaints, applying sanctions and issuing exemptions from the requirements of the CCALA. In practice, these powers are often delegated to licensing officers, who work for the regional health authorities. This process was described by a study participant from the licensing division of a health authority:

**Administrator [04]:** ...we have multiple, multiple policies and procedures for staff [licensing officers] to follow. We have a checklist that basically embodies the entire regulation that staff use when they go out to conduct inspections. ...there are requirements for the facilities to report to us any kind of allegations or concerns or not meeting their regulation on any kind of level.
However, the licensing officers have no authority to inspect or investigate complaints arising from the RCFs that are regulated under the Hospital Act. As a result, the standards and oversight mechanisms that apply to the RCFs licensed under the CCALA are more extensive and rigorous than those that apply to RCFs governed by the Hospital Act.

The BC Government recognized the need to harmonize these two regulations when they passed Section 12 of the CCALA, which would have placed private hospitals, extended care facilities, and public hospital continuing care facilities within the legislative framework of the CCALA. It is noteworthy that although Section 12 of the CCALA was passed on November 25, 2002, it has not yet been proclaimed and brought into force. According to the Ombudsperson (2012) report, the Ministry of Health identified several financial issues that needed to be addressed before the Government could proclaim and implement Section 12 of the Act. When I asked senior-level administrators whether they believed these RCFs would ever be brought under the legislative framework of the CCALA, they unanimously agreed that, because of the financial cost of implementing Section 12 of the Act, it was unlikely. Consequently, different regulatory standards, monitoring, and enforcement processes are in effect for BC’s RCFs.

It is perhaps because of the differences in these regulatory standards that a province-wide investigation of residential care services by the BC Ombudsperson in 2008 reported that the RCFs varied widely in terms of their physical conditions, staffing levels, food services, service delivery models, and philosophical approaches to care. A primary focus of that investigation was the quality of care provided in BC’s RCFs. Two important new acts and one new regulation were developed and passed by the legislature and Ministry, respectively, following the Ombudsperson’s investigation: (a) the Patient Care Quality Review Board Act, 2008, (b) the
On October 15, 2008, the Patient Care Quality Review Board Act (2008, c. 35) was passed. It requires each regional health authority to establish a Patient Care Quality Office to receive complaints about the delivery of services. The Act also requires each regional health authority to establish a Patient Care Quality Review Board. Patients and residents may complain to a review board if they are dissatisfied with the response of a Patient Care Quality Office or if they do not receive a response within 30 days.

In November 2009, Bill 17, the Health Statutes (Residents’ Bill of Rights) Amendment Act, 2009 was given royal assent. For the first time in BC’s history, it established the rights of seniors and other adults in all residential care facilities in BC. The Residents’ Bill of Rights applies to all RCFs in which residential care services are provided, whether in extended care or private hospitals under the Hospital Act or RCFs that come under the CCALA.

The Residential Care Regulation (RCR) was passed on March 12, 2009 and came into force on October 1, 2009, repealing and replacing the Adult Care Regulations, as well as the residential aspects of the Child Care Licensing Regulation. The RCR establishes standards for physical requirements, including bedrooms, bathrooms, common areas, and work areas. The regulation also sets out requirements for admissions, the care provided, nutrition, medication management, the use of restraints and reportable incidents. The RCR includes a requirement for the licensee (RCF) to provide an opportunity for persons in their care, and their representatives and family members, to establish a resident and family council. The RCR also sets out records management requirements.
The new regulation requires that the dignity of persons in care be considered when determining care standards. In particular, the dignity of the individual is to be considered by operators (RCFs) when assessing the adequacy of privacy and of the furniture and equipment located in bedrooms and bathrooms. The regulation also specifies that staffing complements must be sufficient for individuals to receive care in a manner consistent with their dignity. However, measurable standards for “dignity” and "sufficient staffing" have not been specified.

Complementing the introduction of this new regulation, family members and residents can now make complaints to the newly established BC Patient Safety and Quality Council (BCPSQC). In an effort to improve transparency and accountability, reports from the Council are available to the public.

The development and implementation of the Patient Care Quality Review Boards, the CRC, the BCPSQC, and the Residents’ Bill of Rights place greater emphasis on ensuring that the quality of care provided and residents’ quality of life are monitored and measured. However, it should be noted that there is currently no reliable or objective process in place to monitor and evaluate the degree to which residents’ rights are respected. According to the study participants from the licensing division, such monitoring is done by residents’ family members:

Administrator [04]: …what we have noticed … there’s been a huge increase in complaints actually ... like 100 more investigations in a year. ...we believe that it has a lot to do with the Resident[s’] Bill of Rights and people being more educated about what their rights are and families and members of the public are more inclined to speak up now.

In addition to complying with these regulatory standards and processes, many RCFs voluntarily participate in a national accreditation process provided by Accreditation Canada, a not-for-profit, independent organization that provides health organizations with an external peer
review of the quality of their services based on established standards of excellence. These standards are developed, reviewed, and revised by Accreditation Canada and are based upon five elements of service excellence: clinical leadership, people, process, information, and performance. All three study facilities participated in this process and were accredited by Accreditation Canada. The accreditation process involves on-site surveys conducted by peer reviewers who are trained by Accreditation Canada. If the results of an accreditation survey indicate that the quality of service meets or exceeds the national standards, the accreditation process is repeated every three years. More frequent accreditation surveys indicate that a facility has areas in need of improvement. Because participation in the accreditation program is voluntary, it is independent of all governmental processes. Of note, there are no apparent links between the standards Accreditation Canada surveyors apply, the Residents’ Bill of Rights from the Health Statutes Amendment Act, and the Residential Care Regulation that govern licensing officers’ inspections.

**Measuring quality in residential care.** In reviewing the literature on the quality of care in RCFs, one finds that numerous definitions of the term “quality” exist. A particularly well-cited example comes from the US Institute of Medicine (IOM, 1990): “The degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge” (p. 5). However, it also has been noted that operationalizing “quality” from definitions such as this can be both problematic and challenging because they are extremely general and subjective (Castle & Ferguson, 2010). What, for example, is the "desired" health outcome and how are various types of health outcomes (i.e., physical, emotional, spiritual) operationalized and prioritized? Most researchers agree that the resulting measures cannot fully realize the quality concept (Castle & Ferguson, 2010). As a
result, quality indicators (a term used to describe a surrogate measure of quality), rather than quality measures (a term used to describe a measurement of actual quality), became prevalent in the relevant literature.

The most frequently used tool to measure quality of care in RCFs in North America is the Resident Assessment Instrument (RAI), of which the Minimum Data Set (MDS) is a major component (Rahman & Applebaum, 2009). In 2002, the BCMOH mandated the full implementation of the RAI-MDSv2.0 in every RCF in the province. The RAI-MDSv2.0 was developed by InterRAI, an international research consortium that develops comprehensive assessment tools that are principally intended for older adult populations. InterRAI has developed 12 RAI tools designed for use in rehabilitation, home care, long-term residential care and other settings across the healthcare continuum.

The RAI-MDSv2.0 is a standardized assessment tool that was developed specifically for individuals requiring long-term care in RCFs. It includes assessments at admission, on a quarterly basis, when significant changes in health status occur, and annually, for each resident. According to the literature, the RAI-MDSv2.0 was developed to improve individual care planning and the quality of care in RCFs (Morris et al., 1990). Additionally, it is said to provide a multidimensional view of residents' functional capacities, through which a profile of an RCF can be created.

The RAI consist of two primary components: the minimum data set (MDS) and the resident assessment protocols (RAPS). The MDS is a multidisciplinary summary assessment; consequently, the process of completing it should include specific input from the following multidisciplinary team members: nursing staff, dieticians, rehabilitation staff (e.g., physiotherapists, occupational therapists), social workers, and recreation managers or therapeutic
recreation specialists. Each of these multidisciplinary team members is typically required to fill out assessment sections of the MDS that are specific to their profession. In addition to providing a social, emotional, and recreational synopsis of a resident, the MDS includes measures of residents’ functional status and health conditions related to pain, cognition, activities of daily living (i.e., self performance), health instability, depression, and the level of care provided (e.g., resources used to provide the required care). These represent the sections of the MDS for which nursing staff members are responsible.

The process for implementing the RAI-MDSv2.0 begins with an admission background form (often referred to as a pre-admission report, pre-admission assessment, or initial admission assessment). This form must be completed prior to, or at the time of, a resident's initial admission to the RCF. It contains demographic information as well as the resident’s customary or preferred routines. This form is a simple two-page document and is a precursor to the nine-page full assessment.

The RCF has up to 14 days following a resident's admission date to complete the full assessment. The full assessment consists of over 300 items and encompasses the following information: cognitive patterns, communication, hearing and vision, mood/behaviour, psychosocial/well-being, physical functioning/structural problems, continence, disease diagnoses, health conditions, oral/nutritional status, oral/dental status, skin condition, activity pursuit patterns, medications, and special treatments and procedures. On the first day of this 14-day period, observation sheets are distributed to the resident care attendants (RCAs). These

7 The RAI-MDSv2.0 is copyrighted; consequently, a sample of this document could not be included as an appendix.
observation sheets enable the RCAs to provide information to the LPNs or RNs, which will be used to complete the portions of the resident's full assessment.

The observation sheets were developed specifically for the RAI-MDSv2.0. They are intended to capture information related to residents' activities of daily living (e.g., mobility, dressing, eating, toilet use, hygiene, bathing). The relevant information is entered with numeric codes (i.e., 0 = no assistance to 4 = total assistance), which indicate what the residents are able to do for themselves, and how much assistance is provided. The document also captures information related to residents': (a) cognitive patterns (e.g., evidence of altered perception or awareness or of disorganized speech), (b) mood (e.g., self-deprecation or withdrawal), (c) behavioural symptoms (e.g., socially inappropriate behaviour or disruptive behaviour), (d) bowel and bladder control (e.g., incontinent of bowel), (e) problem conditions (e.g., complains or shows evidence of pain), (f) nutritional status (e.g., chewing problems or mouth pain), and (g) activity pursuit patterns (e.g., involved in activities most of the time). These items are selected with check marks to indicate that a described behaviour was observed by the staff (see Appendix F).

Once the RCAs have completed the observation sheets, an RN or LPN enters the recorded information directly into the MDS, which is managed with a computerized software package developed for the RAI (e.g., PointClickCare®, an electronic health record for long-term care, or GoldCare, a healthcare information management software package for community, residential and long-term care organizations). Once the MDS is complete it 'triggers' the resident assessment protocols (RAPs)—the second key component of the RAI system. The RAPs are triggered by specific items that have been coded in the MDS. Because the MDS is considered a "minimum data set" these RAPs are intended to highlight to care providers those areas that may require more detailed assessment (e.g., pain, depression, aggressive behaviour, social isolation). Once
completed, the MDSv2.0 software generates a CAP (Critical Assessment Protocol) for each resident, which highlights what items need to be included in a resident's formal care plan. It is this latter care plan that licensing officers and Accreditation Canada surveyors use when evaluating an RCF’s adherence to standards of care.

Administrator [04]: The legislation requires that a care plan be developed at the time of admission. It may be a short-term care plan, but it should be revised, as needed, depending on the care needs of the individual. It has to be reflexive so when we go in— at the time of routine inspection or the time of investigation, or for whatever reason—we look at the RAI, and it has to be there and it has to relate—it has to speak to what is required under the legislation. So, we’re looking for certain aspects of that care plan to exist at all. Right, and if it doesn’t, then we cite them and ask them to rectify.

Once the admission full assessment has been completed and the subsequent care plan has been developed, the resident is placed on a fairly rigid schedule of quarterly and annual assessments. The quarterly assessment contains a subset of the MDS items (seven pages) and must be completed within 92 days following the last full or quarterly assessment. The annual full assessment must be completed within 366 days of the last full assessment. In addition to the scheduled annual and quarterly assessments, the RAI-MDSv2.0 contains a significant change in status full assessment, which must be completed by the fourteenth day following the determination that a significant change in the resident’s condition has occurred. Prior to each of these assessments being completed, the RCAs are again required to complete the 7- or 14-day observation sheets (see Appendix G). The information in these observation sheets is used to assist the RNs and LPNs in completing each of the assessments. In addition to the information found on the observation sheets, the RNs and LPNs are expected to review information from a variety of sources to complete the assessment; these include the progress notes, physicians’
orders, and the resident's medications. All of the RAI-MDSv2.0 assessments and care plans are stored in the resident's electronic health record (EHR).

In addition to assisting with care planning, the RAI-MDSv2.0 includes outcomes scales for specific areas of concern that staff may have with a resident or a group of residents (e.g., the assessment results of the depressive rating scale, pain scale, self-performance hierarchy scale, pressure ulcer risk scale, aggressive behaviour scale, index of social engagement). This information is used to develop outcome indicators for the facility (e.g., rates of falls, depression, behavioural symptoms, urinary tract infections, decubitus ulcers, or bowel and bladder incontinence), which can be used to measure the quality of the care provided. Since the implementation of the RAI-MDSv2.0, the licensing officers depend heavily on it for their inspections:

**Micro-Level Context: Regulations to Determine Who Lives and Works in RCFs in BC**

In addition to the multiple regulatory standards that govern care practices and processes there is a regulatory framework established in BC to govern who is admitted to live in RCFs and who is permitted to provide for their care.

**Who lives in RCFs—the complex care admission requirement.** Before 2002, the admission requirements for residential care in BC (previously called long-term care (LTC)), categorized residents’ care needs as Intermediate Care 1, 2, 3 (IC1, IC2, or IC3), or Extended Care. Residents were classified according to these categories based on how independent they were in their activities of daily living (i.e., dressing, bathing, and eating) and on how independent they were in ambulation or mobility. In 2002, the BCMOH claimed that many residents assessed at the IC1, IC2, and IC3 levels, and even some at higher levels of dependence, did not require 24-hour nursing supervision; thus, these residents did not need to live in residential care facilities.
This decision was brought to force through the implementation of the BC Residential Care Access Policy in which it was mandated that only those people that require “complex care” would be accommodated in RCFs. Accordingly, the BCMOH identified five groups of people considered to require “complex care”:

1. **Group A** includes people who have severe behavioural problems (e.g., destructive, aggressive, or violent behaviour) exhibited on a continuous basis.

2. **Group B** includes people who, because of cognitive impairment, require total care for their activities of daily living and a secure environment for their protection.

3. **Group C** includes people who meet the criteria in Group B and who exhibit socially inappropriate behaviour (e.g., spitting, disrobing in public, urinating, or defecating in inappropriate places).

4. **Group D** includes people who are cognitively well, are physically very frail, and require professional nursing care for extensive daily nursing interventions (e.g., ostomy care, decubitus ulcer care, oxygen therapy, enteral feeding).

5. **Group E** includes people who are frail and have multiple disabilities and medical problems (e.g., clients who require palliative care with complicated pain management or clients who require continuous professional monitoring because of a psychiatric condition).

Under the Residential Care Access Policy, people who do not have complex care needs must continue to receive care at home or in a supportive living environment. As a result of this policy, only individuals who are extremely cognitively or physically frail or are demonstrating excessively disturbing behaviour are assessed to be appropriate for admission to RCFs.
Consequently, the complexity and burden of residents’ care needs, and mortality rates, increased dramatically once the policy was implemented; yet funding rates, which are often the determining factor for staffing levels, staff education, and training requirements, and the nursing staff mix in RCFs, were not adjusted to accommodate this added complexity.

Furthermore, there are no clear guidelines for the government’s subsidy reimbursement rates to the RCFs and there seems to be a considerable discrepancy based on the ownership status of the facility. For example, in some regions, the owned and operated RCFs receive more funding to provide care to their residents compared with the affiliated or contracted RCFs. This discrepancy is based on the assumption that owned-and-operated RCFs would presumably care for residents with more complex needs; thus, historically the Government funded its owned and operated facilities at a higher funding rate. However, the implementation of the complex care admission requirement mandated that all RCFs care for residents with equally high complex care needs. Despite this new admission requirement, funding levels have not been made equitable between the owned-and-operated facilities and the affiliated facilities, as explained by an administrator from the Health Authority:

**Administrator [02]:** And that [differences in reimbursement rates] was done I think [pause] a few years ago strategically or purposefully you know, because [the Health Authority] could assume greater levels of care, and we could put more resources at it. So we tended to place people with the most complex care needs in owned and operated sites. ...But once everyone became complex care, we needed to increase the level of care [everywhere] because now everyone is getting the most complex clients. But we still haven’t closed the gap [differences in funding levels]. So I would say if there is any distinction, and it’s often pointed out, that the funding and care levels tend to be higher in the owned-and-operated sites.
This discrepancy may be one of the reasons that affiliated RCFs tend to have lower staffing levels than do owned and operated RCFs, as was the case in the study facilities. See Table 4.1 for a summary of the contextual factors of the three participating facilities.

Table 4.1: Contextual Factors of the Study RCFS

<table>
<thead>
<tr>
<th>Contextual Factor</th>
<th>Facility #1</th>
<th>Facility #2</th>
<th>Facility #3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ownership Status</td>
<td>Private For Profit (Contracted)</td>
<td>Private Not-for-Profit (Contracted)</td>
<td>Public Not-for-profit (All owned and operated)</td>
</tr>
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<td>Governing Regulation</td>
<td>Hospital Act</td>
<td>CCALA</td>
<td>Hospital Act</td>
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<td>Accredited with Accreditation Canada</td>
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<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Number of Residents</td>
<td>&lt; 135</td>
<td>&lt; 125</td>
<td>&lt; 150</td>
</tr>
<tr>
<td>Number of Private-Pay Residents</td>
<td>29</td>
<td>6</td>
<td>0</td>
</tr>
</tbody>
</table>

*These ratios are approximate because some units or neighbourhoods may have had different ratios within the facility.

Employees of residential care facilities: The nursing staff mix. Within RCFs, there are three general types of care staff employed: (a) registered nurses (RNs), who are regulated professionals who have completed a post-secondary diploma or baccalaureate degree in nursing (between two and four years of postsecondary education); (b) licensed practical nurses (LPNs), who are regulated professionals who have completed a diploma in nursing (ranging between one and two years of postsecondary education); and (c) RCAs, who are unregulated care staff who
have a certificate (ranging between three months and one year of training). Though there is variation among the Canadian provinces and among the facilities within each province, these formal caregivers usually work in teams (i.e., they are assigned to the same residents and unit (also referred to as a neighbourhood, floor, or wing) for a given shift or rotation). Most often LPNs are assigned as a team leader of these nursing teams, while being overseen by an RN.

In years past, the RNs were actively involved in the direct care provided to residents; however, their role has changed, and they now primarily complete managerial paperwork and have limited personal contact with residents (Anderson et al., 2005; McGregor et al., 2005; Rheaume, 2003). There is now an expectation that RNs will delegate significant portions of their past roles as direct care givers to other staff. In the three participating facilities, medication administration and quarterly and annual RAI-MDSv2.0 assessments were delegated to LPNs and almost all of the work related to residents’ personal care was delegated to RCAs. The disparity between the amount of time RNs and RCAs spend with residents in the provision of direct nursing care is evidence of the delegation of all "bed and body care" to unregulated staff (Foner, 1994). Within the study facilities, the average staff to resident ratios for the RNs ranged from 1:75 to 1:131.

In all three of the facilities, LPNs were the care team leaders and were overseen by an RN. In addition, LPNs were responsible for the administration of medications to residents, documentation of residents’ progress, completion of quarterly and annual MDS-RAIv2.0 assessments, attendance at care conferences, and provision of the start-of-shift report to the care team. This scope of practice for LPNs in RCFs is common throughout BC. These substantial changes to their responsibilities were a result of the Health Professions Council, Licensed Practical Nurses’ Scope of Practice Preliminary Report (Epstein, Kazanjian, & MacAulay,
This report proposed an expansion to the scope of practice for LPNs that would enable them to function in a broader capacity. Of interest, the regulation specifying the LPNs’ scope of practice was not introduced until 2012. In the ensuing years, LPNs were permitted to carry out nursing functions that were consistent with their education, and were not specifically described. This lack of specificity over the past decade caused considerable confusion for many employers and employees in the sector. Notwithstanding this opacity, all nursing services provided by an LPN have always been required, except in an emergency, to be carried out under the direction of a physician or under the supervision of a RN who is providing services to the client (Epstein et al., 2000). The average staff to resident ratios for the LPNs within this study ranged from 1:36 during the day to as high as 1:66 in the evening.

RCAs usually work within a team assigned to a specific group of residents during a shift. Their work shifts are usually divided in a 24-hour period into three 8-hour periods: days–0700 to 1500 hours, evenings–1500-2300 hours, and nights–2300-0700 hours. They provide direct care to the residents, assisting them with all activities of daily living (e.g., dressing, bathing, eating, toileting). The staffing ratios for RCAs in this study ranged from 1:6 to 1:8 during the day shift and increased incrementally to 1:12 during evenings and 1:27 on nights. Researchers have estimated that RCAs provide between 80 percent and 90 percent of care to residents in LTC settings (Pennington, Scott, & Magilvy, 2003). There are no regulations associated with the staffing ratios of RCAs to residents in RCFs in BC. Significantly, when asked what most influences the quality of care provided by RCAs, one administrator (who is responsible for ensuring compliance with regulatory standards) stated that there are not enough RCAs to do the work:

Administrator[04]: It’s the numbers of them, the numbers. I think that they are overworked; I think they are run off their feet. I don’t think they have the time to provide
that, you know, the emotional, taking care of the whole person. I just don’t think that can happen.

A traditional hierarchical model was present in each of the participating RCFs, which ensured that the staff members with the highest education, salary, and position remained furthest from direct contact with the residents. As a result, the care staff members with the least amount of contact with residents had the most control in determining their care. Conversely, similar to other researchers, I found that the RCAs, who provided the majority of care for the residents, received the least amount of training, the lowest pay in health care, and were rarely consulted when decisions were being made about the care to be provided (Blair & Glaister, 2005; Kane, 1994; Stone, 2001; Stone & Yamada, 1998).

**Summary and Reflections**

The regulatory framework that governs RCFs in British Columbia is extensive and complex. Historically, regulations governing RCFs have been based on the medical model, which encourages quality of care to be measured based on timely completion of tasks, consistent adherence to routines, and achievement of objective medical outcomes. Current regulations require that the dignity of persons in care be considered when determining care standards. However, the regulations fall short of specifying measurable standards that would help to ensure staffing is sufficient for residents to "receive care in a manner consistent with their dignity." Thus, a conspicuously absent regulation is one that governs the amount of staffing required to successfully accomplish the standards of practice laid out in these regulations.

This overview of the regulatory framework led me to ponder the possibility that the primary response to a perceived need for improved care practices in RCFs is the creation of more regulations. The depth and breadth of these regulations seem to directly or indirectly influence the quality of work-life and quality of care in the institutions. It is for this reason that I focussed
on the regulatory framework found in BC when describing the context of living or working in RCFs. This chapter provides the reader with a contextual foundation from which the everyday, embodied work experiences of RCAs can be more fully understood.
Chapter 5: The Influence of Everyday Texts on the Provision of Person-Centred Care: Exploring the Embodied Work Experience of RCAs

A central tenet of person-centred care is that it is provided with respect and deference to the care recipient’s unique needs, preferences, and life history (Fazio, 2008). Accordingly, the provision of this care is largely dependent upon caregivers’ access to individualized information about the person to whom they are providing care. With this in mind, I began my data collection with the aim of mapping the work of resident care attendants (RCAs) over a 24-hour period to determine how institutional processes enable or impede the everyday, every-shift exchange of information related to residents' care needs. My initial focus was on what I referred to as “everyday texts”—those texts that are found in the everyday practice of RCAs. I was interested in identifying: (a) the information RCAs regularly access regarding residents’ care needs, histories, and preferences; (b) where such information is stored; (c) how it is accessed; (d) how RCAs share such information; and (e) with whom they share it. This chapter describes the embodied work experience of the RCAs with a specific emphasis on the exchange of information that occurs during three phases of a work shift: at the beginning of the shift (i.e., before the provision of care commences), during the shift (i.e., while care is provided), and at the end of the shift (i.e., after the provision of care).

Beginning the Work Shift: Three Reports—So Much to Learn, So Little Time

Upon arriving at the facility for the start of their work shift, the RCAs’ first task was to receive information about what occurred during the previous two 8-hour shifts. This information was gathered, stored, and shared in two formats—through oral and written reports. Oral reports (referred to as “start-of-shift reports”) are group meetings held with the RCAs so that they can receive information from the team leader (typically a licensed practical nurse (LPN) or registered
nurse (RN). The information deemed pertinent by a team leader is provided orally; it typically addresses the residents' status over the previous 24 hours and specific details regarding their care needs for the approaching shift (e.g., bowel care, appointments, preparations for laboratory testing, such as blood collection).

Written reports included the following: (a) 24-hour observation sheets—sheets used by and for the RCAs to share residents’ care information, (b) communication books—notebooks that enabled the RCAs working different shifts to communicate, in writing, with one another, and (c) bath and bowel lists—lists that detailed the residents’ care requirements regarding bathing and bowel care for the upcoming shift.

Facilities #1 and #3 both held start-of-shift report meetings at the beginning of the RCAs’ shifts and also used communication books. In Facility #2, the start-of-shift report provided by team leaders to the RCAs had been stopped. None of the participants was able to explain why or when this had occurred. This facility exclusively relied on 24-hour observation sheets and a staff-to-staff communication book as the means by which the RCAs shared and received information with each other. All three facilities used bath and bowel lists. In addition to these communication formats, the RCAs of all three RCFs used “unofficial oral reports” to receive and share information, as described below.

**Unofficial Oral Reports**

In almost all residential care facilities (RCFs), RCAs’ work shifts formally begin with a start-of-shift report from a team leader (most often an LPN). In the facilities that I observed, many of the RCAs arrived before they were scheduled to commence work to receive an additional, unofficial oral report from the RCAs who were completing a shift and who had worked directly with the residents to whom they were assigned. Thus, they were able to receive
more details about what had occurred during the previous shift than what was shared during the start-of-shift report. This practice was described aptly by an RCA who consistently arrived for work 30 minutes early:

**RCA [03]:** When I read something on a piece of paper, it’s just quick and trying to be to the point, but the little stuff is missed, like how she [the resident] said, “Ouch” when you turned her. ...and when I go to get her up, there could be a sore there or something like that. Or so-and-so’s legs were between the rails. Well, that’s not always written [on report] and then you go and look at her legs and they’re covered in bruises because it was just how she was turned and then she tried to turn at the same time and it just…. So, I like to know myself what’s going on in my section and who I’m dealing with that day.

**Researcher:** And you find that when you get the additional information that it really does add…

**RCA [03]:** Yeah, the actual hands-on stuff, not just what the RN or the LPN writes that they’re told…and half the time they forget because they’ve got umpteenth pills and turns and changes. And it just…gets lost in the mix.

Several of the RCAs mentioned the need to arrive early to receive an unofficial report because significant events, such as a patient’s fall, had been missed in the start-of-shift report. This was expressed by an RCA when I asked why she started early:

**RCA [02]:** I wanna know how their day has gone, has…. That’s my first question, “Has anybody had a fall?” …because there’s been occasions we’ve come in and didn’t know…and gone, “It didn’t say anything in report, why is so and so in bed? Oh my god, she’s had a fall? She’s got a…how come nobody told us?”

Twice during my observations, information about a resident having fallen was not shared during a start-of-shift report; the distress and frustration this caused the RCAs was profound. It is easy to be critical of a team leader who misses something as important as a fall when giving a report. However, the LPNs, who typically serve as team leaders, reported that they too arrived to
work early to ensure that they had adequate time to gather the information required to give a comprehensive start-of-shift report. The multitude of sources that contained the information the LPNs were required to review before giving a start-of-shift report was explained by a study participant:

**Team Leader [01]:** I would come in in the morning and I would, of course, read the safety communication board…that indicates anybody who’s in infection control or care risk behaviours. Then I read the report from the evening before. If there is any incidences on the evening, then I would read what happened to the individual, the staff, and resident. Then I read the night shift report to see if anybody was awake. Then you plan. Then you look at the 24-hour date book that’s on each side of the nurses’ station and list out: “Oh, so and so has an appointment today at two o’clock.” “I’m going to be calling the doctor regarding this particular individual because his ears need to be looked at and syringed.” “Oh, by the way, can you leave this person in bed because the lab is coming to do blood work?” …any kind of thing like that. And bowels… “OK, make sure that they [the RCAs] are aware of who needs bowel work—that's very important.”

In addition to being able to read multiple sources of information, every interviewed LPN described the importance of arriving early to receive an oral report from the team leader who worked the previous shift. They did this to "fill in the blanks" and to know what they believed to be essential, additional details regarding critical incidents or residents’ well-being. The gathering of this information took time and, similar to the RCAs, the institutional processes in the RCFs required that it be done on the LPNs’ own time. One team leader explained what would happen if she did not come in early:

**Team Leader [2]:** …I wouldn’t have time to research what happened the evening before, or the night before because I give report right at seven o’clock to the care aides. So then I’ve got to start because I’ve got 27 people to give meds [medications] to. …if I don’t start early I’m going to be running behind for the rest of the day.
The majority of the interviewed RNs, LPNs, and RCAs believed that it was essential to arrive on the unit before their shifts officially began so that they could receive an unofficial oral report from the individuals who worked with their assigned residents on the previous shift. In all three facilities, there was no time formally allotted for the exchange of this information. It was done on unpaid time because it was deemed a necessary requirement for the successful and safe conduct of their work. One RN explained that this practice is considered an unwritten expectation of the job:

Manager [11]: It’s a bit of a frustration, but it is a professional expectation that as a courtesy to the person that you’re relieving you arrive with enough time that they don’t have to stay after their time to give you a report, so that’s just good manners, and professionalism, it’s also sort of an unwritten expectation of management as well.

It is worth noting that not everyone came in early to exchange information. If an RCA or LPN was a casual employee who had been scheduled to work immediately prior to the start of a shift (i.e., the casual staff member did not receive the call to work the shift until an hour before the shift began), then the oral exchange of information with staff from the previous shift would typically not occur. Similarly, staff members that demonstrated behaviour often associated with burnout (e.g., being verbally critical of management practices or taking longer rest breaks) did not arrive early to work. Rather, they expressed a determination not to give more to the institution than what was absolutely required. Similarly, the RCAs who worked at more than one facility and who scrambled to get from one facility to another to start a second work shift, what

8 Burnout is a term used to describe a phenomenon observed in employees who suffer from long-term exhaustion and dimensions to the phenomenon: emotional exhaustion, cynicism, and inefficacy. Other researchers have argued that exhaustion is the cardinal feature (Kristensen, Borritz, Villadsen, & Christensen, 2005).
is called "a double" (i.e., back-to-back 8-hour shifts), simply were not able to start early.

Working for more than one facility, to "make ends meet," was common among the RCAs interviewed. Approximately 40% of the RCAs who participated in this study held a second job. Consequently, these RCAs were rarely able to receive this unofficial oral report.

In all three facilities, the institutional process in place did not enable the staff to overlap during the change of shift. Thus, not arriving ahead of when one’s shift officially was to commence resulted in staff members not being able to receive information that had been described as "essential" by the study participants.

**Oral Report**

After receiving their “unofficial” report, the RCAs from Facilities #1 and #3 gathered in a designated area for the team leaders to provide a start-of-shift report. In Facility #1, the average length of the report for the day and evening shifts was less than 10 minutes and provided information for approximately 85 residents. In Facility #3, the report for the day shift was 15 to 20 minutes in length and provided information for approximately 75 residents. The evening shift report was shorter in duration, but was specific to the 12 residents for whom each team was responsible. In both of these facilities, the duration of the night shift report varied significantly and seemed to depend on the leadership style and focus of the team leader. However, the average time spent on the night shift reports was approximately 15 to 20 minutes.

After having completed a few observation periods in these facilities, I began to understand why the day-shift report meetings were so brief. This was explained by an RCA:

**RCA [01]:** By the time you get to your cart and, you know, it’s 7:15 [AM] if you’re lucky, and then you’ve got to make sure you’ve got your adequate supplies that you need and whatnot, and check your bath. And then you’re really probably not starting care until at least 20 after, if you’re lucky—20 after 7 [AM]. So, then you’ve got an hour and ten
minutes to get six people…at least six people washed! And that's only if you’ve got two people that are staying in bed or whatever. So, six people to get up and washed and hopefully get their teeth brushed and all that sort of stuff.

During the day shift, the RCAs had, on average, 15 minutes to provide morning care for each resident, which may have consisted of toileting or changing briefs (i.e., adult diapers), washing faces, hands, groins, and axillae, shaving, tooth brushing, dressing, and hair brushing. When the RCAs were assigned to care for eight residents, the workload dictated that at least two residents would remain in bed for their breakfast and forgo their full morning care until after they had eaten. Thus, it was because every minute counted that the RCAs anxiously watched the clock during the start-of-shift report. There was a tension between needing to hear the information provided during the day-shift report and needing to begin morning care:

**RCA [07]:** Everybody’s sort of there at 6:45 [AM] getting their carts ready. …she [team leader] gives that report and we could be there 5, 10 after 7:00. …by this time everybody’s kind of going, “We’ve gotta get going! We’ve got to get that breakfast!”

Even though there was a pressure to complete the start-of-shift report quickly, many of the RCAs described the importance of receiving report for more residents than those they were about to care for:

**RCA [05]:** It’s always nice to sort of keep an ear out for the other sections on either side of you [because] I have to cover that area when my partners are on their break. …If I can hear that something is going on or going to come up, like if I know that one of my partners’ residents has been given bowel care in the morning and that’s why they’re fussing and on the bell so much, then I know: get over there, get them to the bathroom.

On average, less than one third of the residents were mentioned in a start-of-shift report. Given the extreme time limitation placed on this meeting, only information that was considered essential by the team leader was shared. This usually consisted of details pertaining to
appointments, infections, skin integrity, falls, sleeping patterns, bowel routines, and incidents of aggressive or agitated behaviour.

Although the start-of-shift report was one of the primary opportunities in which the RCAs would formally learn about a resident’s aggression, the information shared was usually limited. Typically, it was reported that "an aggressive incident occurred" and whether medication was given in response. The reports I heard did not contain a description of the actual behaviour (e.g., hitting, biting, kicking, scratching, or pinching), triggers for the behaviour, or any indication of a plan of care in response to the behaviour. The need for more information was expressed by a participant:

**RCA [04]:** If there’s a combative situation say, and they [the team leaders] will be like, “Oh, an incident happened with so-and-so yesterday. We gave him some, some kind of medication…he’s now lying in bed, calm.” …I [need] more details, like: What took place? What kind of medication he’s on, so I know how to…so that I'm not putting myself in danger, and maybe the resident.

During the day-shift oral reports, the RCAs rarely had time to share their perceptions or concerns regarding the residents. Because the evening and night shifts tended to begin relatively less rushed, the opportunity for two-way communication arose more frequently. The benefit of this was expressed by an RCA:

**RCA [01]:** I know in the evening shift they have a little bit more time to sit down and discuss through every single resident and go, “OK, how’s this person been, how's that working?” Ours [day shift report] is kind of like, spit out what there is and go…because we just don’t have the time…

**Researcher:** For you to actually take that time to share information?

**RCA [01]:** Exactly, exactly, which is nice. I know there’s one nurse on evening shift and she sits down and she takes a good…15 minutes [for report] to go through every single
resident and say, “OK, well, this person, they’ve been doing…” She gives her share. And then she asks for what we want or what we need to share, whatever, with them, about that, those residents. …so we’re able to share or put in ideas for their care and stuff, which is nice because you have the time in the evenings to do that, at that time. But we don’t [on day shift].

I was particularly interested in speaking with this nurse who consistently took time to give and receive information during the reports that she led. During my interview with her, she explained why she always took the time to ensure that there was two-way dialogue between herself and the RCAs during report:

**Team Leader [05]:** We sit and we discuss issues. Like, I’ll say, “This resident had a fall. How can we prevent what’s going on? Do we have to put a commode at their bedside?” …There might be several issues that are going on with different residents. And I try to answer all their [the RCAs’] questions. Because, in order for the RCAs to do their job, I need to give them information because that’s the only way we can be one team. And I need them to know what I know so I can depend on them. So they can give me the information back [that I need] so I can take care of the residents.

The majority of team leaders and RNs, however, did not take the time to engage in a two-way dialogue with the RCAs during their shift report meetings. In fact, during some night shifts (when the team leaders had the least amount of pressure on their time), some team leaders did not have report meetings and instead gave a written report sheet to the RCAs to read on their own. Thus, the quality and amount of information flow during report was influenced by both the leadership style of the team leader and by organizational constraints—namely time. In summary, because of the time pressures and leadership styles, the information shared in the start-of-shift reports was typically limited to the most basic information related to residents’ care needs and concerns. In addition, the information most often flowed in one direction—from the team leaders
to the RCAs. It appeared to be especially problematic that these time constraints were present, and little information was communicated, when a new resident was admitted.

**A new admission: Two sides to the coin.** The start-of-shift report was the means by which the RCAs first received information about newly admitted residents. After many days of observation (about my seventh observation period), I noticed that some of the RCAs seemed to take a deep breath as they awaited the announcement of the room number of a new resident. It was then that I first understood that the RCAs were not only being told that a new resident had been admitted, they also were being informed that a resident had died. They indirectly learned which resident had died by the room number of the new admission. Once I became aware of what was occurring, I began to observe the RCAs more closely when they were being informed of a new admission. Upon hearing the unspoken news that a resident had died, one RCA glanced quickly toward a co-worker, whom she knew would understand what she felt. It was a quick, yet poignant exchange followed by the whispered words, "[Anabelle] died?" Her co-worker nodded silently. This RCA then looked down, closed her eyes, and took several deep breaths. She seemed to be silently processing this news. After several breaths, she looked up again and tried to focus on the remainder of the report. She looked as though she was forcing herself to control her emotions because in less than five minutes she would need to be “out on the floor,” getting her residents up and ready for the day:

**RCA [01]:** I get attached to residents and people, but you learn not to get too attached. You know, these people are coming here, essentially, to die. And it’s like…you’re upset too. But you can’t let yourself get upset, almost. Because this is our job, this is what we’re here to do…

One RCA discussed the conflict that many felt with respect to allowing relationships to form between themselves and the residents:
RCA [16]: Patients will steal your heart, patients will make you cry. I’ve seen a male RCA cry when a patient died. …they become your family, they really do. And sure that’s bad, in aspects, but it’s great. When you come to work and you’re working with a [resident who feels like] family.

Researcher: How do you think it’s bad?

RCA [16]: I think because it’s not really encouraged to have these relationships, almost. So, if you do get emotional when they die, people are like, “You knew. You knew it was going to happen. So, why are you upset?”

This finding is significant because the creation of positive relationships between the caregiver and the care recipient is considered essential to the provision of person-centred care (Bowers, Esmond, & Jacobson, 2000). Moreover, RCAs deem the quality of the relationships formed between themselves and the residents to be the central determinant of both quality of life and quality of care (Bowers, Esmond, & Jacobson, 2000; Deutschman, 2001; McGilton, 2002; Schirm, Albanese, & Garland, 1999; Wagner & Colling, 1993) and the residents concur that this relationship is central to their perceived quality of care (Grau, Chandler, & Saunders, 1995). Yet the system only acknowledges this relationship when the resident is alive; once they have died, it seems to disregard the existence of these relationships by forcing the RCAs to manage profound emotion in the context of this brief and targeted report and provides them with little if any support for their grief. In this way, the organizational system may be inadvertently deterring the formation of these relationships. This was explained by one RCA:

RCA [05]: In my first few years here, I had three ladies die on me. And I cried and I cried and I cried. It was horrible, the most horrible thing. And you, you learn to shut that off. It’s not that you don’t care. But you just don’t let [the residents] come in all the way.
Once the RCAs have quietly processed the news that a resident has died they must turn their attention to the information about the new resident. In the majority of reports that I observed, the extent of this information was limited to the resident's name, the room number, and a very brief description of the type of assistance the resident needed related to toileting, transferring, and eating. In two reports, the information was further limited to the statement, "A head-to-toe assessment has been completed" with no additional description of the type of assistance needed and the implications for the resident’s care. The one exception to this pattern was an evening report, during which a description of the resident's social history was provided and the RCAs were able to ask additional questions about the resident's care needs.

**We're working short.** The start-of-shift report was also when the RCAs were usually informed about whether they were going to have to “work short” during all or part of their shift. Working short is the term used when a scheduled RCA is absent from work and has not been replaced with a casual employee or a permanent RCA working overtime. When this occurs, the RCAs are assigned "pickups," which is communicated during the start-of-shift report. Pickups are residents that are added to the list of residents for whom they are responsible to provide care. One team leader informed me that enquiring about whether they were required to work short was always the first question she received from RCAs:

**Team Leader [04]:** "Are we going to be short today?" That’s the first question I get every morning. “Are we short today?” The looks on their [the RCAs’] faces…it's awful.

Without exception, the RCAs passionately described the negative consequences of working short:

**RCA [11]:** The residents suffer so much when we work short. …I was in tears a month ago, and I’m pretty good at handling my stress levels. And it wasn’t any one person. It was the fact that I didn’t have another person there. And I just went to the nurse, I was
like, “I’m gonna pull my hair out. I’m starting to cry.” I’m like, “I can’t go back in that room and tell that old woman I don’t have time to do what I have to do…” …You get a little overwhelmed sometimes, especially when you don’t want to cut corners and you wanna…it’s hard, really hard. Because they’re not machines, they’re people. …They really suffer when we work short. It’s brutal. Because you don’t have as much patience, you don’t have as much time. You’re running and rushing and frustrated, and it’s not good. We’re all used to it, I guess. We have a whole procedure on how to work short. Literally, it’s like a plan. But it ain’t pretty.

The majority of LPNs and RNs also expressed concern regarding the negative consequences of the RCAs working short, for example:

**Researcher:** What really frustrates you?

**Team Leader [06]:** Being short staffed all the time because you know they [the RCAs] work so hard out there and when they’re short every day and you have to tell them, "I’m going to give you an extra person to look after today"–it’s awful. It’s really awful because it’s a backbreaking job. It’s physically so demanding and you know they’re going home and they’re not able to do anything at home because they’re so worn out. I know how tired they are and they’re–everyone’s impatient and maybe snapping at the residents when it’s not their [the resident's] fault too–and I find that extremely frustrating.

Residents and family members also spoke at length about the impact that working short had on the provision of care provided by RCAs. For example:

**Resident [02]:** Well, when they’re short-staffed, it’s a…everybody is like in a chaotic position. They’re running all over the place. And all you hear is, "Now we can’t do this" and "We can’t do that because we don’t have the manpower you know."

**Researcher:** Yeah. How often would you say that happens?

**Resident [02]:** Oh, on a fairly regular basis.
The RCAs were working short during 30% of my observation periods. Statistics related to the occurrence of staffing shortages are not easy to access; however, an administrator from the Health Authority confirmed that this percentage is similar to what they experience in several RCFs within the Health Authority.

**Written Report**

Written reports accessed by RCAs at the beginning of their shifts included the 24-hour observation sheets, communication books, and the bath and bowel lists.

**24-hour observation sheets.** Facility #2 did not hold start-of-shift reports and instead relied on 24-hour observation sheets. The 24-hour observation sheets contained a 1-inch by 2-inch square of paper for each resident, each shift, within which the RCAs from each shift were required to record their observations regarding all aspects of the resident’s care needs. I asked an RCA what she looked for on the 24-hour observation sheet:

**RCA [12]:** …if anyone needs bowel care. Who I need to bath. If anyone had a fall…that I need to be looking for bruising on different areas or any kind of limping or pain of any kind. How they slept. If they didn’t sleep well, I’m not going to wake them at any time, or if they’re still awake, maybe I should…try laying them back down for a few hours.

This facility had an exceptionally large number of residents who had advanced-stage dementia; consequently, the majority of the residents could not share with the staff how their evening, day, or night had gone. It is because of this that the quality of documentation needed to be especially good. However, I found that the 24-hour observation sheets were often sparsely filled out. One RCA explained why:

**RCA [13]:** …it normally depends on who’s working. [Name of RCA] is really good, but other people, you have no idea. And especially if there was casuals [RCAs who do not hold permanent positions], a lot of the time there’s nothing written. Because they’re only
there for a day… So, who cares? …and then they’re out… but that [the 24-hour sheets] is the only place that we ever find anything out.

Due to the limitations set out by the design of the 24-hour observation sheets, when an RCA wanted to record more detailed information, she was unable to do so:

**RCA [02]:** …it’s a one-inch little box, and you can’t fit everything in there. If it was big enough… There’s quite a few things we’re probably missing on a daily basis because you might want to write more, or somebody else might want to write more. There’s no room.

Given the limited space available for written information and the inconsistency within which it was provided, I asked an RCA about how confident she was in the information in the document:

**RCA [12]:** I feel confident that what’s in there is true, but I don’t feel confident that it’s all in there. I think that lots of stuff is getting missed because RNs or LPNs would say, “This happened to so and so last night.” And I’m like, “Well I don’t have that here in my written 24-hour [observation sheet].” And they go, “No, no, it’s on the computer.”

I found that the LPNs and RNs of this particular facility did not document in the 24-hour observation sheets; rather, they documented the residents’ status in the computerized progress notes associated with the computerized Resident Assessment Instrument- Minimum Data Set (RAI-MDSv2.0) in the residents' electronic health records. Similar to the other two facilities, the RCAs did not have access to these progress notes because they did not have access to the residents’ computerized records. I did not witness an LPN or an RN referring to or writing in the 24-hour sheets during any of my observation periods. The LPNs informed me that they simply did not have time to add to the 24-hour observation sheets, and they viewed these sheets as primarily for the RCAs to share information. When asked whether they ever referred to these
documents for information, I was informed that if they did review them, it was primarily to check for items related to the residents' bowel care:

**Team Leader [01]:** If they [residents] have a lot of bowel care issues and stuff, they [RCAs] will leave the 24-hour book sitting on the counter and I glance at it.

The RCAs and LPNs in this facility were using separate institutional texts upon which to communicate residents’ care needs and were not accessing the others' documentation. As a result, the probability of information not being shared between the LPNs and the RCAs was extremely high in this facility, and occurred frequently as one family member described:

**Family Member [12]:** There’s not a formalized process of a nursing [start-of-shift] report and there needs to be! It should include all of the workers at set times! …because it’s so disjointed, and I talk to so many family members, I talk to so many staff, of all levels. And it’s so clear that communication here sucks.

It is perhaps because of this that many of the RCAs expressed the need to share information orally as well as to document in the 24-hour sheets. For example:

**RCA [12]:** I write everything in the 24-hour [observation sheet]. But anything that I really want to make sure that the next shift gets, or if a person needs to know it, I go and tell them.

**Communication books.** The communication books were notebooks used to enable staff working different shifts to share information with one another. In Facility #1, there was one communication book for the entire facility. In Facilities #2 and #3, there were communication books on each unit. One RCA described the purpose of this book:

**RCA [14]:** In terms of healthcare worker [RCA] to healthcare worker, that’s probably the most crucial because we can write, we can explain, we have more than just a little two-by-two box to write down important things….That’s where we write down a lot of communications from the family, like when the family comes down we’ll say…“Mrs.
X’s mother was in and wants her to have a tub bath.”...We can engage in conversation with that, because we don’t overlap with [the RCAs from other shifts] very often. We just have a couple of minutes at the end of the shift to say the important things, but we don’t get into the little nuances like that.

In all three facilities I observed an inconsistent use of the communication book by the RCAs. A few RCAs were observed to begin their shift reading this book. The majority read it only if they "found time" during their shift and many indicated that they "never" read it. Even though this communication book was viewed as important by several of the RCAs, the majority of the study participants noted its limitations. For example, the RCAs who worked in Facility #3 shared stories about the written communication in this book being misinterpreted and causing strife between the three shifts. Instead of it producing better communication and collaboration, there seemed to be a general consensus that it could also produce division among the staff. For example, it was so divisive on one unit in Facility #2 that the book had to be removed entirely. Consequently, since this facility did not have a start-of-shift report, that particular unit was left with the 1-inch by 2-inch boxes and the 24-hour observation sheets within which the care staff could share information about their residents’ care requirements and health status.

**The lists: Baths and bowel care.** Once the report was completed (either orally or by reading the 24-hour observation sheets and the communication books), the RCAs from all three facilities checked two very important lists: the bath list and the bowel list. The residents had weekly baths, which were scheduled on a permanently assigned bath list. Making alterations to the bath list was complicated and could produce a great deal of tension and strife in a facility because the timing of a resident’s bath was often coordinated with the hair dresser, the appointment book (e.g., doctor's visits), recreation programming, rehabilitation staff (e.g., physiotherapy and occupational therapy), and housekeeping (so that the bed could be cleaned).
The other list that all RCAs checked was the bowel list, which was a listing of which residents required bowel care and a description of the type of care required. The RCAs would often double-check this list, regardless of whether it was mentioned in a report. The type of bowel care provided for a resident was dependent upon the RCF’s bowel protocol, and typically became more invasive the longer the resident had gone without a bowel movement. Without exception, the RCAs talked about the importance of the bowel list being accurate and also talked about how this list predetermined much of how they planned their shift. In particular, the bowel list needed to be coordinated with the bath list and the residents’ appointments for the day. Many of the RCAs talked about learning the hard way how important it was to ensure that bowel care produced successful results before the resident was placed into a bathtub or taken out for an outing or appointment. Thus, once they had checked these two lists, they were ready to begin the work of providing care to the residents.

**During the Shift: Resources, Residents’ Care, Risk, Personal Competence and Resilience**

During their shift, the RCAs had access to information from two primary sources: (a) the written information found on "everyday" texts—ADL care plans, tips for care sheets, and care risk symbols and (b) the oral information they received from other RCAs who worked alongside them. In addition to these information sources, they turned to their personal knowledge, skills, and experience to guide their daily care routines. Finally, during their shifts, they turned to each other for support so as to remain resilient in the face of the work-place adversities they commonly faced.

The RCAs began their work with a quick check into the rooms and hallways to see if the residents were all where they should be. As soon as they had accounted for their residents, the
RCAs began stocking their carts with the supplies needed to provide care (e.g., linen, washcloths, towels, briefs, nightgowns). Inadequate linen supplies were a common concern:

**RCA [11]:** We’re always really short on linens. So, part of that first half an hour of my shift is kind of going between the floors and we ration out the linen. We’re like, “Oh, we don’t have enough blue cloths.” ...And sometimes we have to really count them and make sure [everyone will have enough]...because we’re always a little bit short.

A differentiating factor between those work teams that were supportive and cohesive with one another and those that were not was how they managed scarce resources such as linens. When the teams were supportive and cohesive, they rationed the supplies (as described in the above quotation) and ensured that everyone had an equitable amount. Conversely, when the team members did not engage in reciprocating behaviour, the RCAs horded supplies (e.g., they arrived early to work, gathered supplies, and hid them).

Once they had gathered their supplies, they began their routines of providing care to the residents. They unanimously agreed that they had to follow a fairly rigid care routine to accomplish all that they had to do within the allotted time:

**RCA [14]:** We’re so time constrained that we’ve become very routine-based. We come on, we know that we’re going to be toileting this and this person. We’re going to be doing a bath for this person. And, if we don’t get started on that right away then we’re an hour behind. ...If we don’t follow a routine, we’re gonna have to put 10 people in bed at 8 o’clock, and how is that possible?

The RCAs' assertion that they must be routine-based because of time constraints had implications for the residents. For example:

**Resident [02]:** OK. I wake up about quarter after 8, I need help with being toileted and being dressed because I am left-side paralyzed.

**Researcher:** Right. And were you the one that picked to get up at a quarter after 8?
**Resident [02]**: No. No, that’s where they fit me in in the morning.

**Researcher**: How does that work for you?

**Resident [02]**: Well, sometimes it’s good and sometimes it’s a little late, and...

**Researcher**: Ah, yeah, because you’re having to wait…

**Resident [02]**: I sort of hold my bladder…a lot.

I found three "everyday" texts that the RCAs were supposed to refer to when they developed and implemented their care routines for the residents during their work shift. These included: (a) the activities of daily living (ADL) care plans, (b) the tips for care sheets, and (c) the care risk symbols.

**The activities of daily living (ADL) care plan.** All three RCFs had ADL care plans posted somewhere in the residents' rooms. The ADL care plans contained the following categories of information relevant to the residents’ care: hearing, dressing, bath day, oral care, diet, vision, toileting and padding, ambulation, rest times, care risk, bed time, allergies, transfer assistance, and special needs. The information was specific to the residents’ particular needs, but was limited to a description that was one to five words in length. For example, the heading “Vision” would have words such as “wears glasses.” “Dressing” had words such as “total care” and “Diet” had words such as “pureed—total assist.” The one area in the document that may have had more than five words recorded was under the heading “Special needs.” I noted the following examples of information recorded in this section: "Please put glasses on at all time when up in wheelchair," "Ensure foot rests are on and feet are elevated at all times when in wheelchair," and "heel pads must be worn when in bed." Taken together, this information formed what healthcare workers refer to as an individual's “activities of daily living” (ADLs).
The information found on the ADL care plan was drawn from an initial assessment conducted upon a resident's admission to a facility. In two of the study facilities, these ADL care plans were initially completed by an RN who was responsible for the initial RAI-MDSv2.0 of the resident. The one exception to this practice was observed in Facility #1, where the RCAs had been trained to participate in the admission process. In this facility, the RCAs were responsible for completing the ADL care plans alongside the RNs:

**RCA [17]:** We needed more information than what we were getting from the RN assessment. Right? As care aides, we know the questions we need answered. And we know what information we need. And that’s why we started this. Because we didn’t always have a care aide involved in the admission. It was all…they’d just say, “Oh, [Jean], this is Mr. Smith, he’s your resident today.” And then they would give us a five-minute spiel about what they thought we really needed to know. Right? So, we created our admissions committee so that the care aides who are working with the residents get the information from the start.

In all three facilities, the RCAs described the importance of the ADL care plans, especially when a resident was newly admitted or when a “casual” RCA was working:

**RCA [15]:** If it was a brand new resident, [then] that would be the first thing I did. I would go in there, I’d read the care plan from top to bottom. Like, if it was someone I didn’t know.

Although the three participating RCFs had ADL care plans posted in the residents' rooms, it is noteworthy that because of the *Personal Information Protection Act* (PIPA) and the *Freedom of Information and Protection of Privacy Act* (FIPPA) (which focus on the individual’s right to protect his or her personal information), Facilities #1 and #3 may be required to remove them because not all of their residents reside in single occupancy rooms. This has been the case
in many RCFs in BC. The outcomes of having the ADL care plans removed were described by one RCA:

**RCA [16]**: I’ve worked in nursing homes that don’t have them. …You walk in, you don’t know if they [the resident] is a two-person lift, you don’t know if you’re using a maxi-lift or if they can walk on their own. You don’t know their names sometimes, without that care plan. There’s…sometimes there’s not enough information [on the ADL care plans], but there’s enough information to get you through.

While exploring this issue, I asked some residents and family members how they felt about having the ADL care plans up in a place where anyone could read them. They all responded that they felt the benefits of having these documents up and easily accessible significantly outweighed any negative consequences associated with a loss of privacy. For example:

**Resident [01]**: I’m totally fine with having it up there. It’s an easy read for every new person that comes in—“OK, this is what she needs, and this is what her routine is, and this is where she needs help…”

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**Family Member [09]**: We’re human beings. We should be open with our needs. It’s not something to be either ashamed of or to hide from other people–you want people to know what’s wrong with you so they know how to take care of you. Being concerned about privacy or something like that, I don’t think it matters a darn.

According to a person who was responsible for overseeing compliance with the privacy legislation, informed consent was all that was required for RCFs to post the ADL care plans in residents’ rooms. Every family member and resident I interviewed indicated that, if asked, they would consent to having the ADL care plan posted. Why then did so many RCFs remove the ADL care plans from their facilities?
In response to the privacy legislation (and in an attempt to not have to remove the ADL care plans entirely), Facility #3 reduced the amount of information found on them. The resulting outcomes of this were discussed by a family member:

**Family Member [04]:** We can always tell when there’s a new [RCA] because they don’t know which person has thickened drinks. They don’t know what kind of a meal they’re on… and if they’re in a rush, and they’re flying around giving all the wrong meals to people, some people have no milk in their diet, they’re giving them glasses of milk. They don’t have it up on the board anymore. They used to have, you know, the diets up on the board and now they think that that’s a breach of privacy.

Other RCFs responded to the privacy laws by placing the ADL care plans in inconspicuous locations, such as behind a mirror in a resident’s bathroom or in a locked cupboard in a bedroom. A nurse manager from Facility #1 (who indicated that she knew she needed to "deal with" the ADL care plans but was waiting until she was forced to do so by a licensing officer or the Health Authority) discussed the practical implications of the privacy concerns:

**Manager [02]:** I value the privacy that the residents should expect. The problem is that for the safest care for both them and the staff, we need to be informed of what we can do in their best interests. So, it is hard. I know some facilities say, “Oh, put it [the ADL care plan] in the bathroom.” … It’s fine if it’s a single room, but we don’t have all single rooms. It was suggested that maybe we put it on the inside of the closet door. But the closet doors are closed, so you’re not going to find the same usage.

This manager's concern regarding the limited use of the ADL care plan was confirmed by an RCA who reported that the placement of ADL care plans in inconspicuous places meant that they would not be accessed or referred to:

**RCA [06]:** No, I would just totally go through my day without even looking at it, which is awful. But I mean, some of the people you can just kinda, you know what it is you’re doing.
In the facilities where the ADL care plans had already been removed from residents’ rooms, it was an expectation that the RCAs would refer to the residents’ charts (paper-based medical record) for the information they needed:

**RCA [16]:** I found there was no help given at all in the care home that I was at. There was this expectation that you should just know, and if you didn’t know, to go check the big book [the resident’s paper chart], which is the individual file. But, when it’s seven [o’clock] in the morning [and] you have eight patients to get up, you can’t get it. You can’t get the book out for each individual patient and look them up.

This participant, who worked as a casual employee at several RCFs, explained what casual RCAs often did when they lacked access to the information found on the ADL care plan:

**RCA [16]:** I take every single precaution I can, and the drawback of that is that you’re not enabling these patients to do so much for themselves. If they can transfer themselves, and you start using a maxi-lift on them, you’re taking that away from them, that ability. And again, you have to protect yourself. And then you’re stuck using the highest [form of assistance] because as a casual, I don’t know these patients.

The ADL care plan appeared to provide the RCAs with the most accessible written information about residents’ care needs. Even though there was universal agreement that they were important, most of the RCAs indicated that once a significant amount of time had passed after a resident’s admission (approximately two to three months), they no longer could trust the information:

**RCA [01]:** I use it as a rough guess, usually to look at it and see what kind of TENA [incontinence] product they wear, if they’re incontinent, or if they have dentures. Those are mainly what you kinda look at because you can’t really trust as to how accurate it is. …They’re not updated like they should be. We don’t have the time to…when we rotate to a new section. Ideally it would be nice to have the time to be able to go through your residents and change the care plans adequately from what you’ve seen over the last six
weeks, so that it’s correct for the next person that comes in. Like dietary stuff, that’s very important. A purée diet or thickened fluids…if that’s not updated, that’s a big deal.

Of significance, the ADL care plans were not regularly or systematically updated in any of the facilities. Facility #2, which permanently assigned the RCAs to care for particular residents, had the least difficulty in keeping the ADL care plans up to date. This was largely dependent, however, on whether there was an RCA who was able and willing to take it upon herself to update them after they had been initially completed by an RN. Once they were updated by an RCA, the ADL care plan was “signed off” by an LPN or RN. If an RCA was able and willing, the ADL care plans were updated fairly regularly, such as on a monthly basis. If no RCA was able or willing to do the work, the plan remained out of date.

In Facility #3, the ADL care plans were expected to be updated every three months and were the responsibility of the RNs, LPNs, and clinical nurse leader:

**Manager [01]:** What happens is…when it gets closer to three months and there's extra time, either I, or one of the RNs, may go in with a care aide, or LPNs may go in, and just go and change the date and make sure it’s all up to date.

The nurse manager’s mention of "extra time" is telling—it is indicative of the reality that updating these documents was not a priority in this facility and was only done when there was extra time or extra staff. It was for this reason that these documents were not regularly or systematically updated, as explained by a team leader:

**Team Leader [06]:** The RNs and LPNs are supposed to do it every three months but that’s another thing that gets pushed by the wayside because—well, if we have a student nurse, that’s our big chance to do it. But, yeah...not in a normal day, we’d have to have extra staff on.
A nurse manager from Facility #1 described the institutional process for updating the ADL care plans in her facility:

**Manager [02]:** The aides rotate every six weeks. So, when it comes time for them to rotate to the next assignment, it’s their responsibility to ensure that it [the ADL care plan] is correct.

The RCAs from this facility were asked about the process for updating these documents and none indicated that she knew it was her responsibility. In fact, the majority of these RCAs reported that they were not certain whether they were allowed to update the ADL care plan. After observing an RCA successfully settle an agitated resident by wrapping her in a warm blanket, I asked if she had thought about writing this useful tip in the ADL care plan. She replied:

**RCA [04]:** Actually, maybe I should do that. I think I’m allowed to do that. I should double check.

When asked, the LPNs also indicated that they were unaware that the RCAs were allowed to update the ADL care plans without consent from a regulated health professional:

**Team Leader [04]:** I don’t think they [the RCAs] have the authority to change things on it unless I say, "Make sure that’s written on the care plan, I’ll give you the pen."

When it was time to rotate to a new section in the facility, the RCAs did not update the ADL care plans; rather, they verbally shared relevant information with each other:

**RCA [01]:** We’ve got to find out that morning, which, again, sets you behind, right? …You’re trying to figure out just your rough idea of who likes to get up first, who likes this, who likes to stay in bed. But, I usually research it before the actual day of room changes. So, a couple [of] days before, I just ask the people [RCAs] that have been in that section previously or currently, before the changes, and just find out their routine of how they have been doing things. …I don’t necessarily do it exactly the same, I take into
consideration what the residents desire and who’s more cognitively intact and what their needs are and stuff. …usually you find your own way about doing things.

Time was not allotted in the day for this exchange of information, the RCAs were required to do it “on the fly” by finding the time:

**RCA [01]:** You have to find extra time to…usually it’s…at the end of the day. We might be able to find five or ten minutes to seek someone out and say, “OK, do you want to give me the lowdown on this section and let me know what you’ve been doing?” So, we can take some notes and stuff. But yeah, again, we’ve got to find that time.

The process of seeking out co-workers for information, rather than referring to written texts, was pervasive in the three facilities. Once the RCAs had worked with a resident, the majority of them would stop referring to the ADL care plans and instead rely almost exclusively on oral communication provided by other RCAs for additional or updated information:

**RCA [06]:** And it [the ADL care plan] is not always updated so we just have to go with the flow sometimes, just communicating to people that were in there in the last rotation. "What did you do for this person?"

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**RCA [01]:** ...I trust the verbal conversation I’ve had with my co-worker to find out what that person likes and needs and stuff like that.

Of interest, the majority of residents’ family members believed that the ADL care plans were the primary care plans and almost all expressed frustration that the RCAs did not consistently refer to the information found in them. For example:

**Family Member [08]:** No one reads it. It's on the wall behind her bed and it says that she is a choking risk—a “swallow alert”—so she has to be in an upright position to eat. But it doesn’t happen. It's on the care plan but it's not read.

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**Family Member [10]:** It's very frustrating. The care plans are there on the wall. It takes 10 seconds to have a quick look to find out her feet need to be elevated and that she needs a cotton pad between her toes because she has a nail that breaks the skin. These little, little tiny things—they’re in the binder [resident's chart] but they’re also on the wall. Right there. The person [RCA] doesn’t even have to go and get a book and look at it. It’s right there. And it’s not being done. That is very frustrating. It’s very worrisome.

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**Family Member [04]:** We had so many problems with her hearing aid. So I got someone to write in big letters, “Please change batteries on hearing aids every Sunday” on her [ADL] care plan. But it never happened so I still had to tell everyone individually. I had to phone. I was phoning on a Sunday and saying, “Have they changed [resident's name] hearing aid batteries?”

There was a cycle in effect regarding the use of the ADL care plans in RCFs that arises from two pervasive beliefs: the ADL care plans are not used and the ADL care plans are not updated (see Figure 5.1).

**Figure 5.1: ADL Care Plan Cycle**

![ADL Care Plan Cycle Diagram]

There was a general consensus among all of the study participants that Figure 5.1 is an accurate depiction of what occurred in their facilities. It is possible that this cycle is one of the causal factors underlying the RCAs’ predominant use of an oral exchange of residents’ care-related information. It is perhaps because of this cycle that two of the three facilities had also
developed "tips for care" sheets to give to the casual RCAs to assist them “at a glance” in their preparation for the shift.

**Tips for care sheets.** Facilities #2 and #3 had tips for care sheets in addition to the ADL care plans. These sheets contained the most basic of information required for the residents’ care: (a) the type of assistance required for lifts and transfers (e.g., a one- or two-person transfer, mechanical lift required, or whether a wheelchair was used), (b) the type of diet (e.g., puréed foods, minced foods, or a regular meal) and the type of feeding assistance needed (e.g., total feeding or cutting of food), (c) toileting needs and type of brief worn, if any, and (d) routines and preferences (e.g., morning wakeup and rest times). These one-page sheets were a condensed, portable version of the ADL care plan that could be handed to a casual staff member:

**RCA [14]:** It’s one of those tools that we have in place for giving to a casual. Then again, it comes down to a little …one centimetre by five-centimetre box [per heading]—and how can you write everything you need to know in that little box?

Although these tip sheets provided only the very basic of information related to the residents’ care, the study participants agreed that they were beneficial, especially for the casual staff. Participants from both facilities indicated, however, that similar to the ADL care plans, these sheets were frequently out of date. When the casual employees were given these tip sheets, they consistently asked the regular staff to review them to ensure that they were accurate. On every occasion when I observed one of these tip sheets being handed to a casual RCA, a permanently employed RCA was required to provide a verbal update:

**RCA [10]:** I had one…I basically rewrote the entire thing one afternoon. And another, I handed back to my partner. I said, “This is so out of date that there is no point in me even looking at it.”
On three occasions, I observed tip sheets being handed to casual employees that contained information about residents who had died or had moved to a different section of the facility. This problem was also reported by an RCA:

**RCA [03]:** I picked up a shift a week and a half ago on evenings, in a section [of the facility] that I’ve never been in. …I picked up a cheat [tips for care] sheet. Four out of eight [residents] had passed away. So, there are four people on there that I’m…OK, well she’s gone, she’s gone, she’s gone. Who are the other four?…We've had where they’ve just taken a name off, but not replaced it [not made a notation about the newly admitted resident]. That person [resident] was missed until 2:30 [PM]. Not touched from…it would have been before 7:00 in the morning until 2:30 that afternoon because the casual didn't know there was someone in the private room.

The typical response of casual employees to these out-dated sheets was described by an RCA:

**RCA [14]:** Keeping these things updated, keeping them current, it is a lot of work, and it often is not done. …Casuals will come on and say, “Well, I’m just going to do the best I can to get through to the end of the shift and leave it at that.” …Where does that leave the resident…?

The casual employees that I interviewed clearly preferred to receive information orally from the RCAs, rather than referring to written documents. Of interest, although the tip sheets contained information that was primarily relevant to the work of the RCAs, in the two facilities that used them, it was the LPNs or the RNs who were responsible for creating and updating them. One participant explained the process used:

**RCA [12]:** I believe it’s the LPN. She usually collects them. I’m not sure who types them up, if it’s the RN or the LPN.

**Researcher:** So, the LPN initiates the update of the tips for care….
**RCA [12]:** Yeah.

**Researcher:** And what’s the process? She sits down with you and…

**RCA [12]:** No, what I do is, I cross off what’s wrong and write overtop what’s right, and she just takes them.

The study participants reported that a lack of time was what led to the ADL care plans and tips for care sheets being out of date so often:

**Team Leader [06]:** They [the tip sheets and ADL care plans] are great but they’re updated so rarely that…. Yeah, we need to assign a specific person to do that because I don’t know who does that.

**Researcher:** And they need to have the time.

**Team Leader [06]:** They need to have time, yeah. We used to have more time for those things because we had an RN and an LPN working together. The LPN would give all the meds, the RN would do all the paperwork, right. So, they would have time to look at something like that, but now we all have our own [separate work] load. So, it doesn't get done.

My observations led me to consider the possibility that, in addition to a lack of time, there were other reasons for these documents not being updated consistently. First, I wondered if it was a problem that staff members who did not actually use these documents were the ones responsible for updating them. A second explanation for the persistent difficulty in keeping these documents up to date may have been that, unlike the RAI-MDSv2.0, they were not monitored by a regulatory body. They were not considered to be an actual care plan, a part of a resident's official medical record, or a legal document and thus were not regulated. This was clearly articulated by a senior nurse manager:
Manager [03]: How we deal with episodes of violence, violence prevention, all of that, is in the care plan that is not on the wall of the resident. That [the ADL care plan] is not a care plan, that is only how they transfer, what kind of pads they use, and if there are some swallowing precautions. But let’s be clear, that is not a care plan.

Third, because the RCFs had removed the ADL care plans from residents’ rooms (in response to their interpretation of the privacy laws), I wondered if the RCAs had simply become accustomed to "going in blind" such that they no longer looked to, or for, a care plan. Finally, it may have been the case that these two documents were not kept up to date because experienced RCAs simply turned to their generalized or tacit knowledge of how to provide care to "a body," rather than referring to written care plans or individualizing the care they provided for a specific person with unique needs. This was especially likely when the RCAs were engaged in parts of their care work that they found unpleasant (e.g., changing adult diapers), as explained by one RCA:

RCA [22]: It’s a person. You go in there and you might say, “Good morning, Mr. Smith.” But it doesn’t matter if it’s Mr. Smith or Miss Jones or whoever. You’re still just doing the thing with the body. You know if you lose track of the person (you do when you’re doing care), you totally lose track of it. And, that’s the only way that you can change briefs and the messes we clean up, when you disassociate yourself with this person. And, it becomes just a chore and that’s the truth. Otherwise, it doesn’t…I mean, it’s really good to be reminded that they are people and…they don’t like you doing it any more than you like doing it. …You just don’t think about any of that stuff, you just do it.

Care risk symbols: Purple dots, ladybugs, stoplights and incident reports. On more than one occasion, I was struck by how often the RCAs were yelled at, cussed at, or called names by the residents for whom they were providing care. This behaviour occurred so frequently that many of the RCAs had come to view the behaviour as "normal." I was impressed by how often the RCAs were successfully able to diffuse the situation. In these instances, the RCAs used
individualized approaches, which they said they had developed from their past experiences with
the particular resident. Being on the receiving end of verbal aggression was often referred to as
"part of the job." However, being on the receiving end of physical aggression was what the
majority of RCAs mentioned when they described a “bad day” at work:

**RCA [18]:** It [a bad day] looks like a mess. It looks like you’ve been bruised, you’ve been hit, you’ve been…. It just looks awful.

Being on the receiving end of a resident’s aggression or trying to provide care to a resident
who is resistant are two of the primary causes of RCAs’ workplace injuries (Tak, Sweeney, Alterman, Baron, & Calvert, 2010). I witnessed many RCAs clearly working in physical pain. Most reported that they had been injured while on the job. I asked an RCA, who was working with back and shoulder injuries, how many RCAs she believed were also working with occupation-related injuries:

**RCA [05]:** I would bet close to 50% of the people that work here are working with injuries that are never going to leave them.

A young RCA with injuries purposefully worked permanent night shifts because the shift was “easier on her back”:

**RCA [16]:** I’ve been hurt at work. My patient [started to resist and] fell back on me, and I ended up having to get surgery and physio[therapy]. I was off for two years. My ribs are out of place, my hips are out of place, and my shoulder got surgery. I’m a big believer in making the workplace as safe as possible, and not taking risks.

Although residents’ aggression and resistance to care may be pervasive and a risk to employees, information about the behaviour is often, and purposefully, not included in the ADL care plans. For this information, the RCAs must refer to symbols, which the facilities employed to communicate the risk to staff while respecting the residents’ right to privacy. Facility #1 used
purple dots and ladybugs, Facility #2 used stop lights, and Facility #3 used purple dots with Roman numerals placed in a conspicuous location in the residents’ rooms.

**Purple dots, ladybugs, and stoplights.** Facility #3 placed adhesive purple dots on some residents’ ADL care plans to inform the RCAs that these residents had exhibited aggressive behaviour. The process for evaluating whether a resident would have a purple dot placed on her or his ADL care plan was explained by a nursing leader:

**Manager [01]:** If somebody has a behavioural concern, then we start a behaviour flow sheet for seven days. The nursing assistants fill that in for a week and we look and see how many incidents of whatever is occurring. And then, from there, we’ll identify if that resident is a care risk; if they are, they are given a purple dot.

The nurse managers would add a Roman numeral to the purple dots to indicate the level of risk:

**RCA [20]:** So there is care risk I and care risk II. Care risk II are more physically aggressive. Care risk I could be more verbally aggressive, where a II would be striking out, or unpredictable.

Facility #1 also used purple dots, although they placed the dots on the residents’ nameplates immediately outside their rooms. This facility did not use Roman numerals to indicate the level of care risk; rather, they added ladybug stickers to the nameplate if a resident had engaged in an aggressive episode within the past 48 hours. An RCA described her experience with the use of purple dots in this facility:

**RCA [11]:** Some nurses have not been willing to sign the forms when I’m trying to get a purple dot put on the door. And, I’m not saying anything bad about any nurses, that’s not where I’m coming from, but I’ve had some hard times getting my point across. Like, “This resident was punching me,” and they’re like, “Well, he does that every day.” And I’m like, “Well, they should have a purple dot on their door.” And they’re like, “Oh, we’re not just going to go tossing out purple dots left and right.” So, there’s a little bit
of...sometimes it just feels like being a care aide you’re just supposed to accept that. So, I just...approach every door with caution because maybe the nurse didn’t want to put the sticker on the door. You know what I mean? You have enough people swing[ing] at you that eventually you just proceed with caution.

A team leader from this facility indicated that the reason some residents received purple dots and others did not was due to inconsistent follow-through:

**Team Leader [04]:** I don’t know why it doesn’t happen all the time or why I don’t remember to monitor them [the aggressive resident] for 24 hours.... It doesn’t seem like it’s followed up with all the time. Or, if I do that observation tool and I bring it downstairs, are they actually going to be purple dotted or...? It’s just the follow-through with the whole thing, so I’ll just make sure that report knows, staff knows, that they’re aggressive, that’s more what I do now.

Facility #2 did not use purple dots to communicate risk; they used a "stop light" symbol. If the resident's name on the doorplate was printed on green paper, then the resident putatively had no history of aggressive behaviour. If the name was printed on yellow paper, then the resident had occasionally engaged in aggressive behaviour. A red nameplate indicated that the resident had exhibited repeated episodes of aggressive behaviour. Thus, green nameplates informed the RCAs that they could provide care without reservation, yellow nameplates advised the RCAs to "proceed with caution," and red nameplates advised the RCA to "stop" and obtain further information or assistance from the team leader before commencing care.

Once a resident had been identified as having the potential for aggressive behaviour, each of the facilities had a unique method of providing additional information to the RCAs. In the two facilities that used the tips for care sheets, additional information was reportedly found there. When I reviewed these sheets, I found that, because of the space limitations, the most common statement made was: "may strike out." An RCA said:
RCA [12]: "May strike out." A lot of them will say that. "May strike out."

Researcher: But it doesn’t really…

RCA [12]: It doesn’t give you any tips on how to deal with it.

All three facilities also used behaviour flow sheets to aid in the assessment of aggressive behaviour:

Manager [01]: We have quarterly care risk review[s]. …All those residents that are identified as care risk I or II are put on the list and they are reviewed. So, ten days before the review, we’ll put out behaviour flow sheets again for assessment and monitoring and we’ll take those flow sheets and determine with the doctor, the social worker, the nurse, and myself, whether the resident should continue on care risk I, II, or be eliminated [from the list]…based on how many incidents have occurred.

In all three facilities, if a resident was identified as having the potential for aggressive behaviour, then the problem was supposedly listed in the resident’s care plan in the RAI-MDSv2.0, in the resident's paper-based record, or in both. The managers of all three facilities reported that the purpose of a red nameplate, a purple dot, or a ladybug was to direct the RCAs to not enter the resident's room before acquiring additional information from a team leader or the RN on duty. The additional information was expected to be in the resident's formal care plan. However, only one of the study RCAs indicated that when she saw a purple dot she would ask the RN or team leader for additional information. After inquiring, I was informed that the most common plan of action listed on these residents' care plans was to direct the RCAs to go into the room with another RCA when providing care. This may be why the majority of LPNs and RNs felt unable to provide the RCAs with additional information that could assist them in these situations and instead encouraged the RCAs to seek information from other RCAs. For example:
**Team Leader [04]:** The casual workers come to me and ask, “What should I do?” and I’m like, “I don’t know, I’m not with the resident all the time. I wish I knew but I have no idea.” Then I’ll say, “OK, let’s look at the chart and I’ll try and problem solve with you.” Or I’ll say, “OK well, who [which RCA] was with them last week? Let’s go try and find them.”

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**Team Leader [05]:** You know, I don’t know what they’re supposed to do when they see the purple dots. I know what they do do…is they go and talk to other RCAs. They will ask each other, “Why do they have a purple dot? What do I need to know?”

The vast majority of RCAs reported that these symbols (care risk symbols) were of little use other than to warn them to "proceed with caution," as expressed by two RCAs:

**RCA [09]:** It [a purple dot] doesn’t mean much to me. I know these guys’ behaviour so well. I don’t pay attention to the purple dots because I know what triggers them [the residents] and what they’re going to do and when they’re going to do it, usually. I mean, I guess they could have an unpredictable element but…. Yeah, it doesn’t really mean too much to me. I might be extra cautious [when I see a purple dot], but I’m always cautious.

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**RCA [06]:** In this facility, I look at the purple dots like they’re a part of the nametag. I just assume that everybody can snap at any point because there is so much dementia here. And I’ve seen it. I’ve seen the nicest guy turn around and want to hit me in the face for no reason.

The majority of the RCAs viewed the behaviour flow sheets and the related care plans as time-consuming paper work that was of little use to them. For example:

**RCA [09]:** Well, I don’t refer to it [the behaviour flow sheet] for anything. It’s more like I’m collecting data for something [laughter].

**Researcher:** Do you know what that something is?
**RCA [09]:** To see if there is a care risk? I think that’s all it is.

**Researcher:** So you don’t know what happens?

**RCA [09]:** Maybe it’s to [pause]. Oh, this is going back a long time, but maybe it’s to identify the triggers and then put [long pause]…

**Researcher:** A care plan?

**RCA [09]:** Yeah, that’s it.

**Researcher:** And, is that care plan helpful?

**RCA [09]:** No, because you don’t really read that before you do the care [laughter].

**Researcher:** That’s a really honest answer. So, that’s not something that you’re actually going to go seeking out when you see a purple dot and you’re on the floor?

**RCA [09]:** No, absolutely not.

Another RCA articulated a statement that I had heard frequently about why the RCAs did not seek information from the residents’ care plans located in the formal health records:

**RCA [01]:** Yeah, because oftentimes people that have written these care plans around their behaviour aren’t people that work with them every single day!

In all three facilities, the RCAs repeatedly described how they turned to their own skills, their own knowledge of the residents, and their own assessments when dealing with residents who had exhibited aggressive behaviour:

**RCA [01]:** I like to make my own assessment of them because when we come on it’s a new day. It’s a totally different light, sometimes.

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**RCA [15]:** I would go about it just the same way I would go about any other resident. I would take a little bit deeper of a breath, but I would assess the situation. …because
whether or not they have ladybugs, they’re not always physically aggressive. Even the ones with a purple dot, they’re not always going to be aggressive, right? I mean, sometimes they’ll be happy as a clam. So, you definitely assess the situation at first.

If their assessment and subsequent approach were unsuccessful, the RCAs consistently stated that their next step was to seek advice from another RCA:

**RCA [09]:** And if that [my approach] doesn’t work, I’m going to ask my partner what works for them.

The tendency to seek advice from other RCAs, rather than refer to the written documentation associated with the residents’ behaviour was shared by almost all of the study RCAs. For example:

**Researcher:** So, when you see a lady bug, would you be more inclined to go try to find out verbally from another care aide, or to go read...?

**RCA [06]:** Verbally.

**Researcher:** That’s…what I’ve observed. The work and the life of the care staff, it’s all about…

**RCA [06]:** Communication.

**Researcher:** Communication. Verbal communication. Not necessarily written down…

**RCA [06]:** No.

Another RCA stated it more clearly:

**RCA [20]:** Well, if it’s behavioural, first I would check with the care aides to see if there is a history of this or, you know, at sundown or a certain time or what have you. So, check with them.

In all three facilities, the primary method by which the RCAs shared and received information related to risk (and indeed to *all aspects* of the residents’ care) was through an oral
exchange. Because they shared information verbally, what they shared, how they shared it, and even if they shared it were largely dependent on the quality of their working relationships and how receptive they found the other RCAs. This was expressed by several of the RCAs. The following quotations are two examples:

**RCA [16]:** Totally. It’s verbal. They tell me. I definitely take notes, in my head, and then I’ll pass it on to the other aides. But, some people don’t wanna hear the tips. So, you have to tread cautiously. Sometimes, you have to wait until they approach you and ask you because otherwise they might think that you’re trying to tell them they’re doing it wrong or something.

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**RCA [09]:** I’d probably do a little assessment in my head of how they [the other RCAs] might take the information, and I usually…just say, “I don’t know what you know about these residents or what you don’t know, but if you don’t mind I just might tell you a few things that might help.” …If they are…“Oh, that’d be great,” then throughout the day I…give them little tips that they need to know.

The RCAs frequently mentioned how poor working relationships among RCAs led to a breakdown in the transfer of important information. For example:

**RCA [12]:** If two of the girls don’t like each other, one great tip that could save us all time and injury doesn’t get shared.

I witnessed several exceptional examples of freely flowing oral information exchange among the RCAs. Indeed, in all three facilities, effective oral exchange of information among the RCAs was the norm, rather than the exception. Thus, it was through this oral exchange of information that the residents' idiosyncrasies, intimacies, and preferences were shared among care staff members. For example, I witnessed RCAs sharing information pertaining to things such as how to encourage a particular resident to eat, how to prevent a resident from being
aggressive during his bath, and how to enable a resident to remain as independent as possible during morning care.

I also witnessed examples of communication breakdowns due to tensions in their relationships. These breakdowns were often noted to occur at the time that the care being delivered was task oriented and ignored the way in which the resident was responding. On one of these occasions, I witnessed an RCA being hit by a resident—an event that typically required the completion and filing of an incident report. Incident reports were the institutional texts used to formally document, track, and respond to incidents of residents’ aggression or care staff members being injured.

**Incident reports.** If an incident of aggression, by a resident, occurred, the institutional process in all three facilities required the RCAs to inform the team leader and to complete an incident report. I asked the RCAs about this process:

**Researcher:** What’s the process that happens if you get hit or if you’re experiencing aggressiveness from residents?

**RCA [18]:** There’s an incident report form.

**Researcher:** And, do you fill them out every time?

**RCA [18]:** No. I don’t even know where they are in most of the units [in the facility]. I know if it was something that…I have filled one out before, and I was concerned for somebody else. Otherwise…I’ve been bruised and bit and whatever…. What do you do? What is the real point of this form? They’re gonna get a purple dot on their already purple dotted name that nobody pays attention to anyway. But, everybody knows that this happens. So…you try to tweak your approach of it. But, there’s that odd time that…they snap.

**Researcher:** They snap?
**RCA [18]:** And, you get whatever. …As long as I’m not injured in a way that I can see it hurting me down the road or there’s no fixable thing that I can see in my head. I’m supposed to fill that out on my break? …What is the point of that?

This RCA’s question about the point in completing these reports was reiterated by a team leader:

**Team Leader [04]:** I fill out incident reports all the time, and then they get passed on, and then what? There’s no follow-through, there’s no follow-up, there’s just nothing. No education, no in-services on how to prevent these things. So…why…it’s just more documentation, more work for us, for no result.

In addition to believing that they would not make a difference, the RCAs would not complete the incident reports for two other reasons. First, they believed that the reports were unnecessary if they believed that they could “heal” from an injury without requiring a leave from work or professional intervention. This was explained by an RCA who was struck by a resident:

**RCA [19]:** OK. The reason I didn’t do it [report the incident] is because I know that I’m not in…. First of all, I know that with just a little bit of time, and at the gym, my back will be OK. So, I’m lucky in that aspect.

A second reason given for not completing the incident reports was that the RCAs feared being blamed for the incident. This was especially significant in one facility where incidents of aggression by residents had been relabelled residents’ “responsive behaviours.” The idea underling the introduction of this new term in the literature is that residents engage in these behaviours in response to their environments (Dupuis, Wiersma, & Loiselle, 2012). Thus, rather than labelling a resident as “aggressive” or “resistive,” the staff are encouraged to assess the environment to determine what the resident is “responding” to. In many cases, the resident was responding to the RCA who was providing care, and many authors have asserted that how the resident responds is largely determined by the RCA's approach (Speziale, Black, Coatsworth-
Puspoky, Ross, & O'Regan, 2009). It is widely believed that the RCA’s approach can provoke these behaviours, as revealed by this RCA:

**RCA [12]:** And sometimes, I’ll fully admit, it is my approach that day. I didn’t go in with the proper attitude. …I’ll even write that down. You know, that I had a really tough time, to be fair.

Some of the staff suggested that the idea of “responsive behaviours” had been taken too far, and that incidents of aggression by residents now resulted in the “finger pointing” being removed from the residents and directed toward the RCAs. The potential for being blamed for some residents’ behaviour resulted in a reluctance to report incidents of aggression:

**RCA [19]:** Well, like yesterday, I didn’t write a report.

**Researcher:** About being hit?

**RCA [19]:** No. I mean, I did document it in the 24-hour book. And the girl … afterwards, it was really nice what she did, just because…

**Researcher:** What did she do, sorry?

**RCA [19]:** Oh, she just wrote up…”unprovoked.”

Even though this RCA had someone document that the incident was not provoked by her approach, she did not complete an incident report. Documenting the incident in the 24-hour observation sheet ensured that she communicated the incident to the other RCAs. However, the 24-hour observation sheets were read primarily by the RCAs and were discarded by the RNs (with or without reading them) after approximately 2-3 weeks; thus, by not completing an incident report, the event was not captured on a permanent record. The RCAs of this facility unanimously agreed that the fear of retribution resulted in underreporting of incidents of aggression.
An RN from this facility concurred with the RCAs; she informed me that underreporting occurred because of the fear of retribution and also because incidents of aggression were considered something that "comes with the job":

**Manager [11]:** Anything that is not significant enough to require WCB [Workers Compensation Board]—like pinching, spitting, biting—that is under-reported all the time.

**Researcher:** And why do you think that is?

**Manager [11]:** Well, partly because I think that there’s kind of an expectation or an acceptance among the people that are doing the direct care that…that comes with the job. It just comes with the job. You just know this happens, people pinch, people bite. Try and keep from having it happen to you if you can…and often the attitude is, when you do report it, is they say, “So, what did you do that prompted this?” And, then it feels like you’re being punished for being injured.

**Researcher:** You’re being blamed…

**Manager [11]:** Yeah, so I think that keeps people from reporting it as well. They don’t want to be seen as doing something wrong that led to this. You know? So, that’s part of it too.

These findings are consistent with the literature that indicates that the suppression of information related to safety practices in healthcare settings is associated with management practices that focus on blame (Khatri, Brown, & Hicks, 2009; Moss & Maxfield, 2007). Not reporting these incidents meant that this important information was not shared openly with the team leaders, nursing supervisors, or management. Residents’ aggression is recognized generally as a complex issue that typically requires a collaborative approach to address successfully (Bennet, 2007). However, unless RCAs feel able to safely and openly bring these issues forward, a collaborative approach cannot occur.
**Personal competence: Values, beliefs, experiences and skills.** I found early on that the organizational systems in RCFs require that RCAs rely primarily on their individual competence as they navigate the complexities of their daily work. To gain insight into the RCAs' perceived levels of competence, I asked if they had received adequate training in how to provide care to people with complex care needs, such as those with advanced stages of dementia. All of the RCAs indicated that the training they had received about the care of people with dementia was extremely limited. For example:

**RCA [18]:** I don’t know, a lot of it was based on just the physical [part of caring]. I do remember a small part of it being on dementia, and it scared me so much that I was like, “Well, I’m never doing that. I’m going to work with people in the community. I’m going to go into their homes, I’m never going to work in a facility…and I’m certainly not working with anybody with dementia, ever.”... And, here I am.

Most of the RCAs indicated that their limited training about dementia care was largely immaterial because they did not believe that one could learn about how to care for people with dementia in a classroom. For example:

**RCA [15]:** Umm…see, that’s like a loaded question because you can’t know how to work with people with dementia until you do it. Because they’re all so different…right? You can learn, you can read a book that’s 10-feet high and…but then, when you go into a patient’s room [it could still feel like] you don't know a thing.

**Researcher:** Because nothing that you were told to do necessarily applies to this situation with this resident?

**RCA [15]:** Exactly! So yeah, it’s hands on…that's why when another care aide who's been in there doing it says, "This is the best way to do things." I listen. And even then, you have to actually do it in order to really learn; because until you actually do it, you don’t know. And, every day is different. So, how can they [educators] prepare you for so
many different days? You never know and they never know what’s going to happen on any given day.

When I enquired about whether the RCAs had received adequate education or training to deal with some of the most challenging aspects of their work (e.g., death and dying, physical aggression, or mental illness), the majority stated that they had not received "much" training about these matters in their educational programs. Again, they indicated that they learned how to cope with these challenges by "doing." For example:

**RCA [01]:** All the emotional things that we do and the things we figure out on how to care for someone who is dying or someone who is acting out, they don’t teach us that in school. You learn that by being there [in the rooms] with the residents. And you respect that as you go along, and build your own beliefs....

All of the RCAs indicated that "knowing by doing" was how they learned to care for elderly people with complex care needs. In addition, many indicated that, although it did not occur as often as they would like, the education they received from in-service training sessions was valuable. For example:

**RCA [18]:** They [management] do have in-services and stuff here for care aides who are not comfortable with things, like...you know, palliative care when they [the residents] are dying...and they'll try and bring in new information [on other care-related topics such as new incontinence products, new lift and transfer procedures, aggressive residents] because let's face it…things change...and some people [RCAs] haven't been in school for 20 years. So it is important to have those little updates [new information] that you need to know.

Even when the RCAs had received new information at an in-service session or had actively sought tips from other RCAs about how to provide care to a specific resident, they would adapt the information based on their personal experiences, strengths, and beliefs. Thus, when providing
care to a resident, it was their personal experience and skills that they initially turned to when
deciding what to do, when to do it, and how to do it. In many ways, the system demanded this of
them because, unless they were paired with a teammate, they were alone and reliant on their
personal assessment skills and knowledge:

**RCA [22]:** The thing is, people are people, right? And you just, after so many years of
doing the job, you just go in and do sort of an assessment on them, you know? If they’re
speaking to you or if they’re moving around in the bed, you try to figure out what they
can do. Sometimes, you know, it’s…if they’re really [unstable] when you try to sit them
up on the bed, you have to put them back to bed and go ask somebody what the heck’s
going on. So you kind of…you try to be as independent as you can, but you know there’s
a point when you just go, "Hold it, I've got to...like, I kind of need help here."

**Researcher:** So, you’re usually...actually, you’re in there [the resident's room] alone. Are
you ever paired up with another care aide?

**RCA [22]:** No. No.

**Researcher:** So, what do you do if you need assistance?

**RCA [22]:** You can go looking for somebody, but it’s often a waste of time...everyone's
busy, they're in other resident's rooms giving care so they can't come anyway.

When in a resident's room, the RCAs turned to that to which they had immediate and
practical access—their individualized 'tool box' containing their skills, knowledge and
experience. In addition, they relied on their personal beliefs about how to provide care to people.

When asked, the majority of the RCAs indicated that it was their personal values and
beliefs about how they would want to be cared for, or how they would want their own family
members to be cared for, that most often directed their care decisions. For example:

**RCA [18]:** Before I came into this job, I looked after my great aunt, before she passed
away, and I also had a best friend who had severe brain damage from a brain disease that
she died from. So, we took care of her. [From these experiences] I think I was very aware of the dying thing, and how important it is to...have, you know, still look nice, and [for the RCAs to] spend the time, like putting on her favourite costume jewellery...that was really important to me as a family member. So then, coming into care [work], I would think of that the same way.

Researcher: So, it [the type of care you provide] is based on your sense of how you would treat a family member or a friend?

RCA [18]: Yeah, and well, it’s just like, treat others how you would want to be treated, right?

Other RCAs not only applied this philosophy to the way they personally provided care, but also ensured that this method of determining how to provide care was transferred to the student RCAs who were working under their guidance. For example:

RCA [08]: Like, if I have students and I'll say, “Look at my residents and look at yourself in the mirror.” I'll say that “if you're looking at a lady [resident] who's got whiskers sticking out, if that was you in the mirror, what would you be doing? You know, really look at them and think of granny. When you go and see your gran[dmother], do you want to see suppositories laying all over the counters or her brief hanging out?” And then, you sort of see the light coming on and they [the student RCAs] say, "Ooh."

It is a combination of their personal competence and their personal values about care that the RCAs primarily relied on when making decisions about daily care practices. However, it was to each other that they turned when navigating the work-place adversities they commonly faced during the course of a regular work-shift.

Relationships and resilience: We're in this together. Without exception, the RCAs of all three facilities spoke about the importance of the quality of their relationships with their teammates to their work lives. When asked what made the difference between a "good day" and
a "bad day," they unanimously agreed that it had very little to do with the work itself and everything to do with the presence of reciprocating teammates.

**RCA [06]:** Honestly, it depends on who you work with. I mean, I could have the most chaotic day ever, everybody’s got diarrhoea, we have a Norwalk [virus] outbreak...people are throwing up, and it could still be a good day if you have a good team on. You know, they'll come help you and you’ll help them and we figure out a way to make it work. But, if you're working with people who are going, “No, I’ve got my own to deal with…” well then, that's always a bad day.

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**RCA [19]:** Well, it’s great to work with partners that have the same philosophy that you do…that go out of their way to be helpful, cooperative. That’s everything.

**Researcher:** That’s everything. ...and if you’re working with someone that doesn’t want to help you, isn’t there for you, maybe there’s friction…

**RCA [19]:** That makes a terrible day, a day that you have to spend lots of time by yourself. And you’re trying to, but you can't get help when you need it…

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**RCA [20]:** It’s the most important thing to me. It could be the toughest day. There could be [a] Norwalk [virus outbreak], vomit, feces, could be anything. And who cares? You just get it done...because if you’re working with people that you have a good time with, it can still be a wonderful day.

**Researcher:** And if you’re not?

**RCA [20]:** Then I go home and I dwell on it. I don’t sleep at night…and I don't look forward to coming the next day.

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RCA [22]: Um, a good day would be when you’re working with a good team. That makes your day. If you are working with somebody who is miserable, negative, condescending, impatient, not feeling well, um…any of those things, it will ruin your day. So really, it’s generally the staff more than the work that makes the difference, I would say.

It was to their teammates whom they turned when the RCAs faced one of the most emotionally challenging aspects of their work—coping with the death of a resident for whom they had provided care. All of the RCAs indicated that the support they received at work regarding death and dying came primarily from their teammates. For example:

RCA [05]: [Some RCAs] are very sensitive to somebody dying, and it really affects them. But you have so many people around you that have so much empathy. And, yeah. You have support that way.

Researcher: Support from...?

RCA [05]: From your, ah, work mates.

Researcher: Your work mates, some of the other care aides are there [for you], your team…

RCA [05]: Yeah.

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Researcher: Is there support for staff members who are affected by a resident[‘s] death in this facility? Either by management, team leaders, co-workers or…?

RCA [03]: Mostly by co-workers.

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RCA [11]: Yeah, it's more informal support. You know, if you’re crying because a resident passed away, somebody’s going to come up and give you a big hug and talk you through it, for sure. That’s happened to me before. I’m really sensitive.

In the facilities where these supportive, reciprocating teammates were not available, the RCAs were left to cope with death and dying on their own:

RCA [08]: Not much, you know, it’s…one terrible thing with nursing is that we don’t always support each other when these things happen, and we see it frequently. And it is one of those things that we take home at the end of the day and go, "I’m really going to miss her."

The experience of unattended sorrow was pervasive amongst the RCAs, so much so that it seemed to be accepted as "part of the job."

The End of Shift: Providing Information to the LPNs and RNs—Oral Report and Written Records of Care

Unlike the team leaders and nursing supervisors, the RCAs spent almost their entire shift in direct contact with the residents and provided the most intimate aspects of care. Consequently, it was the RCAs who were most likely to first observe changes in a resident's general condition or health status. For example, they would observe how the residents slept, if they had pain or changes in their appetite, or were declining in their physical functioning. They would note how they were responding to their medications or treatments (e.g., had their sleep improved, agitation or pain been reduced, or rash resolved?) and whether they had side effects (e.g., nausea, diarrhoea, agitation, or lethargy). The RCAs were often referred to as the "eyes and ears" of the nursing team. The recognition that the RCAs had an especially important and significant vantage point regarding the health and wellbeing of the residents was expressed by more than one team leader:
**Team leader [01]:** They know way more than even some of the RNs because they’re right there. They can tell you, “You know what, that person’s in congestive heart failure.” I have 35 residents. If I don’t get good feedback from the healthcare workers…. I mean, how can I monitor all of them [the residents]? So, if they [the RCAs] know that there’s been a change [in medication], then they’re able to gauge properly and then they’re able to give good solid feedback to see if it’s working or not.

Consequently, the sharing of information the RCAs possessed about the residents’ health status, with the team leaders, was essential to the management of the residents' care and wellbeing. The flow of information from the RCAs to the team leaders, nursing supervisors, and management occurred in two formats in all three facilities: oral reports (which were expected to occur at the end-of-shift) and written records of care through the flow sheets and observation sheets.

**Oral report.** The managers of all three facilities indicated that the institutional process in place for the provision of information from the RCAs to the team leaders was via a brief, one-to-one, informal oral report at the end of the shift. However, none of the facilities actually had an established time for this end-of-shift, oral report. This may have been a reason why I observed only one RCA purposefully reporting to an LPN at the end of the shift. For the other RCAs, this exchange of information occurred “on the fly” and throughout the shift. This was explained by an RCA:

**RCA [01]:** I know when they teach you in school, you give your report at the end of the day, at the end of your shift, and all that sort of stuff. The relationship that I’ve built, and that I know a lot of the RCAs have built, I think, with the team leaders, is that you give it as you go through the day. You know, “So-and-so’s got a rash.” You don’t wait ‘til the end of the day to tell them.

Many team leaders concurred with this RCA. For example:
**Team Leader [05]:** The RCAs come to the nurses all day. If you’re lucky, they don’t wait until 5 min to 3:00. And I was as guilty as anybody when I was a care aide, I would come to the nurse at 5 to 3 and say, “Oh, this is what I noticed today.” And they’d look at me and say, “It’s too late. Go away.” Now I know why they did that...because you get information from them and you want to assess the resident, fax the doctor, let the other nurse know, document about it in the PCC [PointClickCare®, the software that contains the resident's computerized medical record], write about it in report—all that work that’s going to take place now, and you don’t have time for it. So you just tell the evening nurse, “Oh, the RCA told me blah blah blah.” And you don’t get a chance to do anything with it [the information from the RCA]. It’s very unsatisfying.

**Researcher:** So they come to you throughout the day. But when they come kind of depends upon the day, and it also kind of depends upon ah—

**Team Leader [05]:** Whether or not you see each other.

**Researcher:** Right. You kind of have to find each other. And is it, if you haven’t seen them, do you go seek them out?

**Team Leader [05]:** No.

**Researcher:** They have to come find you.

**Team Leader [05]:** No news is good news! [laughs] Oh, that’s awful.

The unintended outcome of not having an established time for an end-of-shift report is that the RCAs had to find the “right” place and time to pass information on to the team leaders. Many of the RCAs discussed the need to watch and wait for the right time to share their information with the LPNs. When discussing the consistency in response to the information provided to the team leaders about residents’ care needs, an RCA said:

**RCA [01]:** Sometimes not, because they [the LPNs] get really, really busy and I might be telling them at the wrong time and they’re not near anything. And then if they
forget...we’ve got a lot of stuff, we all have a lot of stuff to remember throughout the day. But yeah, normally, I’ll assess the team leader, of where they’re at or wherever. If it’s something that’s fairly important, I’ll ask them, “Do you want me to go write it down and leave a note for you on your desk or do you want me to come back later?” Or, I’ll check with them later and say, “Oh, did you remember to do this, or did you remember to…?”

The LPNs were always "really, really busy" during their “med pass.” The term “med pass” is an oversimplified term used to describe the process of administering medications to residents, which included preparing the medications for consumption, such as crushing and mixing the pill with an appropriate sweetener to disguise the taste or preparing a syringe and needle. Then the LPN had to get the resident to take the medication—often not a simple task; it could take much cajoling, which required time to develop a trusting relationship such that the cajoling was effective. Then, the LPN was required to accurately document what was given and when. Thus, the “med pass” was a highly complex task that required a variety of skills, abilities, and knowledge to accomplish successfully. Given the complexity of the residents’ health needs and the number of medications that were often prescribed to address those needs, the “med pass” consumed the largest portion of an LPN’s shift.

When they were not administering medications, the LPNs were responsible for such things as contacting physicians, receiving and processing physicians’ orders, cleaning and dressing skin wounds, assessing residents’ health status and care needs, attending care conferences, and updating the RAI-MDSv2.0. All of the work that they did had to be documented in the residents' health records—this was most often done in the form of nursing progress notes. The task of documenting the work was time consuming, and since the RCFs used computerized health records, the LPNs were often required to sit at a computer for extended periods of time during a
shift. This caused some family members to question how they were spending their time at work. For example:

**Family Member [12]:** I don’t see them doing much of anything else, except in their little cubbyhole. And giving meds!

In all three study facilities, the predominant time in which the RCAs could access the team leaders was during the “med pass:”

**RCA [14]:** But the LPNs are so busy—that we just see them [when] they come to do the med[ication]s at suppertime because that’s when everybody’s in the same place. …It’s definitely not perfect.

It was during the “med pass” that the majority of the RCAs attempted to communicate to the LPNs their information regarding the residents’ care needs and issues. This behaviour put the LPNs in the precarious position of choosing between listening to the information offered by the RCA or maintaining their focus on the “med pass.”

Medication errors are taken very seriously in all healthcare settings. If an error occurs, then a permanent official record of the error must be created, which results in an internal investigation conducted by nursing supervisors and management. Thus, during a “med pass,” the most important objective for the LPNs was to *not* make an error. Consequently, the LPNs typically chose to keep their focus on the “med pass,” rather than on the information being imparted by the RCAs. This was described by an RCA:

**RCA [04]:** …if they’re delivering meds, they might be, “Well that [what you're telling me about the resident] is not the most important thing right now.”

Choosing not to focus on the RCAs' information or concerns during the “med pass” was further explained by a team leader:
Team Leader [02]: It takes me two and a half to three hours for my medication delivery in the morning because there are 43 residents and the bulk of their medications are given at eight [o’clock] in the morning. And, we’re told that it’s a medication error if we don’t give them within an hour of 8:00 [AM]. But, because we’re giving so many, it’s impossible. …The pharmacies say that’s actually a medication error if an 8:00 [AM] medication gets given at 9:30. But we don’t have a choice because I just can’t be in 27 places at one time. So, it’s a challenge. And you have to be, you have to be awake and alert and you have to just… And then, people [the RCAs] come to you constantly, “Can you come look at this? Can you? This dressing’s coming off. Can you come change it?”

Without exception, the team leaders expressed frustration and fear of making a medication error because they were being pulled in too many directions during a “med pass.” For example:

Team Leader [06]: So they [the RCAs] will come up to me and say, “So-and-so’s got a red area” while I’m drawing up medications for someone else, but because they just put that name in my head I’ve gone up to that person and almost made a medication error—almost given the medication to the person they talked to me about, even though it wasn’t their medications I was drawing because suddenly my brain starts thinking about the other person. And, you could have a medication error because of this—[getting interrupted during a “med pass”] happens all the time; it does.

The unintended consequence of RCAs having access to the team leaders only at “med pass” time is that the information they have regarding residents’ care needs is often missed, not taken up, and not responded to:

RCA [03]: From what I can tell, and it’s just from what I see, a lot of the LPNs and the RNs are so busy with medications and dressings that they don’t have time for the other stuff.

The LPNs were so overwhelmed by the number of tasks that they are directed to do by the RNs, physicians, clinical nurse leaders, and residents’ family members they often felt overburdened when the RCAs came with additional information or requests. Unfortunately, this
additional information was often related to significant and potentially serious health concerns of the residents. For example, I witnessed RCAs informing LPNs of their concerns regarding residents’ care needs, such as a toe possibly becoming gangrenous, an infected eye, a possible urinary tract infection, a rash, and uncontrolled pain. These concerns were all shared orally with the LPNs during a “med pass.” In each of these instances, I saw no action that suggested that the RCAs’ concerns were addressed by the LPNs or RNs. The frustration that occurred as a result of the lack of follow-up was expressed by almost all of the RCAs. For example:

**RCA [03]:** I find that because stuff is missed, it looks bad on you, to family, to residents, to staff, to just…in general. If your resident is in pain and you can’t do anything about it, then you feel awful, and you can’t do anything. And, I can ask and ask and ask, but it doesn’t mean anything is going to happen.

I also found that family members were aware that concerns regarding residents’ care issues expressed by the RCAs and often on their behalf to the LPNs were not taken up. For example:

**Family Member [04]:** I think the communication generally is quite poor and I will tell you why. For example, mom had a dressing on her back; her back was very sore and kind of opening up. The care aide didn’t seem to be able to pass that on to the LPN or if she did, they didn’t take notice of it. So quite often if I came in at three [o’clock] then the evening LPN ended up having to change the dressing because I’d say, “Look, it needs to be changed.”

Without exception, the RCAs indicated that they did not feel it was the LPNs’ fault that they did not act on the RCAs’ information. They expressed the belief that the LPNs were simply overburdened with work and were not able to respond. The perception of many of the RCAs was that the LPNs’ workload was primarily composed of having to administer a large number of medications to a large number of residents with complex care needs and of having to ensure that the RAI-MDSv2.0 was up to date:
RCA [19]: The priority is the RAI, period. So, their time…they need to dedicate there. So, all of the day-to-day stuff, and the actual living, and the actual being—the person—they feel that they don’t have enough time to do what they need to do. And, most of that [what pulls them away] is computer stuff. Their requirements, for the government, I guess, ultimately, the RAI. I think it would be unfair to say that they don’t care. That’s not it. It's just that their focus is different.

Ensuring that the RAI-MDSv2.0 was up to date required that the LPNs spent less time “on the floor” and more time working at a computer:

**Team Leader [06]:** After you’ve done it [RAI-MDSv2.0] enough times, the RAI takes about an hour for each resident. So even when you’re pretty good at it, it still takes a lot of time. And, as an LPN, you feel guilty because you’re not helping on the floor because you know how hard they [the RCAs] are working, but then you’ve got people coming at you saying, "Your RAIs are behind."

An unintended consequence of the introduction of a computerized health record was a reduction in the physical presence of team leaders “on the floor.” The study participants unanimously agreed with this conclusion. With team leaders not having a prominent presence “on the floor” it would seem that an end-of-shift report with the RCAs would have been especially important. This idea was expressed by an RCA:

**RCA [08]:** So, one of my things…to not have an afternoon report drives me insane. To not sit down with your co-workers and go, “You know, I saw this with so-and-so. She doesn’t look herself.” And, somebody will say, “Oh.” But, you’re looking at it from different points of view and to share those points of view is such an important thing in nursing.

Bringing care providers together to share their different perspectives related to residents’ care needs is essential in the provision of person-centred care (Brooker, 2007). The idea that an
end-of-shift report could result in better collaboration was expressed by more than one RCA. For example:

**RCA [14]:** I’ve come across some care aides that say, “Well, I don’t need to know that. I don’t need to know what antibiotics they’re on, or if they’re even on antibiotics. I don’t care. I’m not a nurse. Medications aren’t my thing.” And, then there’s LPNs or nurses that will say, “Well, that’s not the care aide’s job to know what they’re on.” But, we all should be collaborating in this care for this person because you put them on the antibiotics, we should be watching their bowels, which is what the care aide does. And, if we just have a free-flowing conversation about it, it won’t get missed when this person then has diarrhoea for five days.

**Researcher:** But, there’s no oral report…

**RCA [14]:** No. And that’s where that kind of stuff would be shared.

One team leader agreed with this RCA about the value of an afternoon report:

**Team Leader [02]:** Yeah, we keep saying we’re going to have an afternoon report. And, every staff member will come and we’re going to sit and we’re going to talk about the residents—but then there’s never time. They’re busy. I’m busy. It’s…yeah.

**Researcher:** So, that has been proposed but it’s…

**Team Leader [02]:** It’s been proposed, but it goes out the window.

**Researcher:** Right. How valuable would that be to you?

**Team Leader [02]:** I wish I could because there’s always something they might have forgotten. If I read out every name, they’d say, “Oh yeah, I saw this” or “I’m worried about this.”

The outcome of not having a scheduled end-of-shift report was that the RCAs tended to share their information with other RCAs, rather than with the team leaders:
**RCA [06]:** Yeah, other care aides. I normally will go to them [the other RCAs], as well as verbally report it to the nurses because sometimes they [the LPNs] are a little too busy and then they try and write it down. Or, sometimes they’re busy on the computer or whatever and you don’t want to bug ‘em.

**Giving up and keeping silent.** The RCAs appeared to be frustrated with not “getting through” to the team leaders and had given up trying to communicate their residents’ care needs. Many of the RCAs reported that when their concerns were left unaddressed, they were made to feel that "they didn't matter" and they asked, "What's the point?" If an RCA found that the LPNs and the RNs had too frequently not responded to a concern, then she would become less likely to attempt to share information with the team leaders.

Another situation that caused the RCAs to not share information with the team leaders was when they found a team leader's response to be dismissive, cold, or disinterested. Many of the RCAs indicated that if they did not like a team leader they would purposefully not share information with her. The quality of the working relationship between the team leader and the RCAs was a significant determinant of whether information was shared. When the relationships did not support an oral exchange of information, the quality of the written records was ever more important.

**Written records of care provision.** In all three facilities, the RCAs' shifts ended with the completion of the daily flow sheets (filled out at the end of every shift, every day) and observation sheets (filled out at the end of the shift during the residents' “observation period” prior to the quarterly, annual, or change of condition RAI-MDSV2.0 assessments). These sheets, which were both referred to by the LPNs and RNs when they completed the RAI-MDSv2.0 assessments, were the primary means by which the RCAs’ information about the residents was formally documented.
**Daily flow sheets.** The RCAs were required to complete flow sheets every shift for every resident for whom they provided care. The flow sheet contained information about a resident’s status over a one-month period; thus, a new flow sheet was started at the beginning of each month for each resident (see Appendix F). These sheets varied slightly among the facilities; in general, they required the RCAs to code information for each resident on the following items: hygiene assistance, bowel and bladder, pain, skin condition, nutritional intake, sleep pattern, and oral care. For the RCAs, the most important item on these sheets was the record of the residents' bowel movements. They all indicated that they took great care in ensuring that this was documented accurately. I found that this was the only item of the flow sheet that was consistently taken up and responded to by the team leaders. In all three facilities, the LPNs reviewed the flow sheets and then created a list of residents who required bowel care on the following day:

**Team Leader [07]:** I check the flow sheets for the bowel care. That is a very important part of the job.

**Researcher:** Right. Do you look at anything else?

**Team Leader [07]:** Only if I see a lot of blanks and it not being filled. Then I’ll kind of go over and nudge somebody and say, “How come this isn’t done?”

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9 I was unable to receive permission to include copies of the flow-sheets used by the study participants. The documents in Appendix F are a revised version of the RAI-MDS flow-sheets. These updated documents are condensed and provide considerably more information to the users than the ones that the study participants had access to.
**Researcher:** But other than that you’re not actually, like, drawing regular information from the daily flow sheets?

**Team Leader [07]:** No, I want to know if they’re having their bowels…

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**Researcher:** How about the daily flow sheets? Do you refer to them, use them?

**Team Leader [04]:** Yeah, quite often, actually.

**Researcher:** Tell me how you use them.

**Team Leader [04]:** On evening shifts, that’s when we do our bowel records, so we go through all of them and that gives us a good chance to just…to look at their bowels.

I did not find that any of the other information recorded on the daily flow sheets produced any observable action by the RNs or LPNs. This may explain why, for the remainder of the items, the majority of the RCAs ensured that the first column (i.e., the first day of the month) was completed, to the best of their knowledge, and then they simply copied what was recorded in that column for the remaining days of the month.

**RCA [06]:** I would do my first day, and I would write down everything that I thought, and I would just copy the rest for the three days [of my rotation].

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**RCA [15]:** …Most of the time, people will just look at the previous column and copy it because…. I’m guilty of it myself, especially when you’re pressed for time.

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**RCA [04]:** A lot of times, if people get confused or if they have four minutes to do their books, they look at the last person’s charting and they put in those numbers.
RAI-MDSv2.0 observation sheets: Seven-day, fourteen-day, and behavioural records. As described previously, the observation sheets were developed specifically for the RAI-MDSv2.0. The RCAs were required to complete them for the residents in their care that were due for an admission, quarterly, annual, or change of condition assessment. The RCAs filled these sheets during the observation period (usually between 7 and 14 days’ duration) immediately preceding the due date for the completion of the assessment. The LPNs or RNs then entered the information documented on these records into the RAI-MDSv2.0. In addition to capturing information related to residents' activities of daily living, the observation sheets included codes related to the residents' physical, psychological, and psychosocial functioning (see Appendix G).  

A brief review of this document revealed that many codes listed were not easily or readily interpreted without direction (e.g., lethargy, self-deprecation, altered perception or awareness). The RCAs in all three facilities reported that they did not receive sufficient training to complete this document. For example:

**RCA [01]:** It hasn’t really been properly explained as to how to fill it out. ...Everyone kind of fills it out differently, I find. Someone told me a while ago, but we never actually had a full in-service, that I attended anyways, on my days, to actually see—and [have

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10 I was unable to receive permission to include copies of the observation sheets used by the study participants. The documents in Appendix G are a revised version of the RAI-MDS Observation sheets. These updated documents are condensed and provide considerably more information to the users than the ones that the study participants had access to.
them] tell us, show us, how we’re required and why we’re required to fill out that sort of stuff.

This evaluation was confirmed by an administrator when I enquired about the allocation of resources for training the RCAs about the use of the RAI-MDSv2.0 as compared with the LPNs and RNs:

**Researcher:** Is it accurate to say that the focus of the implementation resources was on the professional staff?

**Manager [02]:** Yes.

**Researcher:** And very little, actually…

**Manager [02]:** Virtually none.

**Researcher:** Virtually none was given to the actual care aides.

**Manager [02]:** No, because if we…if um…when a resident is admitted, it [the observation sheet] is completed by the aide…but it’s inputted by [name of the LPN responsible for the RAI].

**Researcher:** Right. But the original interpretation of it [the observation sheet] is the care aide’s, right?

**Manager [02]:** Yes.

The lack of training may have explained why the majority of the RCAs indicated that they completed the observation sheets in the same way that they completed the flow sheets—by copying what was previously recorded:

**RCA [16]:** …A lot of people on the RAIs, the seven-day ones, they get—we just copy what the last shift did. Because, sometimes, how they word it and how they phrase it are really hard to think, when you’re at the end of your shift. And, you’re trying to, and then you’re thinking, “Oh, I don’t need to read this [carefully].” But, you’re doing it wrong
and you know it. I’ve sat there and been like, “I can’t figure this out, I’m too tired.” It’s hard.

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**RCA [19]:** You fill it out day one, and you copy it.

The practice of copying whatever was previously recorded on both the flow sheets and the observation sheets was pervasive among the staff, for all shifts, and in all three facilities. The quality of the RCAs’ documentation was dependent on two things: (a) the accuracy of the record for the first day of the month (i.e., the first column) and the observation period and (b) the stability of the residents' care needs, functioning, and activities of daily living throughout the month and observation period.

Of significance, a review of the development process for the RAI-MDSv2.0 care plans revealed that the team leaders that created the care plans relied largely on the quality of the data provided in the flow sheets and the observation sheets. Many team leaders indicated that they had not received training in how to interpret the codes or the items; rather, their training was limited to how to enter the data from the flow sheets and how to create a care plan from that data. This was described by a team leader when asked if she had received training related to the coding:

**Team Leader [03]:** Not for the actual resident observation—the idea is that we’re supposed to rely on the healthcare worker for information. So, we rely on them for doing that. So…the information is there. …I think I got an eight-hour training on how to input it [data from the flow sheets and observation sheets] into the computer and how to take a proper assessment. But the basis of what I’m putting in there is the information that the healthcare worker has given me and what they’ve assessed in the resident.
The quality and accuracy of the data gathered in the documents associated with the RAI-MDSv2.0 was questionable; however, it was this information that provided the foundation for the care plans found in the residents' official health records.

**Summary**

The everyday, every-shift information exchange within the RCFs occurred in two formats—oral and written. The written information that the RCAs accessed, during a work shift, focused almost exclusively on the very basics of bodily care (e.g., bowel movements, dietary needs, and mobility). The same was true of the written information that they were required to provide (e.g., the flow sheets). A review of the everyday institutional texts developed for the RCAs, to both give and receive information, revealed very little, if any, information regarding the residents' unique needs, life histories, and personal preferences. Of significance, the RCAs of the three facilities accessed only two resident-care related institutional texts that were regularly and systematically updated. These were the bathing and bowel care lists. In addition, the recording of the residents' bowel movements was the only care information documented by the RCAs that was systematically reviewed by the regulated professional care staff and used to plan the daily care routines.

Without exception, the RCAs’ preferred and trusted information about the residents’ care needs was shared orally. Consequently, this was the primary means by which the RCAs received and shared residents’ care-related information. It was through the oral exchange of information that the intimacies, preferences, and unique care needs of residents were shared among staff members. The organizational processes in each of the RCFs, however, did not formally enable the oral exchange of this information among the RCAs. Instead, in all instances, this information exchange had to occur “on the fly” either before the workday commenced officially, or during
“found time” within the work shift. Consequently, this information exchange was largely dependent on the quality of the working relationships among the RCAs. The same was true for the exchange of information between the RCAs and the team leaders.

Thus, for the RCAs, the quality of the care they provided and the quality of their work life was largely determined by their personal competence combined with the quality of their working relationships. Accordingly, very little of their day-to-day work was informed by institutional texts. However, this was not the case for the other members of the care team. The LPNs, RNs, clinical nurse leaders, rehabilitation staff, dieticians, and physicians all engaged in work that was heavily textually mediated (i.e., they produced many institutional texts to describe, justify, and direct most of their care contributions). How then did the work of the RCAs fit into an organizational system that emphasized institutional texts, texts with which they had little engagement? To answer this question, I explored the institutional-level texts in RCFs.
Chapter 6: The Influence of Institutional-Level Texts on the Provision of Person-Centred Care in Residential Care Facilities

There is a saying in healthcare institutions: “If it's not documented, it didn't happen.” This maxim permeates almost everything that professional and paraprofessional healthcare workers do throughout the course of a workday. For example, when an institutional text, such as a physician’s order, becomes activated by an RN or LPN, she will engage in a sequence of actions in direct response to the reading of that text. One of these actions is the creation of a new text, most often referred to as a “progress note,” which describes and justifies the sequence of actions carried out in response to the original text. Accordingly, the text, made actionable by a nurse, coordinates and organizes her actions and consistently requires the creation of more replicable, institutional texts. Thus, the text-work-text process in healthcare settings is established and sustained.

In the study residential care facilities (RCFs), the vast majority of these texts were created and stored in the residents' health records—a reproducible, graphic record that was created for each resident when s/he was first admitted. The health record served as a legal document that described the course of treatment and care provided to the resident. Almost all RCFs use a paper-based health record (commonly referred to as the “chart”); however, the government-mandated implementation of the RAI-MDSv2.0, in 2002, required that all RCFs create an electronic health record (EHR) to serve as a platform for the RAI-MDSv2.0. The introduction of the MDS-RAIv2.0 necessitated the creation of two health records for every resident: a paper-based chart and an EHR for the RAI-MDSv2.0.

This chapter explores the influence of institutional-level texts on the provision of person-centred care. I defined institutional-level texts as those texts developed and implemented at the
facility level, and which were not accessed by resident care attendants (RCAs) on a daily basis. I was primarily interested in the texts that contained residents’ individualized care information; consequently, the institutional-level texts I focused on included the assessments of the residents (i.e., the RAI-MDSv2.0, social history, and recreation assessments), the formal care plans, and the care conference reports. It is noteworthy that these institutional-level texts were specifically developed to ensure quality care for residents. Thus, according to the regulatory standards, these texts should have actively influenced the RCAs’ daily work practices. I found that, with the exception of the social history assessments, the RCAs of all three facilities did not engage in any observable activity with these texts. However, I found that the same was not true of the regulated healthcare professionals (i.e., the RNs, LPNs, recreation therapists, social workers, dieticians, and physicians), who frequently referred to these texts to provide and receive residents’ care information.

I began to see the information flow between the RCAs and other members of the healthcare team as if it were divided by a fence. The side of the fence where access to the institutional-level texts was made practical, expected, and necessary, in the day-to-day work activities, was where the regulated healthcare team members were situated. The other side of the fence, where access to the information was not practical, but which was often still considered expected and necessary, was where the RCAs were situated.

With this image or simile in mind, I looked for “gates” in the fence through which information was able to pass. I determined whether the “gates” were: (a) closed when they needed to be open (i.e., there was no practical access to the information); (b) open with two-way flow (i.e., the information flowed easily in both directions); (c) open with one-way and “top-down” flow (i.e., the information flowed only from the regulated healthcare professionals down
to the RCAs); or (d) open with one-way and “bottom-up” flow (i.e., the information flowed only from the RCAs up to the regulated healthcare professionals). Within this fence image, I mapped the residents’ care information flow between the RCAs and the other members of the healthcare team for each of the three facilities. See Figures 6.1, 6.2, and 6.3. The legend for these figures is as follows:

1. Red gates = closed gates
2. Blue gates = open, one way, top-down
3. Green gates = open, one way, down-up
4. Grey lines = connected texts/access to information
5. Dotted red lines = unconnected texts/no access to information
6. Blue and Green lines with arrows = connected text/information access with direction of information flow specified.
Figure 6.1: Facility #1 - Information Exchange Map

RESIDENT PAPER-BASED CHART
- Physicians Orders
- Vital Signs
- Physicians Progress Notes
- Daily Care
- O.T. P.T. Assessment
- Legal Documents

Admission Assessment
- Sensory
- Motivation
- Skin Head to Toe
- Hygiene
- Communication
- Bed Preference
- Nutrition
- Mobility
- Coping
- Behavior
- Mood
- Activity Level
- Prehospital & Weather

Workload Committee
- (WIP) Team

Annual Care Conference
- Multidisciplinary Review
- Action Plan Review
- Social Work Review
- Family Planning Review

Action Plan

Nurse Notes
- Assignments
- Task Lists
- Bath Lists

Report

Living Care Plan
- Meal Plan
- Medication
- Bath Cycle
- Daily Care
- Therapy
- Vision
- Umbilical Care
- Bedtimes
- Allergies
- Bedtime
- Eye Care

WORKLOAD REFERRAL FORM

MDS 2.0 RESIDENT ASSESSMENT INSTRUMENT
- Behavior & Mood
- Medical History
- Dietary
- G.T. P.T. Rehab
- Social History
- Recreation Assessment

RAPS & TRIGGERS
- RESIDENT CARE PLAN

Incident Report
- Purple Dots & Lady Bugs

Daily Flow Sheet
- Bowels
- Nutrition
- Medication
- Activities

Mood Behavior Flow Sheet
- Cognitive Patterns
- Mood & Behavior
- Health Status
- Activity Patterns
- Special Treatment
- Physical Function
- Structural Problems

7-Day Observation
- Closest Patterns
- Meal & Behavior
- Health Status
- Activity Patterns
- Special Treatment
- Physical Function
- Structural Problems

Done Quarterly

E-MAR
- Physicians Orders
- Immunization
- Weight + Vital
- Risk Management
- Therapy Minutes

No Access
- By Care Aides
- By Residents
- By family members
- By team leaders
Figure 6.2: Facility #2-Information Exchange Map
Figure 6.3: Facility #3 - Information Exchange Map
The three figures focus on the key texts that informed the work of care giving in RCFs. As described previously, the majority of these texts were stored in two healthcare records—the resident’s paper-based chart and the EHR. An unintended consequence of the implementation of the EHR was the requirement for duplicate documentation of each resident’s status. This duplication was described by a manager:

**Manager [15]:** So, there’s dual logging [documentation] of everything. They [the regulated care staff members] are doing the paper charting and they are required to do the RAI charting.

I questioned a study participant who oversaw the EHR in Facility #1 about how a system that required dual documentation was maintained. She explained:

**Manager [01]:** The physicians’ orders will always be in the paper chart. We’ll always have a hard copy of those. The pharmacy will always receive a faxed copy of the medication [prescription]. Because they need to see the actual writing or the transcription of the actual writing. The physicians are, I think most of them are, quite adamant that they remain on paper.

The two records (i.e., the EHR and the paper-based chart) were used for different purposes by the various health professions and were not integrated, as described by a manager:

**Researcher:** What would you say is the biggest interface between the computerized record and the paper chart? What connects them? Is it people talking with one another? Are there documents that do?

**Manager [01]:** Not really. Unfortunately, no. They both just…sit alone, on their own. ...They're both needed, but they don't really…interface. No. So, it’s basically people talking.

The figures depict how the texts within these two records were connected and whether the staff members on both sides of the fence had access to the information contained within them.
The figures include both the “everyday” texts and the institutional-level texts and demonstrate the interconnectedness and directionality of the information flow between them.

In all three facilities, I found closed gates, which affected the RCAs’ access to the institutional-level texts that contained residents’ individualized care information. These texts included the pre-admission report or assessment, the RAI-MDSv2.0 quarterly and annual assessments, the annual care conference reports, and the formal care plans.

**Pre-Admission Reports and Admission Assessments**

The process of creating the multitude of institutional texts that eventually were used to create plans of care for the residents began with a pre-admission report (also called a pre-admission assessment or admission assessment). This assessment contained residents’ demographic information, a brief social history, and basic care or needs information that the healthcare team ideally would access before, or immediately following, a resident's arrival.

Access to the pre-admission report was described by a social worker, who served in a managerial role:

**Manager [04]**: So, we’d write up what we call a pre-admission report that goes on a common hard-drive [the electronic health record] so that all the staff can read it...well, maybe, OK.... So, the RNs, the LPNs, the clinical nurse leader, the dietician, the physiotherapist, us [the social workers], the director of resident services...they can read it. It’s something that’s a shared document that everyone can read before the person moves in.

In the above quotation, the social worker's pause and clarification was in response to my inadvertently having raised my eyebrows when she said, "All the staff". In all three facilities, the RCAs did not have access to the residents' electronic health records; thus, they could not access the pre-admission reports or the admission assessments unless a hard copy was purposefully
printed and placed in the resident's paper chart. Hard copies of these assessments were placed in residents' paper charts in Facility #2 and #3:

**Manager [02]:** We allow the aides access to the charts...well, so we should. And, a hard copy is in there.

However, as described by many of the RCAs, even when these assessments were placed in the paper-based charts, they did not consider their access to be practical. For example:

**RCA [11]:** We rely on knowing that information [on the admission assessment] from other staff, mostly...probably because it’s, it’s not like we’re allotted a time [to read them], especially on days and evenings. You’re, go, go, go, you’re done. You don’t have time to sit and read a chart. Maybe at the end of your day… but at that point, you’ve already worked with them [the residents] all day, so you’ve figured it out. You kind of get used to just walking in blind.

The information found on the admission assessment and report varied slightly between the facilities and, in general, included the following: degree of family involvement, behavioural presentation and care risks, health issues, prescribed medications, cognitive functioning, infection status, skin condition, and information pertaining to the resident's activities of daily living. Based on this assessment, the nursing staff were required to develop a written care plan, "that will guide caregivers in protecting and promoting the health and safety of the person in care" (Residential Care Regulation, 2009, p. 31). According to the regulatory standards, this care plan was required to be in place within 48 hours of a resident’s admission. The process of creating the first care plan was described by a nursing manager:

**Manager [11]:** I have to have an admission care plan within 48 hours of the person being admitted, so it is largely cobbled together from whatever the pre-admission assessment says because I don’t know this person and often I haven’t had the opportunity to meet any family. Even the healthcare workers and the LPNs hardly know anything about them...you know, during that two-day period. So, I’m just taking everything on faith, but

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it’s a licensing regulation that we have to have a written care plan in 48 hours. So...I make it up...sort of, based on what somebody else is saying they saw because I really don’t know anything about the resident myself.

None of the RCAs that I interviewed had access to or referred to this initial care plan. Rather, as described previously, the information deemed necessary for the RCAs to know on a day-to-day basis was manually transferred from the admission assessment onto the activities of daily living (ADL) care plan. Consequently, the written information that the RCAs had practical access to was distilled to the most basic of care needs and was primarily limited to care of the body and activities of daily living (e.g., toileting, transferring, sleeping, and eating).

As previously described, the management of Facility #1 had prepared some of their RCAs to be involved directly in the admission process for new residents. The manager of this facility drew one of these specially trained RCAs off the unit, and employed an additional RCA, for four hours, to complete her regular duties, every time a new resident was admitted. The process was explained by an RCA:

RCA [01]: It’s just me and the RN that’s the supervisor [who's] on. And, usually both of us–they [the RN] do the nursing part of it. They have their own little checklist, and then we have our checklist, so we kind of team up together and we’ve also got to fill out their [the resident's] care plan adequately…. So, normally I do that.

Researcher: So how do you share that [the assessment information]? How does that get transferred?

RCA [01]: Usually verbally. More often than not they come to me and ask or I go to them and share.

Researcher: The care aides or the nurses?
**RCA [01]**: The care aides and the nurses too, both, but the nurses don’t usually have a lot of time to ask. They’ll kind of ask, “What are they like?” And I’ll give them a really quick, brief overview.

**Researcher**: So the care aides and the nurses, they typically come to you, because they know that you…

**RCA [01]**: Did the admission.

A significant phrase in this quotation is "we team up together." In addition, it is noteworthy that both the RCAs and the regulated nursing professionals sought information about new residents from the admitting RCA. Thus, this particular RCA was recognized and respected as a full and important member of the healthcare team.

It should also be noted that, in addition to conducting the initial assessments, these RCAs spent four hours with new residents and their family members to assist them in their transition to the facility. During this time, they labelled the residents' personal belongings (including clothing, eyeglasses, dentures, and hearing aids), helped the residents settle into their rooms, introduced the residents and their family members to other residents, provided them with a tour of the facility, oriented them to the facility’s routines, and answered the residents’ and family members’ questions. Thus, in this facility, it was an RCA who was central to the success of residents' admissions to the facility. By placing RCAs in this position, the manager had demonstrated her trust in them to represent the facility, particularly during a critical time in the formation of relationships between residents, family members, and the care team. The family members of residents at this facility unanimously agreed that they had very positive experiences at the time of the initial admission.
RAI-MDSv2.0: Admission, Quarterly, and Change of Condition Assessments

In all three facilities, none of the RCAs had access to the RAI-MDSv2.0 assessments. Indeed, the majority of the RCAs were not aware of the existence of these assessments. Further, no RCA was aware that the data from the RAI-MDSv2.0 flow sheets and observation sheets, which they completed at the end of every shift, were used to complete these extensive assessments and to develop care plans for the residents. It is remarkable that the RCAs did not have a clear understanding of why this information was collected or when and how it was used. For example:

**RCA [01]:** We’ve never actually been sat down and told, “This is where it goes, this is why, and this is why you have to do it, and this is how it affects you.” …It would be nice to have that information because then maybe we would actually desire to do it better. Because right now…it’s just…this useless piece of paper that we’re required to fill out, but we don’t know why. Just sign your initials and carry on.

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**RCA [20]:** After we’ve filled them out my understanding is the RN or the LPN puts the data onto a computer and then we never see them again. And, it might be another three months and that [resident’s] name might come back again to do another week’s observation.

The lack of a feedback mechanism meant that the RCAs were not aware that they were, in fact, contributing to the completion of the comprehensive assessment and the subsequent development of the resident's care plan. However, as previously described, the accuracy of information captured in these documents is questionable because of the pervasive challenges the RCAs experienced interpreting the codes coupled with their lack of awareness regarding how the information was used. This is perhaps why the majority of the nurse managers and team leaders responsible for the initial assessments and subsequent development of care plans trusted an oral
transmission of this information from the RCAs, rather than reliance on these forms. For example:

**Team Leader [03]:** Yeah, and then it becomes a big time-waster when you have to go down and actually get the real information…. We could save ourselves a lot of time if they just did it right the first time, instead of…I get this flow sheet, which doesn’t make any sense because one day they [the resident] can toilet themselves and the next day they’re a total assist for the toilet. And it’s like…I have to go down, I have to talk with somebody, I have to say, “How does this person toilet themselves?” And then we [the team leaders] feel so much stress because we don't have enough time…it just becomes a whole vicious circle.

Another nurse manager explained that, even if she could trust the observation sheets, the completion of a proper assessment took time, nonetheless:

**Manager [11]:** I am responsible for the first full assessment. I use the daily care records [the observation sheets] as little as possible. First of all, often they are not complete. They haven’t filled out every section, or they’re filled out but the information is inconsistent and contradictory and I can tell that something’s wrong. So I go down and talk to the healthcare workers and to the LPNs about what they have seen in all of these various categories.

**Researcher:** So you have to go talk to them?

**Manager [11]:** Yes, I always go talk to them because I don't trust the care records [the observation sheets]. But honestly, I have to say–even if one was done textbook right, you still don’t get enough information to fill out the admission assessment from that document itself. You have to go down and talk to people. You just have to. And more important than…not more important, but equally important is you have to meet the person [the resident]. And, you have to do a hands-on examination anyway. To do the admission assessment, you have to look at their skin, you have to test their balance, you have to look at their gait…you are actually seeing them. A lot of staff have been told,
“Here, you're getting these documents and that will do for the assessment—aside from maybe checking their balance or something.” But, it’s not true. It's not enough.

To conduct a detailed, accurate, full assessment takes time—time that every team leader who participated in this study indicated was not available. As a result, Facility #1 created a permanent, part-time position for a team leader who would be solely responsible for the completion of all aspects of the RAI-MDSv2.0. This was not the case in Facilities #2 and #3, where the responsibility for completing these assessments was shared among the nurse managers and team leaders. The time it took to complete an accurate assessment, rather than simply rely on the information found in the observation sheets, was described by a team leader:

**Team Leader [04]:** Yeah, well [laughter], we’re supposed to be doing those [RAI-MDSv2.0 assessments] as well, but when? And, I totally agree. I think that we should, but I would like more time to be able to do them. Each team leader is assigned six residents, but literally, to do these RAI and MDS and care plans, you need at least two hours per resident, upon admission, to sit down with them and actually do it right.

Unless it is appropriately factored into their schedules, finding the time, in addition to their normal day-to-day responsibilities, to conduct these assessments accurately was challenging for many of the team leaders.

**Care Plans**

According to the Residential Care Regulation of the BC Community Care and Assisted Living Act (2009), a care plan was to be developed for each resident in a manner that took into account the resident's: (a) unique abilities, (b) physical, social, and emotional needs, and (c) cultural and spiritual preferences (81.2.b.). In addition, to the extent reasonably practical, the care plan was to be developed with the participation of the person in care or, if the person was not capable of participating, a representative (81.2.a.i.ii). In most cases, the representative would
have been a member of the resident's family. Further, according to the regulations, the care plan was to include a plan to address each of the following: medication, oral health, nutrition, and recreation and leisure. If applicable, the care plan was to also address falls prevention, behavioural intervention, the use of restraints, and the risk of elopement. These care plans were frequently between four and six pages in length as a result of their requisite inclusivity and comprehensiveness.

Only the RCAs who worked in Facility #2 had access to the formal care plans, which were generated as a result of the completed the RAI-MDSv2.0. However, even though a hard copy of these care plans was placed in a binder, making it practical for the RCAs to view them, only one of the RCAs I interviewed had ever read one. I asked this RCA if she had ever referred to the care plans when providing care:

**RCA [18]:** Never.

**Researcher:** Why?

**RCA [18]:** ...the information is always old and it’s stuff that doesn’t really apply to me. You know, for a quick reference, I’ve got to go all the way back to that book. It’s not going to be up to date, and I have to wade through a bunch of information to get to what I need, so, even though it's there, I never look at it.

I found that the RCAs never referred to these care plans, and the vast majority were unaware that such care plans existed. Having found this, I turned my attention to determining how the care plans informed the practice of the regulated healthcare team members:

**Team Leader [06]:** So, for these care plans, um...I just tick off the little box that says “will be addressed in care plan” and then–because apparently this computer is going to spit out that care plan for that resident, but I’ve never actually seen the care plan come out. But even so, I keep ticking the box that says it will be addressed so...
**Researcher:** So, you've never seen the care plan. But, do you see the RAP [Resident Assessment Protocol] sheets, at least?

**Team Leader [06]:** We have a binder for RAPs and outcomes and it just sits in there and then every time a new one [a quarterly review] comes up, we throw the old one out and keep the most current one. Um, yeah. So, you could technically look at that and see what their issues are. If you looked at their RAPs and their outcomes you could get a picture of what they [the resident] is like.

**Researcher:** But does anyone do that?

**Team Leader [06]:** Nobody does that, no.

**Researcher:** So, would you say it's just paperwork sitting in a binder?

**Team Leader [06]:** Yes, but it's just like before, we used to write care plans in their charts and–I was never good at them–but nobody ever read them anyway, so it was a total waste of time. You would spend hours writing these things and nobody looks at them. The RCAs don’t have time; they’re much too busy looking after the residents to read the chart.

In all three facilities, I found that, similar to the RCAs, none of the team leaders referred to the care plans to direct the care provided. Instead, they most often indicated that, if they needed information regarding a resident’s care needs, they would ask the appropriate RCA directly or refer to the ADL care plan in the resident's room:

**Researcher:** Do you refer to the care plans that are created [from the RAI-MDSv2.0]? Do you actively use them?

**Team Leader [04]:** Occasionally.

**Researcher:** Do they inform your practice, at this point?

**Team Leader [04]:** I wouldn’t say so, no. I usually go to the living [ADL] care plan...
This description was reiterated by an RN who worked as a casually employed team leader and nurse manager in several facilities:

**Manager [11]:** In my role, as a casual [employee], I don’t read those care plans. I read the ones [ADL care plans] that are kept in the residents’ rooms. The thing that I need to be concerned with is, "Are they a swallow risk?" I need to know that right away. So, to have to read through a care plan and navigate all of the information, I don’t have time when I’m doing med[ication]s for 30 to 35 residents, especially on an evening shift. I always say to the staff, "If it [the ADL care plan] is out-dated, could you please let me know?" So, I go to the staff or I go to the room if I really need to know more information about the individual.

**Researcher:** So have you never read one?

**Manager [11]:** I have yet to read one. The only time that I might read one, and that’s a real *might*, is on an evening shift, late at night, after I’ve already cared for the individual and I might have a few extra minutes. And, it’s not even the care plan that I read, it’s the admission physician’s history or the admission sheet that the social worker has provided to you...that's the nitty-gritty, that's the helpful information.

A team leader at Facility #1, who was unaware that the data gathered for the MDS-RAI v2.0 resulted in the creation of care plans for the residents, said:

**Team Leader [07]:** Oh, OK, that’s for the RAI. And, we have an LPN who, that’s all she does. She takes that information and puts it into the computer.

**Researcher:** Into the RAI?

**Team Leader [07]:** Into the RAI.

**Researcher:** And how is that information used? How does it get sent back to the front line?

**Team Leader [07]:** It’s supposed to be sent to a central data centre.
Researcher: No, I’m sorry, I meant communicated back to the care staff, the team leaders, the care aides? It’s going into RAI on the computer and then it’s creating something, right?

Team Leader [07]: Yeah, but we don’t see.

Researcher: You don’t see it?

Team Leader [07]: No, not that I know of. It’s going to a central data centre.

Another team leader indicated that, although she did not refer to the care plans, the clinical nurse leader, who served as a resource for her, did refer to the plans:

Team Leader [01]: Have I used them? I haven’t, personally. But, I know our clinical nurse leader has. And that’s really important, because you know, she’s our clinical nurse leader, she’s our resource, she’s…she’s the researcher. She knows.

In all three facilities, the care plan, which was the institutional text created to both direct and represent the care provided to the resident, was not taken up or activated by the majority of the members of the healthcare teams. It is noteworthy, however, that this care plan, required by government regulation, was the plan that the licensing officers referred to when evaluating an RCF’s adherence to the standards of care:11

11 The BC Community Care and Assisted Living Act named a Director of Licensing and Medical Health Officer, who held powers and duties, under the Act, including the issuance of licences for RCFs, inspection of the facilities, and complaints investigation. These duties were delegated to licensing officers who were responsible for about 1,050 RCFs in the province.
Admission and Annual Care Conferences

When a resident was admitted, approximately six weeks were allowed for the person to “settle in.” During this time, all of the admission assessments of the various professions were to be completed and the first RAI-MDSv2.0 care plan was to have been created. It was at this time that an admission care conference was scheduled. During the conference, a resident’s family members would meet with the multidisciplinary team responsible for their relative's care:

**Manager [02]:** The first conference usually occurs within four to eight weeks of admission. And, it’s that soon after admission so that the family can have some contact with us and see how they [the resident] is settling in.

The purpose and value of the care conferences were described by a team leader:

**Team Leader [04]:** I think it’s good to take a step back and look at the person as a whole. What is our main goal with them? And, what kind of things have we really not looked at and we might need to? Or, just make sure that what we do look at is still being addressed and still being cared for. And the family, if they have any concerns…and just kind of making sure that everyone’s on the same page, really. It's about making sure that the resident’s getting the care that they need.

The team members included in these conferences typically included a team leader, a dietician, a recreation department head, a social worker, a registered nurse, the director of care (or head of the nursing department), and a rehabilitation staff member (i.e., a physiotherapist or occupational therapist). If available, a pharmacist and the resident's physician would attend. Although the potential benefits of assembling a large care team were many, more than one family member recalled feeling overwhelmed and unprepared for the first meeting:

**Family Member [06]:** I was unprepared for the care conference. I was surprised at the number of people sitting around a table when I entered the room. I had no idea that each aspect of [resident's name] care would be represented at the conference. Had I known in advance, I would have put a number of thoughts, concerns down on paper to bring up at
the meeting. Instead, I felt very out of touch as people asked me questions and provided me with information that I wasn’t prepared to absorb. Now, I would like another meeting, after six months. I have lots of questions to ask and comments to make, but I believe I have to wait until the end of the year.

This family member was correct in her belief that she would need to wait a year for the next care conference. Unless there were significant extenuating circumstances, these multidisciplinary meetings occurred once a year following a resident’s admission care conference:

Manager [10]: Every year. When a person comes in, it’s six weeks after admission or close to that…and then it’s every year thereafter.

Many of the family members expressed how important they believed these meetings were and also their frustration that they were held only once a year:

Family Member [05]: You know, it’s once a year…and I know they don’t even have enough time to do that one care conference. But, it’s only half an hour and I’ve finally got everyone’s attention all together, but it’s too short, and I’ve got too much to tell them. And so, boom, then it’s done with and it’s almost like, “Well, we had to do it and now we’ve got that out of the way…”

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Family Member [03]: The annual care conference is, to me, just not enough. Not enough at all.

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Family Member [02]: I think you need to have them, I think once a year is not enough. I think once every six months would be more appropriate, given how quickly people of that age can go downhill...
When I enquired, all of the managers indicated that holding these meetings more frequently would be very time-consuming and operationally challenging:

**Manager [02]:** It’d be nice if we could have them a little more frequently, but I can’t get all the therapeutic services together on more than one day.

To fit these meetings into their regular workday, many attending staff members missed their unpaid rest breaks. The result of this practice was explained by a family member:

**Family Member [03]:** They asked me what I thought, so I was able to give them some feedback, but we were very crunched for time. They were all on their—you know, on part of their lunch break. It was tough.

The majority of the team leaders I interviewed reported that the additional burden their attendance at these meetings placed on their full workdays was worth the benefits they received. For example:

**Team Leader [05]:** Care conferences are great! Care conference day is busy. For example, today I didn’t take a lunch because of the care conference. I think I got mostly everything done. But, I like care conferences especially when the family can be here, because you get the benefit of the family’s point of view. You get their questions, their suggestions; they know that resident very well. They can give you insights into that person that you never would have guessed. And, they tell you things they’re concerned about. You can address them. You get a lot of…you get a lot of information passed on from all the different team members, all in one place. And I like that. If only we could have all the RCAs there too…that would be perfect!

Although these meetings were supposed to represent the multidisciplinary care team, in Facilities #1 and #3, the RCAs either never or very rarely attended the meetings. Without exception, the RCAs indicated that they simply did not have time:

**RCA [05]:** We just don’t have that time. I wish we did, but we don’t.
RCA [03]: If they covered me, I would go. But, I can’t leave my residents for an hour to go to that meeting.

This opinion was reiterated by a nurse manager:

Manager [02]: I would encourage the aides [to attend the care conferences]. But, because of the increasingly complex care required by the residents, it’s really hard to bring them off the floor for half an hour and then for them to go back, and unfortunately— I’m sorry, it’s bottom line—I don’t have the money to be able to pay for somebody to come in [to replace them].

Consequently, in these facilities, the individuals who provided the most direct of care were often not in attendance at a meeting intended to bring the multidisciplinary care team together for a comprehensive evaluation of the care provided. The team leaders from each of these facilities indicated that having the RCAs attend these meetings would have been beneficial:

Team Leader [04]: I had a care conference, yesterday. The family member asked, “How are you handling mom’s incontinence?” I was like, “I don’t know. I don’t change her briefs. I don’t, you know, do that kind of thing. So, I will get back to you on that.” It makes you look stupid because you don’t know anything about that. I mean, am I supposed to know about all 45 residents and how they go? I mean, I should really but…I can’t know and remember, not with everything else I have…

Because the RCAs did not regularly attend the care conferences, I asked a study participant to describe the process in place to ensure that the RCAs’ knowledge of the residents was shared in the meeting:

Team Leader [06]: Well, a lot of it I have…I might ask them about…but…actually, I had the care aide come with me last week, which was great because they see a whole different side, right? They know them [the residents] better than I do for sure!

Researcher: And do the care aides most often come or most often not come?
**Team Leader [06]:** Most often not. Quite often they’re not—they’re too busy. And it’s only in the last little while that we started including them…

**Researcher:** How often do they attend since you started including them?

**Team Leader [06]:** Um, I’ve had twice probably in the past year that I’ve had a care aide come with me.

Several nurse managers informed me that the RCAs should have attended the care conferences because they had more information about the residents' care issues, needs, and routines than the team leaders or nursing supervisors. For example:

**Manager [09]:** The team leader’s been so far removed; they’re hearing things for the first time that they had no idea was even a concern. And, as for me, as the RN, I might have only looked after that resident for a couple of days during the entire year, so it feels totally inappropriate for me to be there…because the families generally don’t even know who I am. And, then we have [the manager] tell us to just fake it, just pretend that we know. A new LPN was voicing her concerns…in being an inappropriate care conference attendee…and was told by [the manager] to just fake it and pretend you know what you’re talking about. Now how fair is that to a new LPN who is trying to go by her standards of practice? And, the family’s going to know, they know their relative better than we do.

All three facilities had a care conference form, which each team member was expected to complete so that an interdisciplinary perspective of the residents and their care needs was captured. In all three facilities, the RCAs did not have access to this document once it was completed.

Facility #2 was the only facility that expected the RCAs to attend the care conferences regularly, yet they were still unable to replace them with other staff when they were in attendance. It is because of the staffing shortage that when these RCAs attended, they were
invited to speak first and then leave the meeting before the other team members and family members shared their information. This procedure enabled them to return to the unit as quickly as possible to care for their residents. In an attempt to capture the knowledge that the RCAs possessed consistently, Facility #2 created a space on the care conference form for input from the RCAs of each work shift. In this facility, the team leader began the care conference by reading aloud what the RCAs from the three shifts had recorded, so as to provide a synopsis of the resident’s care for the family members. After the synopsis was read, each team member was invited to speak. I asked the RCAs who attended these meetings about their experiences:

**Researcher:** Talk to me about the care conferences. Are they useful? Do you feel like you’re listened to? Do you feel like they are valuable?

**RCA [19]:** Mm…oh…hmm. The care conferences…well, that’s another one where we’re always thankful it’s not our day, is the truth. Because they start at 9:30 on Tuesday mornings…. So, for us…we always have a bath usually, unless it’s a Monday. It’s just busy, right?

Another RCA explained why she was thankful when she did not have to attend a care conference:

**RCA [07]:** Yeah, so we have nothing to do with them [the care conference].

**Researcher:** Really?

**RCA [07]:** No.

**Researcher:** But you fill out a sheet…the one the LPN reads and then you can...

**RCA [07]:** Then we do nothing. We don’t talk.

**Researcher:** Oh, so would you say that it’s not really an empowering thing for you, to bring up concerns to share?
**RCA [07]**: Oh, absolutely not.

Another RCA shared why she did not speak during these conferences:

**RCA [13]**: We write everything down on that sheet before the meeting and the nurse reads it for us and then she turns to me and says, "Do you have anything to add?" And I say, “Well, not anymore.” So, why am I there? There’s no point. It’s a waste of time. Um, but besides that—whatever happens out of that meeting—like med[ication] changes, all those goings-on…. We don’t hear a thing about that.

**Researcher**: So, you don’t have any feedback from the care conference at all?

**RCA [13]**: We hear nothing after that.

I found that if the RCAs were going to participate actively in the care conferences, then they needed to believe that their opinions counted, that what they had to say mattered, and that the regulated healthcare professionals would not speak for them. If these conditions were not in place, the RCAs’ attendance at these meetings often produced the unintended consequence of their feeling disempowered, rather than empowered, which diminished their feelings of being valued members of the healthcare team. Further, because the RCAs were unable to stay for an entire care conference, they did not benefit from the information shared by the other members of the care team and the family members, nor did they learn whether the care plan goals had been revised. Consequently, similar to Facilities 1 and 3, a complementary process needed to be in place to ensure that the information from the care conferences was shared with the RCAs. In the other two facilities, which had a start-of-shift report, the information was transferred via a one-line message indicating that a care conference had occurred:

**Team Leader [04]**: I usually write it on report; it’s brief because we only have one line to write—so, I usually write, “Care conference today” and whether there was any family
involved. And then I kind of just give a brief, whatever: “There’s no concerns” or “We’re still managing this.”

It was apparent that the process for transferring information from the care conferences to the RCAs was not effective. When asked if they had ever received information regarding what was discussed or the decisions made at these meetings, they all indicated that they were unaware of any care decisions made as a result of a care conference. The following are examples of the responses from RCAs employed at each of the three facilities:

RCA [16]: We’re not in it, so we couldn’t tell you.

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RCA [08]: No, I’ve never heard anything.

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RCA [12]: Not that I’ve ever heard, no.

Person-centred care requires that residents, or their representatives, directly influence their care planning. When I enquired about residents’ attendance at the care conferences, I was informed that, for a variety of reasons (e.g., limited cognitive or physical ability, family or residents’ preferences, or the facility’s established practice) it was rare for residents to attend their own care conferences. However, I identified one resident who regularly attended these conferences:

Researcher: Do you attend the care conferences?

Resident [02]: Absolutely. Once a year.

Researcher: And tell me about your experience with them.
Resident [02]: They’re wonderful because a lot of times, um, that’s the one time that I hear how I’m doing.

Researcher: It’s how you hear how you’re doing…

Resident [02]: And it’s how everybody else hears how I’m doing, too, in other areas. It’s like everybody’s on the same page with me at the care conference, and that feels good to me. That everybody knows how I’m doing, in all the areas.

Researcher: And do you set goals or…?

Resident [02]: Know what? I haven’t.

Researcher: How about the care plan that’s in the chart? Have you ever seen it?

Resident [02]: I’ve never seen it.

Given that the RAI-MDSv2.0 care plan was expected to represent the multidisciplinary care goals for a resident, it seems reasonable to expect that a review and revision of the care plans, if necessary, would be a primary topic of discussion during a care conference. All of the study family members reported that they had never heard of nor seen a care plan. For example:

Family Member [02]: And I think it would be nice to have more of a plan in place that could be referred to during the meeting.

Researcher: So you didn’t actually ever see the care plan?

Family Member [02]: No.

During my interviews with family members, team leaders, and nurse managers, I found that none of the facilities included a review of the RAI-MDSv2.0 care plan during their care conferences.

Researcher: The care plan is not actually taken into the care conferences in this facility. Why is that?
Manager [02]: I don’t know. …when we first started doing care conferences, way back when, I think we were taking them and we were doing things a little differently anyway. As time progressed, we don’t seem to take them in, and we seem to take even less time. …I think that maybe they [the care staff] know their residents well enough that they know what should be on the care plan, what—what our goals are for the resident or what the resident’s goals are. But, I can’t give you a good answer to that, I’m not sure.

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Researcher: So, are they [care plans] used in the care conferences?

Team Leader [01]: Um…no.

Researcher: No, the RAI care plans aren’t?

Team Leader [01]: No, but sometimes we’ll talk about them. Sometimes they have been, but not ongoing. ...No... actually, we should...but we don’t talk about it.

A potential consequence of not conducting reviews of the care plans during a conference was that concerns raised by family members may not have been adequately addressed. An example of this was described by a family member:

Family Member [05]: I realized, “Wait a minute, didn’t I bring that up on the last conference? Oh yeah, we did—that hasn’t changed.” And it’s been a year! And I checked the [ADL] care plan. It wasn’t updated. So then, my next care conference, I decided to write down everything I talked about, and said, “Let’s do this, let’s do that, and do a check list…”

The system in place inadvertently ensured that the RCAs were joined on their “side of the fence” by both the residents and their family members; that is, the information found on the assessments and care plans was extremely, if not entirely, inaccessible.
The Institutional-Level Texts That Contained Individualized Personal Information

Within the RCFs there were two primary institutional-level texts that focused specifically on the residents as persons with social, emotional, and spiritual needs. These two texts were the social history assessment and the recreation assessment.

**Social history assessment.** Completing a social history assessment of a resident was typically the responsibility of a social worker. It often included gathering information related to such things as a resident’s previous occupation, a description of the family and significant relationships, stories of important or major life events, lists of important places or locations, and achievements. When completed, this institutional-level text contained the most individualized, personal information about the residents that could be found. Only the RCAs in Facility #2, who had permanent assignments (i.e., they worked with the same residents and never rotated to a new section or unit in the facility), had practical access to the residents' social histories. Once completed, a hard copy of the document containing the history was placed in a binder on the unit where the resident lived. An RCA in this facility described the importance of this history:

**RCA [12]:** I think the personal history is one of the most important things that we get. It makes them [the residents] a person. You see all these things that they did—they were a mom, they worked at this place and did all these things. The more in depth someone’s personal history is, the better off we are. I read every bit of it and I usually read it way more than once.

I asked this RCA to elaborate why she found the personal history to be one of the "most important things" she accessed and why it needed to be "in-depth." She explained:

**RCA [12]:** Um, example? [Resident's name]…when he first got here, he freaked out in the bathtub. And I couldn’t figure out why, because he’s the nicest man. He would scream, “Jesus, Mary, and Joseph” and be really upset, and I thought, “Jeez, this is really weird.” I looked in the history and there was nothing there. So I talked to his wife and she
said, “I never thought to put that in there. When he was four years old he got dangled over a well by his father, ran away and never went back home. He lived with his Grandmother.” Now, I can see why lifting him up [using the mechanical lift] and going to put him in water was scaring him. Now, I shower him so I don't have to use a lift. He still doesn't like it. But, now I know why. So, I can do things differently and make it much easier on him; be slower, you know, don’t wash his hair until the very end…

**Researcher:** Because you have that history?

**RCA [12]:** Now I know why, and that gives me a lot more compassion. It gives me some insight into how he might feel. And that’s huge. Like, why is he behaving this way with me? And, same with women that are striking out and stuff. When you read that form and find out they’ve got a history of marital abuse or whatever. Then I know why. When I’m pulling their pants down, why they're getting so upset and maybe fighting me.

In all three facilities, the social workers struggled with completing the residents' social histories. This was explained by a social worker:

**Manager [05]:** One of our goals is trying to do a social history for each person. When they come in we do the pre-admission and there’s a little piece of social history there. We try to collect as much as we can, from family and stuff…at least to get a sense of what their [the resident's] interests are, who was really important to them, and their passions in life, or…you know, just something about who they are as a person, at least something. But, we're not always able to do a proper social history. We don’t have time...[starts to cry]. Like, when I think of the things that we don’t do that I want to do, it kind of makes me sick. It’s just…it makes me want to cry. That can be so frustrating! Because you know, you *know* that person-centred care is what makes a difference. Part of that is having enough really great staff [RCAs] on the unit, but we also have to be able to do our job to help give them the information that they need to know about this person…like, things that they can’t ask this person because of the dementia.
It is important to reiterate that the RCAs did not have access to the residents’ assessments, which were stored in the electronic health record. One RCA explained how it affected her when the social workers were not able to complete and print a hard copy of a detailed social history:

RCA [12]: Yes. That’s the one thing. When people have a small personal history, it makes it really difficult. Sometimes now it’s very limited and most often it’s all filed on the computer now. And this means I don’t have any of it.

Researcher: Now you don’t have access to it?

RCA [12]: I mean, I still usually have that one initial...that will give the brief personal history, and they [the social workers] do try to encourage families to do more, but before [the RAI-MDSv2.0] we could look back at all sorts of different things...but now it’s “chart will be found on computer” or whatever it says in there. And so now I can’t look back.

At the time these observations and interviews were undertaken, Facility #1 did not complete full social histories of their residents, and instead relied on the limited social history section found on the RAI-MDSv2.0:

Manager [06]: We don’t have a real social history assessment here. The social history that they’re using [in the RAI-MDSv2.0] has some information, but it’s not extensive. It does not ask all the things that oughta be asked, or I feel oughta be asked.

When I enquired about whether the RCAs had access to the limited social histories found in the RAI-MDSv2.0, a social worker replied:

Manager [06]: So…you might…you could ask the aides if they’ve seen that…I assume they do. I know the team leaders do. But, whether the aides get to that or not, I don’t know.

I explained to the social worker that if the information was only located in the residents' electronic health records, then the RCAs did not have access to it. In a subsequent interview, the
same social worker described a new initiative to develop a more substantial social history assessment process and to provide the RCAs better access to the information:

**Manager [06]:** So, I’ve been trying to design a better social history assessment and a way to disseminate it…that would both satisfy the needs of the social history form in PointClickCare® [the RAI-MDSv2.0 software platform], which nobody ever sees, right. One of the ideas was to put it [the social history] in the [paper] chart. Um, oh! And, when the resident is newly admitted, the other idea would be for [their social history] to be read at shift change. So, at least one time they would read it, and it shouldn’t be too big a time demand on them, and I think people would be interested, right?

During this interview, the study participant expressed a genuine commitment to ensuring that the RCAs had better access to this information. A family member from the facility reported that she, too, believed that the RCAs would benefit from having access to such information:

**Family Member [02]:** Have you looked at that document that [the social worker] has, called the social history? When he showed that to us, I think it was the same month that you came, in April, I thought at the time that was something I wish we could have filled out when my mom was admitted here because it was more of the whole person. And I thought that the information would have been really useful for RCAs, particularly if you didn’t have family that were coming in all the time. That would give you more insight into the person as a person.

Although collecting a detailed social history is generally accepted as a necessary requirement for the provision of person-centred care (Kitwood, 1997), the practice in RCFs had come under scrutiny because of the requirements of the province’s *Personal Information Protection Act* (PIPA) and the *Freedom of Information and Protection of Privacy Act* (FIPPA). A social worker discussed the idea that collecting a detailed personal history might be a breach of a resident's right to privacy:
Manager [06]: On the one hand, you want nursing staff to know what they need to know to help work with the residents. On the other hand, is anybody really...knowingly, agreeing to giving that personal information to 200 people? It’s not even just about the privacy laws. A lot of times, what I try to do is put myself into the perspective of the resident. So I’m living here...what would I want? Well, do I want my personal information read to a hundred people? I don’t know. I’m a reasonably private person; I don’t know that I would want that. But, I also know that...unless, well, unless people [the nursing staff] know who the individuals [residents] are...I mean, they’re trying to care for them and meet their needs.... So, I don’t know, I struggle with it. I don’t think there’s a real obvious answer.

The impact of the new way in which the privacy legislation was being interpreted was felt by the RCAs in Facility #3, where the amount and type of information collected in the social history assessments had been changed:

RCA [09]: I’ll say it's a vague personal history. I know, over the years they’ve changed that a lot because we used to have a lot of information, but now I guess they felt that it was against the person’s right to privacy and that it might taint the way we view the resident if all the information was in there. For example, if so-and-so beat their wife, it might affect the way I give that person care and treat that person. So, that kind of thing is no longer in there. Now, it’s just very basic: "So-and-so had three children and they’re from Regina."

Thus, in Facility #3, only a brief personal history was included in the residents' health records. A hard copy of the form was placed in the residents' paper-based charts, as explained by an RCA:

RCA [09]: Well, we have a personal history in the chart.

Researcher: Does it get read? Do you have time to go access that?

RCA [09]: When you have time you can go access the chart any time. They’re always there.
Researcher: How often do you have time to actually go and do that?

RCA [09]: Rarely.

I did not observe an RCA accessing a resident's paper-based chart during any of my observation periods. The reasons were discussed with a participant who worked both as an RN casually employed in several RCFs and as a permanent instructor in the RCA and LPN educational programs at a local college. She described why the RCAs did not often read the paper-based charts:

Manager [09]: They’ve been shut out of reading charts.

Researcher: Oh, tell me about that.

Manager [09]: So, some RNs will allow them, some facilities will allow them to read histories. Many facilities say it’s not their right to read a chart. So, therefore, they’re terrified to go and to get them so that they can know more about the residents that they’re getting into the personal space of. And, even if they actually can go read them, they don’t have time.

Researcher: They don’t have time? And that’s the thing, having access to and actually being enabled by having it built into their routine?

Manager [09]: Yes, and to understand what they’re reading. A chart is two inches thick. A chart is put together from most recent history to past history. Care aides are not taught in any provincial curriculum how to gather data from a chart. Practical nursing, yes, it’s built into the curriculum development that they will understand where to access information. So to say, “Well, they have access to the chart, they have access to the care plan within the chart…” that is not really feasible…that’s just…those are words that are on a policy somewhere, but it’s not really feasible.

It is noteworthy that in two of the three facilities, the nurses' stations were purposefully located off the unit, so as to provide a relatively homelike environment for the residents.
Consequently, to access the residents’ records, the RCAs would have had to leave the unit. This may provide one explanation as to why the RCAs rarely read the residents’ charts, even though they were "allowed" to access them.

After finding that the majority of RCAs lacked practical access to the institutional-level texts, I was interested in knowing how they obtained the individualized information typically found within them. I learned that, if available, they could receive this information directly from a resident’s family members. Every family member I interviewed informed me that they shared information regarding their relative's needs, preferences, and social histories directly with the RCAs who cared for them. For example:

**Family Member [03]:** Um, well, the first year when she was in her own room it was easier to have a bit more of a conversation with somebody [an RCA] that came in. So just in conversation we’d be talking and I’d say, “[resident's name] used to have her own business” and “she’s fussy about this or that” or “this is what she likes in terms of programs or food.”

Though the family members unanimously agreed that orally sharing information was the most effective way to transfer this important information to the RCAs, they agreed that it was time consuming and often repetitive. They often felt a need to relay information individually and separately to all of the RCAs:

**Family Member [04]:** I have taken care individually to speak to every single caregiver that takes care of her and talk to them about her.

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**Family Member [05]:** …talking to them. And, I talk to each one of them on every shift. So, that’s why I’m sometimes here a few times on the same day.
The transfer of this information was often dependent upon the quality of the relationship that had been established between a family member and the care staff. The ability of the family members to develop relationships with the RCAs was largely dependent upon their time, energy, personal health, proximity of their own residence, and availability. Further, the unwritten, yet pervasively accepted and acknowledged rule in each of these facilities was that the RCAs could receive information about the residents from their family members, but they were not permitted to share any information in return:

**Family Member [08]:** They [the RCAs] were told by management that they were not allowed to talk to family members. That started at the beginning of the year. So, there has been a little bit of stress factors for [us and them] because—"we’re not supposed to talk to you." So, that’s been a bad issue.

I was informed that this "rule" had been implemented because the RNs and the LPNs had a more "complete" understanding of the residents. It was stated that if every RCA talked to the family members about the residents’ care needs, then the family members would likely receive conflicting and incomplete information because the RCAs were not fully aware of the residents' health issues (e.g., prescribed medications, diagnosis, and physician’s orders). Thus, the managers had implemented the rule to centralize where the family members would receive the information they sought, and to attempt to ensure consistency in the information provided. Although the managers did not mention it, many of the RCAs believed that this rule was in place to ensure that they did not talk to the family members about management’s practices or institutional systems that negatively affected their ability to care for the residents. Regardless of the reasons for the rule, it was another means of creating a one-way gate for communication between the RCAs and the residents’ family members. Notwithstanding the rule, if the RCAs
trusted and cared about the family members, they would willingly communicate with family members, despite the risk of reprisal. For example:

**Family Member [07]:** I know one of the care aides that I became quite close with, I mean she got into trouble for talking to me because one of the other care aides or an LPN or somebody saw her or heard her--overheard us having a conversation. And, you know, she knew that she was being heard, but she didn’t care anymore because she just--you know needed somebody to talk to about stuff. And, she got reported and I heard it sort of through the grapevine somehow that she got into trouble because she was…

**Researcher:** She was talking to you?

**Family Member [07]:** She was talking to me and it’s like--that’s awful.

**Recreation assessment.** It is a recognized standard that RCFs have a recreation department with staff members employed to ensure that residents are able to continue to engage in meaningful leisure (Adams, Arnott, & Boothman, 2008). A strong association exists between aging people’s ability to continue to engage in meaningful leisure and their subjective well-being (Brajsa-Zganec, Merkas, & Sverko, 2011); consequently, recreation staff members often play an important role in determining residents’ quality of life (Adams et al., 2008). In the RCFs, trained staff members were required to conduct assessments of each resident's leisure history, needs, and preferences. The documented recreation assessment was another institutional-level text that contained information specific to the individualized needs and preferences of the residents.

Before the implementation of the RAI-MDSv2.0, the format of the recreation assessments was unique to each facility (i.e., not standardized), and they were stored in the paper-based charts. The RAI-MDSv2.0 included a specific, albeit limited, section that addressed the recreation and social needs of the residents. Subsequent to the introduction of the RAI-MDSv2.0, the recreation department heads used this section of the RAI-MDSv2.0, rather than the paper-
based assessment. Thus, in all three facilities, the RCAs did not have access to recreation assessment information. A recreation director explained:

**Researcher:** I know it [the recreation assessment] is now in PointClickCare® [the RAI-MDSv2.0 software platform], but do the care aides have access to PointClickCare®?

**Manager [08]:** No.

**Researcher:** So is there any way to get that information to them?

**Manager [08]:** No, there is no way that the care aides get it now. Before, they could because they [the recreation assessments] were in a binder [the paper chart].

**Researcher:** Right, but they’re not anymore?

**Manager [08]:** No, so right now, there is no way...except if they had permission to go in and read my assessments on the computer.

**Researcher:** Which they don’t. So, at this point, if they want to find this information out, they need to come to you directly and talk to you?

**Manager [08]:** Yeah.

To some, it may seem insignificant that the RCAs did not have access to information about the residents' recreation and leisure interests. However, for the majority of residents, their ability to attend a recreation program was largely dependent upon how the RCAs organized their routines during a shift. For example, if attending a morning bible study was important to residents, their RCAs would have needed to ensure that their morning care was completed before breakfast. Similarly, if social events in the evenings were what the residents enjoyed, they relied on the RCAs to organize their evening routines to accommodate their attendance. It was the RCAs' schedules that predominantly enabled or impeded the residents’ ability to participate in their preferred recreation programs. If the RCAs were unaware of these preferences, they could
not accommodate them. I found that the sharing of information related to residents' recreation and leisure program preferences primarily occurred verbally.

**Missing Links Between Assessments, Care Conferences, Care Plans, and ADL Care Plans**

I had determined that it was the ADL care plan that was the primary text with residents’ care information to which the RCAs had practical access. However, in all three facilities, I found no obvious connection between the ADL care plan updates and the RAI-MDSv2.0 care plan updates or the information added to the care conference forms. This observation was confirmed in each of the facilities and from the care-team staff members, at every level. The following are examples of responses to my questions about the matter; the informants represented each facility and every level of the staffing hierarchy:

**Researcher**: What is the interface between the RAI[-MDS 2.0] care plan and the living care plan or the activities of daily living care plan that’s on the walls in the resident’s room. Is there an interface? Is there a cross-reference?

**Manager [12]**: No. I don’t think so.

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**Researcher**: So, since there's no link, necessarily, between the care plan that’s up on the wall and the care plan that’s in the chart...I've heard that sometimes these can actually be opposing.

**Manager [11]**: Yes, very different.

**Researcher**: And yet, the RAI[-MDS 2.0] care plan is the one that’s supposed to be…

**Manager [11]**: It’s not. The one on the wall [the ADL care plan] is the important one.

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**Researcher**: So, there’s a living care plan and then there’s the RAI care plan. Do these inform each other? Do they interact?

**Team Leader [03]**: No.

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**Researcher**: Correct me if I’m wrong—there really isn’t necessarily a clear connection between the care plans at the bedside and the RAI care plans?

**RCA [14]**: No. They often can be very different.

A team leader described an unintended consequence of the lack of formal connection between the ADL care plans and the RAI-MDSv2.0 care plans:

**Team Leader [03]**: Like, for example, we had decided we were going to make a [resident] a bed bath [a blanket bath or all-over wash given to a person confined to bed] because she was not comfortable in the tub chair. I’d seen her myself going in looking very uncomfortable in that [tub] bath, so it was time to make her a bed bath. And, so I went, “OK, let’s check the care plan and make sure there’s nothing in the care plan about that…” because sometimes family will have requests and stuff like that. So, I opened up the care plan from, you know, September of 2010 [2.5 years ago], this resident was supposed to be a bed bath.

**Researcher**: Oh, no one knew?

**Team Leader [03]**: No one knew! So, there it was in the care plan, and it was there from two years ago. But, it wasn’t being followed. And, so that was a clear indicator to me that people were not reading them and that the appropriate channels hadn’t been followed with making sure everybody knew that the care plan had been changed.

**Summary and Reflections**

The RCAs in all three facilities rarely if ever engaged in observable activities with the institutional-level texts that contained residents’ individualized care information because they
lacked practical access to them. Consequently, although they were designed to direct care, none of these texts influenced the RCAs’ day-to-day work practices. The one exception to this practice was the documented social history assessments produced in Facility #2. These texts were used by the RCAs and many indicated that they altered their care practices as a result of the information found in those texts.

The care plans were not systematically reviewed or revised during the annual care conferences held at any of the facilities. In all three facilities, the care plans, assessments, and completed annual care conference forms did not have any clear articulation with one another. The information contained in these institutional-level texts, which was intended to direct care, was not consistently reflected in the ADL care plans or the tips for care sheets—the primary texts that the RCAs accessed.

It would be reasonable to assume that the outcome of these odd practices was pervasively poor quality care, and perhaps a total absence of person-centred care. Yet, this was not necessarily the case. Indeed, much (although certainly not all) of the care I witnessed was exceptional, person-centred, and thoughtful, despite key institutional-level texts not actively influencing the care. My observation was discussed with a family member, who posed an important and thought-provoking question:

**Family Member [07]:** So, if the care plan does not, has not, ever directed care, then it begs the question, what is directing it? I mean, is it just purely individual?

My answer to this question was "yes", on a day-to-day basis, it was the individual RCA who predominantly determined whether person-centred care was provided. The RCAs lacked practical access to much of the information found in the institutional-level texts generated specifically to direct their care practices. As a result, the organizational system required them to rely primarily on their individual competence and beliefs when they provided care to the
residents. Based on this finding, I assert that it was the RCAs, themselves, who directed much of the care. Although the RAI-MDSv2.0 required significant resources to complete and maintain, it had little if any influence on the care provided; it was a system disarticulated from the decisions made by the RCAs, the direct providers of care.
Chapter 7: The Influence of Information Exchange between Management and the Care Team: Essential Gates of Communication

The effective exchange of residents' care information between RCAs and other members of the care team is essential to the quality of the care provided. The exchange of information pertaining to organizational systems and management initiatives, which can directly and indirectly affect the daily provision of care to residents, is equally important. It is for this reason that I conducted an analysis of the quality and directionality of the information exchanged between the resident care attendants (RCAs) and management of the three study facilities.

I found both formal and informal gates of communication between the senior members of the management team and the RCAs. I use the term “formal gates of communication” to describe the opportunities or structures created for a specific, pre-determined purpose of information sharing between management and the care team (e.g., committee meetings, staff meetings, memos). “Informal gates of communication” were those opportunities or structures that encouraged and enabled spontaneous, informal, information exchange between the care staff members and management. Unlike the formal gates of communication, the informal gates were used to share both personal and professional information; thus, these gates were used to create and sustain personal relationships between management and the care team.

The care staff and residents' family members indicated that their perceptions of the quality of information exchanged with management was influenced by three factors: (a) the primary format used (e.g., oral vs. written), (b) the directionality of the exchange (e.g., one-way vs. two-way), and (c) the presence of informal, open gates of communication. In this chapter, I first explore the use of written versus oral information exchange between management and the care staff. Next, I discuss how the informal, open gates of communication influence organizational
trust in the workplace. Finally, I close the chapter by examining the differences found between successful and unsuccessful formal, two-way gates of communication between management and the RCAs.

We Need to Talk: Written Versus Oral Communication With Management

A distinguishing feature among the three study facilities was their use of written and oral communication. In Facility #1, the executive director and the director of care spent a significant amount of time out of their offices; they were often found in the various care units. Because they were purposefully available to staff throughout the day, much of the information they shared with, and received from, the staff occurred through oral, in-person exchanges. For example:

**Manager [14]:** Yesterday, I went up and called all the staff together, and I said, “I understand there’s some concern about the layoffs, how it’s going to work, what are the issues that you guys have…blah blah blah….” And, I wasn’t sure [what I was going to say exactly] when I walked in. I had just been asked if I would come up and talk to them, so I did. Another example? Ah, just before you got here I talked with the second floor staff about making sure we keep the common areas clean, neat, and tidy because we’ve got to sell those rooms and we need them [the RCAs] to sell them.

This manager believed that being available “on the floor” and giving and receiving information orally from the staff was the primary means by which she cultivated the organizational trust and teamwork that I had observed. She explained:

**Manager [14]:** It’s being out on the floor. It’s having mini-conversations—so, if I’m walking down the hallway and I see a group of three staff, and they’re obviously engaged in some kind of dialogue around what needs to be done, or their work, I will stop and engage. I’ll stop and I’ll talk with them about, “OK, what’s going on? What do you need from me?” And frequently, that’s how it’s actually put…is “What do you need from me? What do you need from me to get your job done?”
By being out of her office and frequently on the floor where the RCAs were engaged in their work, this manager actively created open, informal gates of communication between herself and the care staff. These open gates of communication enabled this manager to have information acquired directly from the RCAs about what they needed from her (and from the organization) to do their jobs well. As a result, the RCAs who participated in this study perceived this manager as being both receptive and responsive to their concerns. This perception seemed to be closely associated with the staff members' positive morale.

In contrast, in-person, oral communication was not the primary method of information exchange between the care staff members and managers of the two other study facilities. In Facility #2, the RCAs indicated that management relied primarily on memos to communicate with them:

**Researcher:** How would you describe the communication in this facility?

**RCA [13]:** Not so good.

**Researcher:** Um, let's start with management; is there any communication from the top down?

**RCA [13]:** Yeah, right from the top, it’s right from the top. All we get is a lot of memos about this and memos about that—we’ve cut down a forest. We’ve used every tree there is.... Memos everywhere.

I asked another of this facility’s RCAs whether she found the use of memos for communication to be effective:

**Researcher:** Do you read them [the memos from management]?

**RCA [19]:** No.

**Researcher:** No? Um, that's bluntly honest.
RCA [19]: It’s the truth, no.

Researcher: How does it feel to receive memos from management?

RCA [19]: [long pause] Yeah, very empty.

The RCAs of Facility #3 also indicated that communication with management, who primarily used email for information exchange, was equally distant and impersonal. For example, when I asked an RCA how the communication was from management, she replied:

RCA [09]: From management? To me?

Researcher: Yeah.

RCA [09]: [Laughing] That’s hilarious. Well, right now I would say it’s non-existent because I haven’t been on the email.

Researcher: Email?

RCA [09]: It’s all done by email now.

Researcher: Email.... So, but you only have one computer downstairs that the care workers can access. So, how many care workers work on days for instance?

RCA [09]: On days, twelve to fourteen.

Researcher: So fourteen will have access to one computer–are you supposed to look at it during your work hours?

RCA [09]: Oh, well, yeah, but you can’t. You couldn’t if you wanted to [laughter].

Another of this facility’s RCAs explained that, regardless of the logistical challenges of this form of communication, management expected them to have read the information transmitted via email:
RCA [08]: Well, one of the problems is communication from management; all of it comes through email now. And in our jobs, we don’t get the time to really read our emails. If you’re starting at 7:00 [AM] there's no way you have time to check your emails. But, management sends an email and they come down and say, “Did you do this? Well we sent you an email.”

Researcher: And, how does receiving an email with information from management feel?

RCA [08]: A little impersonal, like you’re not quite as important as you might [like to] think you are.

An RCA of this facility expressed frustration because this communication format had reduced management's responsiveness to her questions and concerns:

RCA [10]: Put it this way, I emailed my manager three weeks ago and still haven’t heard any reply.

Researcher: About?

RCA [10]: Job postings. I had some questions to do with the unit and location.

Researcher: Is it typical for care workers to email the manager? Is that how you…

RCA [10]: When you try and talk to her, she’s never around.

Researcher: OK, so you’re doing it through computer, email…

RCA [10]: It’s easier because [otherwise] I come in on my days off and wait for an hour to try and talk to her.

Researcher: To try and talk to her, OK. Does she ever do walkabouts where she actually comes to you on the floor and asks you?

RCA [10]: I’ve never seen her.

Researcher: You’ve never seen her?
RCA [10]: In five years working on that unit I saw her once, and it was to come down to
tell us [she had received a complaint about us] being too noisy on a night shift and then
she went back and sat down [in her office], and that’s it.

Because of the systems in place, neither of these communication formats led to the creation
of open, two-way communication between management and the care staff. In addition, this one-
way communication was often perceived to be disrespectful because it did not encourage nor
enable the RCAs to provide feedback. Many of the RCAs from Facilities #2 and #3 reported that
their managers rarely sought their opinions. For example:

RCA [12]: Yeah, it would be so nice if they [management] asked us, “What do you think
of this idea?” And you know what? Honestly? It makes you feel really good…when
someone asks you. And, if they would just do that a little more often with a lot of
people…I think it would be really, really good. But there’s that [she's] “just a healthcare
worker” out there.

The perception from the RCAs in these facilities was that written, one-way communication
kept them on the “other side of the fence” when facility or unit-level decisions were being
made—even when those decisions pertained to the direct care of the residents. This practice led
some of the RCAs to believe that they were neither valued nor respected as full members of the
healthcare team. This belief was expressed by an RCA:

RCA [01]: We don't have the responsibility of the RNs and the LPNs and the pills and all
that stuff, but I think our job is equally as important. And lots of people don't know that
because they just think that we're professional ass wipers. And really, that's not near what
it is [that we do].

The reliance on written communication, rather than in-person, oral communication,
enabled the managers to remain in their offices during most of their workday. This seemed to
negatively affect the relationships between management and the RCAs. In addition to affecting
the development of positive relationships, because the managers were rarely present on the
nursing units, they rarely observed the RCAs doing a good job. The RCAs reported that the times
they saw managers on the nursing units was when negative feedback was being delivered.
Unfortunately, when asked, the majority of the RCAs reported that they did not regularly or
actively feel appreciated by management. For example:

**Researcher:** Do you feel like you’re appreciated [by management]?


Most of the RCAs indicated that it mattered a great deal to them whether they felt
appreciated by their managers and peers. For example, in response to my question regarding
whether she felt appreciated by management, one RCA replied:

**RCA [03]:** No. You’re just another little pawn in the grand scheme of things.

**Researcher:** So, would things be different if you felt...?

**RCA [03]:** …needed and wanted and respected and appreciated. Yeah, because the
residents can’t show appreciation. Well, most of them can't, you know?

**Researcher:** Yeah.

**RCA [03]:** So, when your manager and staff show that you are appreciated, it makes you
feel like, "I can go to work and I’m actually doing something." Not, "Oh god I have to go
to that place again...and again and again."

Expressions of appreciation for the RCAs most often came directly from the residents or
from the residents' family members. For example:

**RCA [09]:** That, I think, is the worst part of the job. I don’t feel valued [by
management]...but when, you know, you see the difference you can make with a resident,
that is where the value comes in.
Another RCA described how she felt when she received an “illicit” gift of appreciation from a family member:

RCA [12]: Yeah, I just got it today. Um…[a family member] brought me a Starbucks card, which…we’re not really supposed to accept gifts, unless…. It’s a card. It’s under ten dollars, so whatever…

Researcher: Then you’re allowed to?

RCA [12]: Well, even then we're really not...but, she just wrote on the card, “You don’t know how much we appreciate all you do and how good you are at your job.” And I just…it was really nice…because…I don’t hear it very often from management. Sometimes I do. I’m lucky. I’m one of the lucky few. But very rarely do you hear it. So I am…I’m so grateful when I get it…because it confirms, it’s like…I am doing a good job. You know? …because there are rough days.

At the end of my first interview with the first RCA I shadowed, I thanked her for her time and for teaching me so much about her work. She replied:

RCA [05]: You’re very welcome. ...you know what? This is probably…this is probably the only time that a nurse aide feels this appreciated.

Researcher: Really?

RCA [05]: Yeah. It’s not communicated all the time to us. I mean, we hear it, but…it seems like it’s said on the fly…. But…when you put it down on paper, into a study, into a thesis, into…that makes us feel like we have…worth and value.

This sentiment was expressed by many of the other RCAs. Although it was an affirmation that participating in this study was a positive experience, I received these comments as bittersweet commendations. Statements such as these indicate that a lack of appreciation from management further intensified the discordance that some of the RCAs experienced in their work environments.
Informal Gates of Communication

The informal gates of communication were those opportunities or structures that encouraged and enabled spontaneous, informal, information exchange between the care staff members and management. The successful creation of open informal gates of communication seemed to be dependent largely upon the quality of the relationships the staff members had developed with the managers and the trust they had in them. The management of Facility #1 was viewed by the majority of its staff, residents and their family members as respectful, supportive, and responsive. Participants from this facility described high levels of trust in management. It was perhaps because of this that the quality of the inter-professional relationships I observed in this facility was extremely high. The phrase, "we're like family here" was repeatedly stated by the study participants of this facility. When I asked a senior manager at this facility how she helped to cultivate the “sense of family” and trust that pervaded the work environment she explained:

Manager [02]: By trying to be open and respectful of everybody. Every single person should get the same amount of respect as you yourself expect. And we try and encourage them [the care staff members] to be open. If you have a problem, come and see me. Come and tell me your problem, let’s see if we can deal with it. A lot of them have been here for a long time. A lot of people [the RCAs] came in just after they left school, and they’ve stayed here. ...and I just think it’s because we really appreciate them. I think they’re the best bunch of people I have ever worked with, and I’ve been an RN for over 40 years. I just think they’re amazing. So I can tell when they’re down, and they’ll come and speak to me. I probably know more about their private life than I know about my own [family].

The open, informal gates of communication that this nurse manager cultivated helped to create high levels of trust with the care staff. The executive director of this facility, who also
created open, informal gates of communication, discussed the importance of trust between herself and the members of the healthcare team:

**Manager [14]**: I think that’s why I excel in my position, because people trust me, they will follow me, they believe me, and I’m all about that...

Many of the RCAs also spoke about the importance of establishing good, trusting relationships within their teams. For example:

**RCA [14]**: When you’re a care aide you really have to trust the person that you’re working with and build a solid relationship. If there’s conflict between you [and your team], then no one is safe, not you and not the resident. So, I think it’s one of the most critical things to do, is build a good relationship with the people that you’re working with, because it affects the family and resident as well, because if they see us arguing about care, about personalities, about whatever it is…they don’t feel comfortable with us.

The RCAs informed me that trust was essential to the development of reciprocating teams (i.e., teams of staff members who actively took care of each other as well as the residents) and that reciprocating teams were essential to RCAs' resilience. The active presence of reciprocating teams was a feature that distinguished Facility #1 (where reciprocating, supportive teamwork was observed throughout the facility) from Facilities #2 and #3 (where teamwork, albeit present, was sporadic, at best).

It is noteworthy that Facility #1 had the most challenging staffing ratios of the three facilities (i.e., each RCA was responsible for more residents to care for per shift as compared with the RCAs of the other two facilities) and a difficult physical environment (e.g., no overhead ceiling lifts, the greatest number of four-bed wards, and the most limited storage area). Yet, the presence of informal, open gates of communication between staff and management seemed to reinforce the creation of both trust in management and reciprocating teams, which enabled the
RCAs to remain resilient in their day-to-day work, regardless of the workplace adversities that they faced. This was described by a member of the management team of Facility #1:

**Manager [13]**: But, as far as a workplace, [facility name] staff are awesome. It’s an older building. A lot of the bells and whistles and the technology aren’t here because of the type of building it is–no overhead lifts, no storage, small hallways. You know, it’s challenging every day. But the staff just pull together. And it's because of the good relationship from a management level to staff—the dialogue is ongoing…and the staff are awesome. Incredible. Incredible amount of pride in what they do.

The sentiment expressed by this manager was reiterated by *every* staff member at every level of the hierarchy within the facility. An example came from an emphatic team leader:

**Team Leader [07]**: And I think all of us feel that, you know, we're like a family here. Um…it’s heavy. I've got 47 residents and that's more than any other facility that I know of. And, I’ve chosen to work here rather than other places that are closer and possibly newer and shinier. I come a long way to go to work here because I love working here. I love this establishment. I love the people I work with. I have the best director and administrator that I’ve ever worked with. And, we’re talking from the East Coast all the way to here. We have a lot of staff who have been here for 20 and 30 years. That tells you a story right there. I…I want to retire from here. And...if I needed a facility to put a loved one in, this would be my top choice.

Similar sentiments regarding their management were not expressed by the staff and residents' family members of Facilities #2 and #3. In each of these facilities, the staff and residents' family members indicated that they did not have access to open gates of communication with management. Rather, they spoke extensively about the negative outcomes that occurred as a result of managerial communication practices that diminished their trust in the organization. An RCA from one of these facilities provided this example:

**RCA [12]**: People [the RCAs] are really angry here right now.
Researcher: They are very angry here right now. Do you know why?

RCA [12]: Management not telling you stuff, management not listening, is what I’m gathering…. In the last couple years, I’ve seen some really upbeat healthcare workers [RCAs] get really bitter, really angry at management.

An RCA from the other of these two facilities spoke about "another" RCA who actively avoided staff meetings with management for similar reasons:

Researcher: When I was first here, there was a care worker that avoided the staff meeting because they [the meetings with management] were so upsetting. Tell me about that...

RCA [08]: Yeah, she felt she wasn’t ever listened to and so she gets too upset when she attends those meetings [with management]. So now, she refuses to go.

Researcher: And she actually bathed one of your residents instead...to be able to avoid going?

RCA [08]: So, then I could attend the meeting, yes. Then I just tell her what was said and that's better for her.

The RCAs and residents’ family members of Facilities #2 and #3 spoke extensively about their desire for management to be more open, transparent, and honest in their communication. They indicated that the lack of transparency damaged their trust. This appeared to be especially important to the RCAs because when asked, "If you could pick one thing that would help make this job better, what would it be?" they often spoke about improving communication with management. Two RCAs from one of these facilities provided these examples:

RCA [12]: If everyone would be honest, like truly honest, it would make a huge difference. If management would communicate better and be more open!

*******
RCA [13]: I, really, I think it would be better communication with management. You know...honest communication. There’s a lot of…um... I don’t like dishonesty. That really bothers me. Especially when I know you’re lying. ...and no one feels they [management] are honest with us.

A family member from the other of the two facilities provided this example:

Family Member [07]: [Manager's name], just so, does not want us [the family members] there. She does not want us to talk with her. She doesn’t want us to have a voice. She doesn’t want to tell us anything. She–I don’t–I am just astounded at…[laughs]. Like, how do you–how do you manage this way?

When I asked this family member to explain the situation by giving an example, she described the lack of transparency from management regarding an initiative that had been implemented just before the commencement of this study:

Family Member [07]: I said to [manager's name], "You need to give us a better explanation of these changes that are planned because I understand you’re going to do this [implement a new staffing rotation]." And she said, "No, we don’t. We haven’t got any other changes planned." And I replied, "OK, well the staff seem to think you do." And she was like, "No, we’ve said absolutely nothing." OK, well, saying absolutely nothing and actually not doing anything are two different things. So, I knew I was kind of lied to because I had heard it from the staff and that's why I took it [straight] to her. And, then, within no time they had changed the rotation. So, again, it’s just...there's not much trust.

The organizational initiative that the family member was describing was one that directly affected staff rotations and assignments. The initiative required staff members to rotate throughout all units of the facility and to work a “blended” shift rotation (i.e., work both day and evening shifts). Before this initiative, the RCAs had worked in specific sections of the facility on permanent, non-rotating shifts (i.e., exclusively day, evening, or night shifts). The family
members and staff of the facility reported that the initiative had resulted in negative effects for both the staff and residents. In addition, they found that management had been dismissive and unresponsive to their concerns. For example:

**Family Member [07]:** She came to us and went on and on telling us how very successful these changes are. And we're telling her, "No, it’s not successful; it is not a successful initiative. We are trying to tell you that." She wasn’t listening. In the end, she did sort of open up a little door to ask us if there were other things we needed that could help make it better. I said to her, "You know what would be really helpful is—could we just have a list of who’s working on a shift? Could we just know during this time period these four people or three people are working and where they are working so that I know when I need something for my mom, I know who to go to, to ask. Because if the staff are always moving around now we, as family, need to know who to go to when we need help or have questions.” She [the manager] thought that that could be possible; she thought that [the RCA assignments] could probably go up [posted on an accessible bulletin board]. Well, I don’t know, that was back in July, when you came.

**Researcher:** That was two months ago.

**Family Member [07]:** Nothing’s happened. The only thing that’s happened is that any trace of anybody’s names anywhere in that place have all gone away apparently because of some privacy issue and I don’t know what the hell that’s all about.

This initiative directly affected the provision of care in the facility. However, the care staff, the residents, and their family members reported that they had had "no say" in whether it should be implemented, how it was implemented, or in the evaluation of the outcomes that occurred as a result of its implementation. The staff and family members did not believe that there was an open gate of communication through which they could openly give and receive information about this initiative. The absence of open gates of communication with management directly affected the level of organizational trust experienced in this facility. Furthermore, the disempowerment
experienced as a result of the staff and family members’ perceptions regarding the way in which the initiative was implemented seemed to have severely damaged the morale in the facility.

**Formal Two-Way Gates**

Formal gates of communication were used by the managers of all three facilities to exchange information regarding facility-wide, organizational initiatives and systems that would have a direct impact on the provision of care (e.g., quality improvement initiatives, policies and procedures, standards of practice, scope of practice, staff scheduling). Often times, these formal gates of communication were purposefully and exclusively one-way (e.g., the use of a memo to announce a new initiative, policy, or procedure). At other times, the management actively and purposefully worked to establish a formal gate of communication that was two-way (e.g., a committee that included both senior managers and care staff members). When the formal gates between management and the healthcare team were open in both directions (i.e., two-way) it served to ensure that the provision of care was both high quality and safe. Consequently, I defined a successful, formal two-way gate of communication as one that enabled information to be exchanged freely and openly in both directions (i.e., top-down and bottom-up). For a formal two-way gate to be considered “successful,” in my evaluation, it had to have an effective feedback loop through which the individuals on both sides of the fence had equal access to information pertaining to the outcomes that occurred as a result of the initial information exchange.

Similar to the informal gates of communication, the presence of successful formal gates was largely dependent upon management practices that consistently demonstrated respect of, responsiveness to, and recognition of the RCAs (and the other healthcare team members). These two-way open gates, in effect, enabled the RCAs to have genuine access to the “other side of the
fence” thereby enabling them to be empowered and equal members of the team. Unfortunately, although many efforts had been made, not all of the facilities had established successful, formal two-way gates. The following provides a description of two successful, formal two-way gates and two attempted, but unsuccessful, formal two-way gates.

**Successful formal two-way gates.** Only two successful, formal two-way gates of communication between the RCAs and management were observed. Both were observed in Facility #1. It is noteworthy that Facility #1 was the facility that had open, informal gates of communication and ensured that the RCAs actively participated in the residents’ admission process.

*A workload committee.* Facility #1 had a workload committee of which the RCAs were active members. The responsibility of the committee was to ensure that each of the sections (i.e., groups of residents) to which the RCAs were assigned were comparable in their workload. If an RCA had a concern about the workload in a particular section, compared with another section, she could take the concern directly to the workload committee. The executive director of this facility explained how the committee worked:

**Manager [14]:** Well, it’s essentially several RCA volunteers—they receive a concern from a care aide or group of care aides—they talk to their peers—they identify what the issues are, where the problem areas are. Then they represent their peers in a meeting with myself and [the Director of Care]. We discuss it and then we troubleshoot some solutions. That’s essentially it.

**Researcher:** That’s it. And the workload committee meetings, they're not on a set schedule? It’s as needed…

**Manager [14]:** Ad hoc.
Researcher: It’s ad hoc. And so a care aide on the floor can initiate a workload committee meeting happening…

Manager [14]: Sure, of course.

This committee was successful in large part because it enabled the RCAs to have direct and meaningful access to the senior members of the management team. In addition, the views and opinions of the RCAs were actively sought and referred to when working towards solutions that would subsequently be implemented in response to the concerns brought forth directly from the RCAs.

Workplace injury prevention teams. A workplace injury prevention [WIP] team\(^\text{12}\) was established through a corporate initiative of the for-profit company that owned and operated Facility #1. The WIP team was responsible for responding to all risks associated with the lifting and transferring of residents. The mandate of the WIP team was to reduce the number of musculoskeletal injuries sustained by care staff members as a result of unsafe care practices. According to the healthcare team members of Facility #1, the WIP team was very successful in achieving its aims. For example:

Manager [02]: What made the greatest improvement in our decrease in injuries on the job is the…[WIP] team because we have accurate assessments as soon as a care aide feels that a resident has deteriorated and needs to be reassessed. The…[WIP] team has care aides on it so they can go and assess the resident at all different times and shifts. They will also often try to get one of the…[WIP] members to do the assessment who is

\(^\text{12}\) The names of the "Injury Prevention Programs" in Facilities #1 and #3 have been changed to ensure the anonymity of the organizations.
working the same shift as the person [RCA] who put in the referral. So they can see together how to solve the problem…

A member of the WIP team explained how the team worked:

**RCA [21]:** Here’s an example of somebody, it was a gentleman whose room is very crowded. They [the referring RCAs] were having trouble getting him changed during the night, so I went up, I did the assessment, and I’ve written a reply for them [the referring RCA]. So that they know that we’ve addressed it, and we’ve replied to them. And they [the referring RCAs] always sign their name, and print their name, and where they’re working, so that I know who to respond to.

**Researcher:** Wow, that's a great feedback loop!

**RCA [21]:** Yeah, and now that they [the RCAs] have seen how it works, they know that I’m not just doing it for the resident, I’m doing it for the care aides, too. And it's working because I know for a fact that we have way fewer WCB [Workers’ Compensation Board] claims now.

The executive director of this facility explained why she had made the decision to include the RCAs on the WIP team:

**Manager [14]:** She [the RCA you interviewed from the [WIP] team] runs the…[WIP] team. She is the chair of the…[WIP] team.

**Researcher:** Oh, OK, I didn't know that. I interviewed her. She’s very committed.

**Manager [14]:** Yeah, she’s very committed. I think she’s the driving force. The thing is, I think, from a manager’s perspective, if you get somebody who wants to, is able to, is committed to, you just give it to them and get out of the way. You say to them, “You do it” and then you let them do it!

This manager, however, did not simply “get out of the way.” Similar to the RCAs who assisted with the admission process, the RCAs who were key members of the WIP team were
compensated for their participation and were not asked to do the work in addition to their normal
duties. An RCA explained the WIP team’s process of completing quarterly assessments of all
residents and their rooms to update the ADL care plans. When it was time to conduct these
assessments, the RCAs did not do them “on the fly,” but rather were given a day to complete
them:

RCA [21]: Oh yeah, we get paid. They give us a day off with pay, well, not a day off
but–they give us a paid day to do this.

Researcher: So they are relieving you four times a year to do these assessments?

RCA [21]: Yeah.

There were two factors that were particularly remarkable about the WIP team and the
workload committee. First, the RCAs were able to make referrals directly to these teams. They
were not required to rely on a regulated healthcare team member or supervisor to activate a
response to their concerns (i.e., they did not have to inform a team leader of their concern, who
would then complete a referral on their behalf). Second, both of these initiatives were managed
by and for the RCAs. The open, two-way gates that these teams created enabled the RCAs to
have full and direct access to the “other side of the fence.”

Unsuccessful formal two-way gates.

Injury prevention program. Facility #3 had an injury prevention [IP] program that was
similar to the WIP team described above. The goals and objectives of the IP program paralleled
the WIP team's objectives. Of significance, the program also had representative leaders who
were RCAs. However, as described by an RCA, the outcomes of this initiative had not been
successful:
Researcher: Does it work? If you go to her [the…[IP] program team leader, who is an RCA], do you get feedback? Do you find out? Is there good communication?

RCA [10]: Depends which…[IP] program person you deal with.

Researcher: Oh, OK.

RCA [10]: There is one that–it’s just an extra paycheque so it’s not really anything, and then there’s the other that tries to do what she can, but she can only do so much. Right?

Researcher: But, it’s–would you say that it’s a beneficial thing to have a colleague, a co-worker that you can go to directly and that hopefully you get a feedback loop from?

RCA [10]: Not really.

Researcher: No? How come?

RCA [10]: It’s just a middleman. Another middleman to another giant scheme of things. It’s just another person that you go to that has to still relay it to that manager that you could’ve relayed it to yourself, or the team leader, or whatever.

Researcher: Oh, OK, they [the IP program team leaders] are not really empowered to make the changes like that [finger snap] are they?

RCA [10]: No, not that I’ve ever seen.

In this facility, the IP program team leaders were not entrusted with any power to respond actively to the concerns of the referring RCAs. Rather, they were powerless intermediaries within the organizational hierarchy typically found in RCFs.

Team huddles. Facility #2 had recently implemented “team huddles” for the purpose of bringing the healthcare team members together and of giving the RCAs a voice as they addressed their concerns regarding residents in need of palliative care or residents who were exhibiting aggressive behaviour. It is noteworthy that it was the manager of this facility that led the team
huddles that addressed issues associated with residents engaged in what was termed "responsive behaviours." Thus, the RCAs had direct access to the manager during these meetings. The goals and purpose of these team huddles were described by a manager:

**Manager [12]:** What it did was it gave healthcare workers a voice. It got healthcare workers, LPNs, RNs, and us [management] together once a week, per a unit, to really talk. …and the most important thing about huddles is…healthcare workers have a voice.

The RCAs’ impressions of these huddles varied. For example, one RCA found them to be very positive:

**RCA [18]:** Yeah. When they do it, you go through the whole unit and they look at every resident. And that’s a time that you can really voice your concerns because, before these huddles, you would have to track somebody down. If you had an LPN that doesn’t really have the ability to make decisions, then you’d have to track down the one RN in the building, and you know, who knows what kind of day she’s had or how busy she is. And, she may not even care if she’s [employed on a] casual [basis]. So, you would have to track down somebody who cares to fix this problem that you’re seeing with a resident every day, and it was hard.

Other RCAs did not evaluate these huddles positively—first, they did not believe that there was an effective feedback mechanism that informed them of the outcomes of the meetings; second, they did not feel able to initiate concerns during the meetings; third, they often felt spoken for, or spoken over, by other team members. These experiences were described by two RCAs:

**Researcher:** Right. Um, talk to me about the huddles. Do you find them useful? Do you feel like you’re heard? Do you feel like there are outcomes as a result of them?

**RCA [23]:** I’ve never seen the outcomes of any of the conversations that I’ve been at.

**Researcher:** So, once they do a huddle...
RCA [23]: That’s it.

Researcher: If a decision is made, you don’t feel like there’s a feedback loop to tell you what happens after that?

RCA [23]: No, not after that…

Researcher: Do you feel though, at least, that it gives you an opportunity to state your opinion, to verbalize it to the team?

RCA [23]: Well, do you want to know what I’ve found, the huddles that they’ve been doing, they come in and they tell you what they’re going to talk about. Originally, we were under the understanding that the huddle would happen if we had things that we wanted to talk about.

Researcher: So, concerns that you would be able to initiate…?

RCA [23]: That we would bring up, yeah. But it’s not that way. They pick stuff that they want to talk about.

Researcher: So you don’t feel like it’s empowering…

RCA [23]: No!

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Researcher: Do you feel like the huddles give you a voice, an opportunity to have a voice that you didn’t have before?

RCA [24]: You know, they probably do…I mean…as long as it’s…being received.

Researcher: Received?

RCA [24]: When I get to speak, most of the time what I’ve said is pretty well received. …but like I said, my issue is when other people in other areas answer questions about care for me. Those are my questions and I should be answering them.
Researcher: So, are you feeling like other team members speak for you or instead of you?

RCA [24]: Yeah.

Researcher: And, how often does that happen?

RCA [24]: All the time.

Researcher: Tell me about that.

RCA [24]: They answer direct care questions for healthcare workers, when they are not the ones doing the direct care. Like the LPN that was in the huddle was saying that [residents' names] are much better for care now. [pause] I said, “Really?” I said, “No…actually they are about the same with care. They are just a challenging as before.” She says, “Oh, no, no, I can give med[ication]s much easier now.” And I said, “But giving med[ication]s and doing peri[neal] care are two completely different things.” When they’re answering questions that should be answered by me, it's not really getting everyone's perspective. And same with rehab[ilitation therapy]. She answered questions for me yesterday and talked about how someone was doing so much better. And I thought, “You’re only seeing them to walk them to an activity, which is a valuable thing, too. But you can’t say because of that the care is easier because care is always going to be a little trickier than walking someone to an activity.” When I'm giving care, I’m in their space, right?

Researcher: Very much, you're in their very private, personal space.

RCA [24]: Exactly. So, sometimes, I just get really frustrated during these meetings.

There were two differentiating features between the successful and unsuccessful formal two-way gates. The first was that successful, formal two-way gates enabled the RCAs to have their concerns, opinions, and ideas heard by the people in senior management positions. Where there were unsuccessful gates, the RCAs did not consistently feel heard and did not perceive the
information sharing to be “open” or truly “give and take;” rather, it was seen to be more
directional and one-way. A second distinguishing feature of these gates was the consistency in
follow-up to the issues brought forward. In the successful two-way gates, the RCAs expressed
satisfaction with the amount and timeliness of the follow-up to their concerns. The same was not
true of the unsuccessful gates.

The distinguishing outcome between the successful and unsuccessful two-way gates was
whether the RCAs felt empowered as a result of them. Unfortunately, the presence of
unsuccessful two-way gates was not benign because they resulted in the RCAs feeling and
expressing both disempowerment and a lack of trust in management. Consequently, the presence
of unsuccessful two-way gates produced negative outcomes associated with workplace morale.
This finding led me to ponder the possibility that exposing the RCAs to an unsuccessful attempt
at a formal, two-way gate may have produced worse outcomes in morale than not overtly
attempting a formal, two-way gate at all. In other words, if the information was truly only able to
flow in one direction, the managers would have been well served to openly acknowledge it,
rather than trying to claim that the opposite was true.

Summary and Reflections

This chapter broke from the original trajectory laid out for this institutional ethnography;
had I followed that trajectory, I would have proceeded directly to exploring the boss texts
following an examination of the institutional-level texts. That was the intention as I began
writing. However, I found that the analysis presented in this additional chapter was required for
two reasons: first, to more fully understand how information exchange between management and
the care staff members influenced the provision of person-centred care, and second, so that a
shimmer of light upon a potential "way forward" could be produced as a result of this study.
On more than one occasion during my data collection and analysis, I struggled with not becoming dispirited by what I found. I was determined to not allow myself to come to the conclusion that the "system was simply too broken to be fixed," a conclusion drawn by William Thomas (Hayeden, 2004), founder of the Eden Alternative and considered by many to be a pioneer of the long-term care culture change movement. Though many times I wondered about the accuracy of Thomas’s statement, I would not allow myself to come to the same conclusion because I believed to do so would have meant giving up on the RCAs, the residents, and their family members.

Finding successful, open two-way gates of communication between management and the RCAs provided the "light" that I was determined to find. These gates were essential to both the quality of care and quality of work-life in RCFs. Thus, I believed that their importance in the workplace required that a comprehensive description be provided of what enabled their success.

The success of the gates was largely dependent upon the primary format used by management to share and receive information. The use of oral, in-person communication was unanimously preferred by the study RCAs. Oral communication helped to create and sustain informal, open gates of communication between care staff and family members with management, and these gates were essential to the level of trust within the organization. In addition to the creation of trust, the presence of informal gates of communication was a prerequisite to the success of the formal, open two-way gates of communication between management and others of the healthcare team. Finally, unless the formal gates of communication were open in both directions and had an effective feedback loop, the care staff did not feel empowered, nor did the gates positively affect the level of trust felt by the staff members towards management.
Whether the RCAs felt empowered as a result of the gates of communication with management was a distinguishing characteristic between those gates that were successful and those that were not. It is perhaps because of this that the presence of successful, two-way gates of communication seemed to be linked with the care staff members' morale in the facility. The staffs' morale in the respective facilities was in turn associated with the presence of supportive and reciprocating teamwork, and it was teamwork that the RCAs repeatedly indicated most influenced the quality of their work life. Therefore, the importance of open gates of communication between management and the care team should not be underestimated.

The majority of the care staff and the residents' family members I interviewed at Facilities #2 and #3 presumed that the blame for the presence of unsuccessful two-way gates should be placed squarely and solely on the shoulders of the managers. That presumption was erroneous. I found that the managers of all three facilities were equally committed to improving the lives of their facilities’ residents. They also were equally dedicated to their work; each worked many more hours each week than their scheduled 40 hours. They cared greatly about the residents, the staff, and the family members. In summary, all three were doing the very best that they could within their positions. Thus, to more fully understand the observed differences in the managers' exchange of information within their facilities, we must widen our lens to look beyond the institutions and to explore the “boss texts”—those translocal texts developed outside of the particular institutions and which were implemented in all of the provincial residential care institutions (e.g., the relevant laws, regulations, and standards of practice).
Chapter 8: Boss Texts: Explicating the Ruling Relations That Influence the Provision of Person-Centred Care in Residential Care Facilities

In Smith’s (1990) analysis of the everyday world, she elucidated the relations of ruling—the social relations that dominate people, the forms of knowledge that develop, and the organizations that administer and manage them. She characterized ruling relations as being determined by power within a social structure and composed of the complex set of rules by which the world is organized. These formal rules may or may not be fully known by the individuals within a local setting (or institution), but they ultimately affect their work activities and experiences. Within an institutional ethnography (IE), explication of the ruling relations is accomplished by a comprehensive examination of important “boss texts”—the translocal texts developed beyond the local institution, and implemented across multiple settings. Within healthcare settings, these boss texts include such things as laws, regulations, corporate initiatives, and standards of practice, each of which are powerful outside forces.

The boss texts I examined were those that influenced resident care attendants’ (RCAs’) access to information and directly or indirectly influenced their ability to provide person-centred care. I have shown that the RCAs lacked practical access to written, personalized information regarding their residents’ care needs and preferences. In addition, many RCAs lacked access to organizational information that could affect their daily care practices. Accordingly, the key boss texts that influenced the RCAs’ access to organizational information and residents’ care information are explored here. In an attempt to present a balanced perspective, I discuss both the positive outcomes as well as some of the unintended consequences that were the result of the activation of the selected boss texts.
The aim of IE investigations is to reveal points of disjuncture with governing processes and practices (Cambell & Gregor, 2008). A disjuncture has been described as that moment of disquiet between the actuality of a person’s experience and the actionable institutional realities (Smith, 2005). Within an IE investigation, a disjuncture is believed to be imposed by boss texts, which govern the structure and organization of the replicable texts used by workers of an institution. Thus, the unintended consequences are examined through an exploration of the disjuncture associated with the boss texts.

Access to Organizational Information: Exploring the Boss Texts That Influence Gates of Communication Between Management and Care Staff Members

The regionalization of health care in British Columbia (BC) significantly affected the autonomy of residential care facility (RCF) managers and, in turn, influenced their exchange of information with the care staff members who report to them. In BC, regionalization of the healthcare system was recommended by the Royal Commission on Health Care and Costs in its 1991 report Closer to Home (BC Royal Commission on Health Care and Costs, 1991). Two years after the report’s publication, the Government of BC announced a health reform initiative, New Directions for a Healthy BC, which marked the beginning of healthcare regionalization.

BC’s regionalization took place in stages, and its successive iterations resulted in considerable restructuring and reorganization of health service delivery and administration (Weaver, 2006). A central feature of this regionalization was the movement away from local governing bodies that had been responsible for the administrative decisions of a single healthcare institution (i.e., local hospital boards) to governing bodies that were responsible for the administrative decisions of an ever-increasing number of healthcare institutions (i.e., boards of health authorities, which would oversee multiple acute, community, and residential care
institutions). The final restructuring occurred in December 2001 when the BC Government merged 52 health organizations and regions to form a new governance and management structure of five large regional health authorities organized by geographic zones (i.e., the Fraser Health Authority, Interior Health Authority, Northern Health Authority, Vancouver Coastal Health Authority, and Vancouver Island Health Authority) and one provincial health authority (which coordinates or provides provincial programs and specialized services, such as cardiac care, cancer care and transplants).

Immediately following the creation of the health authorities, the BC Ministry of Health (BCMOH) introduced a population needs-based funding (PNBF) model, which allocated funding to the authorities based on the characteristics and utilization patterns of the residents living within the various regions. In addition, the BCMOH established formal performance agreements, which outlined expectations for the delivery of patient services, health outcomes, and healthcare spending. These performance agreements were constructed as three-year “rolling” documents and were updated annually between 2002/03 and 2004/05. A central feature of these influential boss texts was the requirement for each authority to produce a balanced budget by 2004/05. Consequently, fiscal restraint was a major focus during the first three years of the health authorities’ existence (Weaver, 2006).

**Some positive aspects of regionalized health care in BC.** Proponents of regionalization stress that the restructuring of the province’s healthcare system has resulted in better continuity and standardization, improved cost saving measures, reduced duplication of support and administrative services, and improved accountability of service providers (Hawkins, 2001). Similar beliefs were held by the senior administrators I interviewed:

**Administrator [03]:** The merger of the three health regions into one health authority has gone a long way to standardizing care levels across [our region], both in infrastructure
spending and in staffing levels. I mean, there were big differences between [the] south, centre and north [health authorities], and in funding going to residential care, and therapy in residential care, and just a lot of different things. I think we’ve been able to bring in some [region-] wide resources in education and quality control, so I think it’s good. I think [our Authority] is small enough that it’s still doable.

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Administrator [02]: I think that some of the positive things have certainly been reducing administrative costs because they merged some of the administrative systems. They reduced some of the duplication because there were three separate health regions here, so they consolidated a lot of that. I think it helps especially in smaller communities who were not as [well] resourced, previously. You can bring the whole Health Authority['s] resources to bear, so you’ve got the power of a much larger organization.

A disjuncture: Disempowered managers. The creation of the health authorities led to the centralization and standardization of administrative and financial systems across residential care facilities (RCF) in BC. This change effectively moved the power and authority to make important decisions (e.g., staffing levels, quality improvement initiatives, staffing rotations) out of the RCF managers’ hands and placed it in the hands of people that were much higher up the organizational hierarchy of the newly formed authorities:

Administrator [03]: The managers have very little autonomy within [the Health Authority]. We [the group of RCF managers] get together as a management group and define our goals, objectives, our quality measures, all the accountabilities that we want done. But many of those are handed to us. So, yeah we have the perception of authority and autonomy and maybe we have a little bit of discretion in how we implement these [initiatives] in our facility. But, you’re pretty much told what needs to happen.

A manager concurred with this senior administrator:
Manager [15]: Pretty much the only autonomy I really have is prioritizing everything that needs to be done. Other than that, I have no power. None whatsoever....

The managers of the three study facilities indicated that it was frustrating and disempowering to not be able to put time, energy, and resources into initiatives that they wanted to implement, and which would be based on their unique understanding of the needs of the staff, residents, and family members within their specific facility. For example:

Manager [14]: We talked about this at the [manager's meeting], the corporate requirement to meet the corporate objective and not allow sites to identify and select our own initiatives. It has to be corporate [initiatives and objectives] and it’s so disempowering for the managers.

Not only were the managers receiving top-down, one-way directives from senior administrators within their public and private healthcare corporations, they were also receiving directives and objectives from multiple "bosses" from various positions of authority within the organizational hierarchy of the entire Health Authority. This was described by a senior administrator:

Administrator [03]: The provincial government has a number of expectations. We get directives from the Ministry [of Health], we get directives from WorkSafe [BC; the workers’ compensation board], we get directives from people from health and safety—you know, doing MSIP [musculoskeletal injury prevention] projects, and then people from infection control and violence prevention. So, the average facility manager feels like there are about 20 bosses out there telling them what to do.

13 The "people" she was referring to were individuals who were responsible for overseeing the various safety initiatives (e.g., injury prevention, infection control) that had been implemented at a regional, authority, or provincial level. These individuals may or may not have worked in concert with one another.
Regionalization led to the standardization of safety initiatives (e.g., infection control and violence prevention) across multiple healthcare settings. The standardization of these initiatives meant that they were often externally driven. The impact of being required to focus primarily on externally driven initiatives, directives, regulations and accreditation standards was made evident when a clinical nurse leader was asked to describe a regular day. In her response, she described the previous day's work during which she spent the entire shift responding to the "20 other bosses":

**Manager [01]**: I basically have to prioritize what needs to be done. Typical day? Let’s just give you an example of yesterday. … We had a residential services conference call for two hours. There are a whole bunch of initiatives and standards for accreditations that we had to review, and then review with the staff, and ensure was completed. So, of course, from there I came and I did an audit on one of the units of the charts. I asked an RN to do another audit on the other side of the unit for charts and we—let’s pick the pneumococcal vaccination. So, this is an accreditation standard where the residents need to have the pneumococcal vaccination on admission and at least once in their lifetime. And, if it’s not done, we need to obtain the doctor’s orders. And, the policy procedure that we follow means that I had to create a list of how many people had not had the vaccination, and the other nurse gave me her list and from there…. Well, I kind of kept it on my desk because then I got called away to another meeting and then of course staffing called saying that we were short staffed. So, I’ve got to deal with…and then, of course, there are clinical issues that I need to address on the floor. And then…in the meantime, I’m still dealing with some accreditation standards that I have to meet. So, another one is identification. So, looking at wristbands and things like that. …So I ended up…I bounce. I find I bounce a lot and I’m trying to get prepared for meetings and things like this. We also had quality council…. Let’s see, at 1:45 [pm] we had another meeting that all the quality council team attend and we went through all the period stats [statistics of outcomes that were monitored by the Health Authority] and we reviewed all those, and that is something that we do on a monthly basis.
Similar to other managers and supervisors who participated in this study, this clinical leader's day was primarily filled with responding to external directives, regulations, and standards. Some managers inadvertently indicated that a "good day" was one when they were not disrupted by issues concerning staffing or care needs within the facility so that they could get their work done to meet the external regulatory standards without interruption. Thus, rather than being able to focus their time and attention on responding to the expressed needs of care staff members, residents, and their families, they focused on the directives of people in positions of power outside of the facility. As a result, the managers and leaders of the RCFs were placed perpetually in a position of being reactive to translocal initiatives and directives, rather than being proactive in their attempts to meet the immediate and particular needs of the care staff members and residents within their facilities.

Each of the participating managers described how challenging it was to manage and implement the large number of directives they received from various people in external positions of power. For example:

**Manager [15]:** There is the expectation that I know and understand the corporate direction, policies, accreditation standards, [and] licensing issues, and that I am able to speak to them and to [inform staff and residents] that that’s what we’re doing. So, there is a lot of top down push to implement [corporate initiatives] on the ground.... There’s a lot of things we don’t have a choice but to implement....

The remark that the managers had no choice but to implement corporate initiatives was reiterated by a director of the Health Authority:

**Administrator [03]:** And, I mean, the picture is so big, that [the] restructure [changed staffing levels or assignments] that the manager gets blamed for started at the provincial level where they sit down with the CEOs [chief executive officers] and the finance people at the health authorities and say, “OK, we are going into collective bargaining next year,
we need collaborative gains. Where are we going to find money to put on the table with the unions? Oh, well here’s a few long term care facilities that have more staff than our model says they should have. We could whack out the staff, take the money, and put it on the table for bargaining...” So, then it comes down and the manager gets told, "Take this much money out of your budget. This is the staffing model. Go do it."

All of the managers spoke about how difficult it was to implement corporate directives that they knew were not in the best interest of the residents or the care staff members. For example:

Manager [16]: And I knew that that [cutting staff positions] was just totally the wrong thing to do. But, I had nothing to do with that decision. It’s my job as a middle manager to implement decisions from above.

I asked another manager about an initiative that she had implemented in her facility regarding staffing rotations and assignments. This initiative had had a dramatic impact on the home life and work life of the RCAs in her facility, and had not been well received by the staff, residents, or their family members. She explained her role in the implementation of that initiative:

Manager [15]: Sometimes I feel more like the drainage plug. Taking all this crap and…and trying to filter it, purify it, make it manageable, palatable.

Researcher: Palatable for the staff?

Manager [15]: For the staff.

Researcher: Yes?

Manager [15]: However, this [the corporate initiative] is such…a challenge for a group of individuals [the RCAs] who are often barely making ends meet, if they are [at all]…and so disruptive of their home life that I wonder…and they had no say in it, at all. [Laughs]. And, you’re the messenger. …The interesting thing about that is on some level, I didn’t have a say either.
It is noteworthy that the majority of the care staff members and family members who participated in this study viewed the facility managers as being at the top of the organizational hierarchy. One of the managers who participated in this study indicated that it was surprising to her how much autonomy her staff believed she had:

**Manager [15]:** It [my autonomy] is limited. It’s very limited. It’s certainly perceived by the staff as a huge amount of autonomy and that surprises me.

Thus, rather than seeing their managers as middle managers, who often had to implement initiatives with little or no autonomy, the managers were perceived as having a significant amount of autonomy and authority at the facility level. As a result of these erroneous beliefs, the care staff members placed the blame, their resentment, and sometimes their anger about unwelcome corporate decisions solely at the feet of their managers. Further, it seemed that the less empowered the managers and nursing supervisors felt in their ability to respond to the needs of the care staff members, the less willing they were to ensure that there were open gates of communication between themselves and the staff members. This behaviour led to the erosion of trust between the care staff members and their managers, which in turn, eroded the quality of the relationships between them.

**A second disjuncture: Whose side of the fence are you on?** The power structures found within the health authorities and corporate providers of residential care services (e.g., private-for-profit corporations, which oversaw multiple RCFs) often led to the creation of “fences” between the managers and the care staff members who reported to them. Two managers spoke about how this environment made them incapable of cultivating a sense of team spirit for themselves and the care staff members. For example:

**Manager [15]:** I think that the expectation of upper management is that we are the voice for upper management and that that’s the side of the fence [we are required to be on].
There is a line drawn there. This side of the fence [is for management]. The other side of that fence is the other [care staff members]. So that’s an expectation.

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Manager [16]: It’s a very tricky line to walk—you’re expected to be a team player, but the definition of the team is the upper management. You’re expected to be a member of the corporation, which goes totally against the way I see myself. I never wanted to be a corporate player, but that’s what happened.

This manager explained how being required to be on the corporate team often affected how and what organizational information she shared with the care staff:

Manager [16]: Now, even though my director would have explained things [openly with me] it came down [from the Authority]. You know that wasn’t her decision, that’s from above…. So, how much am I allowed to tell the staff? …I can’t blame. I can’t say, "I think this is a terrible idea, but I’ve been told by “so and so” that this is what has to happen." So, you have to frame it because that’s your expectation, you are a corporate player. So, you have to frame it, and figure out how you frame something that you do not believe in, in a way that you get people to try and make the best of it.

It was the "framing" and "purifying" of corporate directives that likely led many of the RCAs in two of the participating facilities to feel as though management was "lying" to them and "not being open." When the managers were unable to speak openly and candidly about corporate initiatives, closed gates of communication were created at the facility level, which negatively affected the trust felt by the RCAs toward their managers. This was described by a nurse manager:

Manager [01]: I also see that she’s [manager of the facility] trying to make a difference, and she’s trying to help. But, you know what? It’s still—it’s not—the staff aren’t trusting. Yeah, the staff aren’t trusting. But, the problem is that she’s caught in that as well because…. You know what? This [corporate initiative] is brought down and [corporate
personnel are] saying, "This is the plan." Yeah, it’s a tough one right now. I think the trust has been broken from the staff and this is just, speaking honestly…. I try to be very positive and try to encourage. I try to tell the staff that we're doing everything we can and that the support is there. But, they’re not believing me anymore.

Another manager emphasized the importance of ensuring that her staff knew and felt that she cared for them as a means of fostering trusting, responsive relationships with them. However, she also indicated that the directives from the "corporate team" could negatively affect her ability to create positive relationships with her staff:

Manager [16]: Yeah, it does really help if you make people [the RCAs] feel–feel cared for. I’m sort of wincing because you’re not supposed to do this as a corporate player, but sometimes you have to be willing to stand up on behalf of your staff and just say, "Well, I’m sorry but I gave her that day [off]." [And some corporate figure says], "Well, yeah, but you shouldn’t have." [And, I reply], "Well, yeah, but I gave it to her because she needed to have it and we’ll put that as a--shall we put that as a vacation day or a sick day? Oh, we’ll put that as a sick day." And then I get heat because [a corporate figure says], "Your sick time is way up and so you can’t misuse it!" But, you have to have that judgement, and I know that, in the long-run, being that supportive to that person in a time of distress is going to make a huge difference because then…. It’s the same with any kind of leadership thing. If you have a relationship with a trusted leader you will go so much further for that leader than you will for somebody that is just a corporate mouthpiece.

When I asked this manager to elaborate on the importance of being an advocate for the care staff, she indicated that, if a manager wanted to keep her job, advocating for the staff by going against a corporate initiative was not an option:

Manager [16]: Well, you’re paid by that team, the upper team, and you’re expected to act on behalf of the corporation. So, you know you have to make the best of it. You can’t not do it [implement a corporate initiative]. And, you know that those decisions impact care. So, you have to make it happen the best way that you can, so that you still continue to be responsible for the best care of the residents. But, it’s very difficult. It’s very
stressful. I’ve known more than one person who’s been fired in a leadership position because: "You just don’t fit with our vision of how things should be done in this corporation."

**Researcher:** Wow.

**Manager [16]:** You’re out. So it’s very precarious for…. If you’re a person who has a family and a mortgage and you know things are happening and you think, "Oh, this isn’t good." But sometimes you have to toe the line. So, it creates internal distress, dissonance for some people. We’re not going to go back [to a more decentralized system]. I can’t see that happening. So, I think what starts to happen is you get people now in management positions who are more business oriented. They’re not care oriented. ...And so they will function very effectively in the corporate model, but the care part is getting lost.

Of interest, even though the managers were clear that their "team" was the corporate officers, none felt supported by corporate personnel. Instead, they revealed how alone they felt in their positions and that there were very few, if any, people that they could turn to for support. For example:

**Manager [15]:** This is a very “alone” job. Very alone. There is no even really safe place for me to turn to. If I do take a frustration up the ladder, is that a reflection on me? Is that a reflection on my capacity to perform in the position? So, you asked about autonomy. It’s forced autonomy. If I want to do my job, then I do it, and I don’t fuss. And, I take the directions and I get them forward. And I get measured on the statistics…on my injury rate, on keeping within a budget, on our sick time/overtime, those are the bars.

These "bars," primarily measured in numbers and calculated as statistics, were used to determine whether the managers were in regulatory compliance and meeting the corporate expectations. It took a great deal of time to collect the data from which these statistics were produced. They were used by corporate headquarters, the BCMOH, and various regulatory bodies (e.g., licensing and accreditation) to measure the quality of care provided in the RCFs.
Because of the intensified regulation of residential care services, the amount of time that the managers spent in collecting this information had increased substantially over the past decade. The focus required the managers to spend more time in their offices, thereby making them less accessible to the staff, residents and their family members.

One manager explained how her inability to spend time creating and fostering a healthful team in her facility was something for which she was ultimately responsible. Yet, she was unable to do anything about it because of the organizational systems in place:

Manager [15]: The thing is, is that you–you wear it. Like, absolutely wear it. This is me not talking to staff. This is me not developing trusting relationships. And, you own that. Even though I understand the system and so on, I’m actually very human. And, I think...well but, that [not being able to create positive relationships with her staff] is not what I mean to do. ...But, but it’s also what is happening.

The systems in place negatively affected the relationships between the managers and the care teams in Facilities #2 and #3. It begged the question then, how was the manager from Facility #1 able to create open gates of communication despite the corporate and organizational challenges that she shared with the other two managers? First and foremost, this manager admitted to being often behind in the “paperwork” that was demanded due to regulatory standards and thus expected of her by corporate headquarters:

Manager [14]: Honestly, the paper work piece, oh, it’s such a struggle. [laughter] It really is. It’s not–it’s something I have to force myself [to do]…because I think it’s working with the staff to trouble-shoot issues [that's more important]. So, staff [members] know that if they bring something to us, then we will follow through. So, there’s a high level of trust. I think, if they see that we’re doing for them or for the residents, that they will also do [for us]…. It’s about being out on the floor. I think that’s kind of it. I think it’s kind of walking the walking.
Despite significant and sometimes overwhelming pressures, this manager held firm in her commitment to place the needs, issues, and concerns of staff, residents, and family members as a priority over the paper work required by external initiatives and regulations. In addition to this, she indicated that being at a distance from corporate headquarters likely enabled a stronger sense of autonomy in her facility:

Manager [14]: I think the other part, honestly, is the fact that we’re a stand-alone facility, thousands of miles from our head office. I think that’s significant.

Researcher: Really? Tell me about that.

Manager [14]: …I think it’s significant because we….It’s a rarity that we would get anybody from corporate head office coming through our building. …So, we foster more independence, maybe, that way.

This observation did not imply that this facility was not required to implement corporate initiatives that the staff did not agree with or that were believed might adversely affect residents’ care. For example, as a cost saving measure, the corporate leaders required this facility to change the incontinence products they used to a less expensive brand. The RCAs in the facility repeatedly expressed frustration about the poor quality of the new briefs. When the nursing manager was asked about the staff members’ concerns, she replied that she was equally disempowered to make any change in response to their discontent:

Manager [02]: I said to the staff when we first changed, I said, “This is what we have to use, so please try and use it. It’s no good complaining and saying you want to go back. I don’t have that authority.”

The ruling relations present in the health authorities and large corporate residential care providers led to a lack of empowerment of mid-level managers, which, in turn, led to a trickledown effect of disempowerment of direct care staff members and then, unfortunately and
ultimately, to residents and their family members. The closed gates of communication and the
disempowerment that occurred as a result of them, led to disgruntled staff members who
exhibited very low morale at work. The behaviour attributed to low morale (e.g., taking longer
breaks, not responding to residents’ needs because they are perceived as "excessive," persistent
complaining about management and other staff members) ultimately eroded the quality of
teamwork experienced by the RCAs. In this way, low morale directly and negatively influenced
the quality of care provided in RCFs. Thus, the influence of the ruling relations on the provision
of person-centred care in RCFs was substantial.

**Access to Care-Related Information: Exploring the Boss Texts That Influence Gates of
Information Relevant to Residents’ Care**

The 2002 BC Government and health authority performance agreements specified two
expectations that led to the implementation of key boss texts, which significantly affected how
residents’ care information could be obtained, who had access to that information, how the
information was to be stored and shared and for what purposes, and how the information was
used. First, the agreements laid out an expectation that the health authorities would increase the
proportion of home and community care clients with high care needs remaining in their own
homes (rather than living in an RCF) from 45% to 57%, by 2004/05 (BCMOH Performance
Agreement, 2002). This expectation led to the subsequent development and implementation of
the Access to Residential Care Policy—Complex Care. Second, the agreements laid out an
expectation that a new assessment tool for residential care would be fully implemented. This
expectation mandated the use of the RAI-MDSv2.0 in all RCFs in the province. I examined the
influence of each of these boss texts on the provision of person-centred care in RCFs.
**Access to Residential Care Policy—Complex care.** Before 2002, access to subsidized residential care, in BC, was based on the temporal order in which a person's name was placed on a wait list at each individual RCF. In addition, people in need of residential care services could independently select the RCFs for which they would be waitlisted. As beds became available in a selected RCF, one's name moved up the list. Consequently, many residents and family members were given ample notice (often many months) prior to a bed becoming available. During this time, the admitting staff had the opportunity to create relationships with the resident and her or his family members, and to conduct a thorough pre-admission assessment. For example, the social worker or the head nurse from the admitting RCF would often visit and assess a prospective resident, in the community, prior to admission. This was described by an RCA who, at times, would be invited to attend and assist with the pre-admission assessment:

*RCA [09]:* I don’t know who does the assessments now. We used to. Years ago, we would even go sometimes out with them [head nurse, team leaders, or social workers] to meet a resident and see if they were appropriate for our place [RCF]. Ah, the good all days. Things have changed. [Laughs]

Thus, once the prospective resident was actually admitted to the facility, a completed social history and detailed pre-admission assessment was immediately available.

However, because the admission process was based primarily on a "first-come, first-served" model, it often did not accommodate people who had relatively urgent care needs; there was no way to mandate that they be given priority for placement. Consequently, people with urgent residential care needs often awaited placement in acute care hospitals; they became "bed blockers" in the acute care system until they were able to access an RCF bed (BCMA, 2006). These people, referred to as hospital patients who require "alternate levels of care" (ALC)
because they could not be cared for at home yet they did not require acute care services, were blocking a bed from someone who did (Walker, 2011).

In an effort to reduce the number of “bed blockers,” the BCMOH (2009), removed the waitlists of individual RCFs and implemented a needs-based access system through the enactment of the Access to Residential Care Policy. This policy, which remains in force, requires placement in residential care services to provide priority access for people with relatively greater needs, as established by the various health authorities' assessment processes. Thus, the amount, type, and timeliness of services provided to people in need of residential care is largely determined by the results of a standardized, computerized assessment process conducted by a case manager of a health authority.

The information gathered from the assessment process is entered into a common database from which the care needs and risk levels of prospective residents can be evaluated and compared with others, thereby enabling the health authorities to manage and prioritize their region-wide, internal “waitlist.” The assessment forms used in this process dictate what information is and is not gathered; consequently, these electronic documents have some inherent bias (i.e., the assessors focuses on the information prioritized by the documents, rather than on information that the assessors or the people being assessed may believe is most pertinent). It is also noteworthy that the accuracy and thoroughness of the information obtained in these assessments is especially important because the information is used to create “electronic matches” between a person’s assessed needs and the available RCF beds within an authority.

Once a “match” is made, the RCF bed is offered to the person determined to be in need of publicly subsidized residential care. The policy, often referred to, albeit erroneously, as the "first available bed" policy, requires that the eligible person has to agree to accept the first appropriate
bed offered within the local area, consent to be admitted to the facility, and agree to occupy the
bed within 48 hours of being notified of its availability, unless alternative arrangements are
approved by the health authority. It is noteworthy that personnel of the health authorities were
quick to correct the public’s error in thinking that the policy was about the first available, rather
than appropriate, bed and its intention, as explained by one administrator:

Administrator [03]: It is not first available bed…the policy is first appropriate bed.

Researcher: “Appropriate bed.” OK. Thank you. I will change that.

Administrator [03]: “Available” actually is kind of redundant because the bed’s available or it’s not. So, “appropriate;” it is defined as…you have a set of care needs…that bed can meet those care needs and you need to accept that bed.

People awaiting placement in a publicly subsidized bed are required to accept the bed once it is offered to them. According to the BC Ministry of Health (2012), "If the first available bed is turned down, the health authority will assume a client’s need is not urgent and move their name off the priority access list” (p. 1). If the bed is declined, people in need of residential care can apply to a private care facility. However, private-pay residential care beds cost $5,000 per month or more; consequently, for many people in need of residential care, the latter option is not viable.

BC residents have to be assessed to be at “significant risk” and have “urgent needs” to be deemed appropriate for publicly subsidized RCF placement. Once they meet those requirements, they typically wait one to three months, on average, before they are offered placement (BC Office of the Ombudsperson, 2009). The number of people awaiting subsidized residential care exceeds the number of available beds.

The positive aspects of the Access to Residential Care Policy. Relatives and informal caregivers often become physically or emotionally unable to continue to care for a loved one at
home, before they will consider placement in an RCF (Yaffe et al., 2002). This resolve is likely one of the reasons that so many frail seniors are admitted to acute care hospitals to await placement in residential care. Unfortunately for these seniors, acute care hospitals are not designed to meet their restorative, supportive, or rehabilitative needs; there is an abundance of literature indicating that people who require alternate levels of care do not fare well in acute care settings (Walker, 2011). For example, researchers have shown that these people are more susceptible to advanced functional deterioration and to hospital-related infections, falls, and other adverse events (Covinsky et al., 2003; Fortinsky, Covinsky, Palmer, & Landefeld, 1999).

Consequently, minimizing the amount of time frail people await placement in hospitals was a positive aspect of the Access to Residential Care Policy. Without exception, the family members who participated in this study and who had a resident admitted to an RCF directly from an acute care hospital reported that they were immensely relieved once their loved one was transferred from the hospital setting. For example:

**Family Member [09]:** Yeah. They desperately wanted to get her out of hospital. They “re-eee-ally” wanted to…they made it as unpleasant as possible! And, she was there for three months.

**Researcher:** How much notice did you have before they moved her?

**Family Member [09]:** Ah, we were away.

**Researcher:** Oh, you were away! So there was no family support to help her transition into this facility from the hospital?

**Family Member [09]:** No, there was not at the time. But between…whoever was involved…I guess the authorities who do the placement…we got all the information. It was only a matter of days that we were back here. But, she accepted the transition. Well,
you would, from where she was. It was horrible in the hospital for her. And so, coming here was obviously going to be an improvement.

*A disjuncture: It is people on paper.* When an RCF bed became available, a brief description (e.g., single-, double-, or four-bed ward and the gender of the roommates, if applicable) was entered into the computerized database. Thus, other than describing the available bed, the care staff of the receiving RCF, who were responsible for admitting new residents, had little to do with the generation of an “electronic match.”

**Manager [05]:** So, I’m in the middle of an admission right now. So, there would be certain characteristics…the particular vacancy right now is a female. It’s in an all-female unit. So, I can designate "all-female." So, then it matches, ideally, with someone, hopefully, that would match the profile, based on the prioritization of the Health Authority, which I have nothing to do with.

Thus, a "match" was made when the characteristics of the bedroom (e.g., all-female) and the unit within which the bedroom was located (e.g., secured or locked unit so that ambulatory people with dementia could not leave unattended) match the assessed needs (or description) of a prospective resident (e.g., ambulatory female who had a tendency to wander). Another study participant expressed discomfort when describing this process, which she believed reduced people to paperwork.

**Manager [06]:** Then they [the Health Authority] would match us with someone and we would get that, you know, the person. Well, we don’t actually get their name. We get their paperwork…. So, we print that out and look at it and then start the process. Sometimes they’ll ask us to sort of preview people and ask, “Is this a fit [match]? Would this person’s needs be met in your facility, and if so which unit?” And then we kind of roughly…. But it's just paperwork. It’s people on paper. It’s so hard.
Given that important decisions were made on the basis of this assessment process, the data included in these institutional texts needed to be accurate and thorough. Unfortunately, the staff members involved with admissions, at all three facilities, expressed concern and frustration about the accuracy of the information. For example:

**Manager [05]:** So, from the “get-go,” I have to try to figure out if this [the information provided by the Health Authority] is accurate. And, those [assessments] could be current, ancient.... Sometimes the phone number for the family isn’t even correct or sometimes we have a physician’s name on that front information sheet that is so out of date.

**Researcher:** The information isn't always correct, current? So, a lot of this is problem solving for you?

**Manager [05]:** Yeah, there may be times when they have a facility stated where this person is residing, and they’re not there! [laughter] I have to wonder where are they…missing in action? So, there is, I mean, I don’t blame it. It’s systematic. It’s people. There isn’t time. No one has time to actually thoroughly do these assessments and update things.

Many of the study RCAs expressed frustration over the inaccurate information that accompanied newly admitted residents. For example:

**RCA [01]:** Oftentimes we’ve had admissions that come in and we’ve got this whole write up from the hospital that says, "This is what the person’s like." And, they’re not really like that at all!

I observed the impact that inaccurate or out-dated assessment information had on both residents and RCAs. A particular resident, who was independent in almost all of her activities of daily living, was uncomfortable receiving assistance. During the beginning of shift report, however, the RCAs were given very different information regarding this woman’s care needs:
**RCA [10]:** Um. New residents? Nobody knows anything about them. You were there for the one. Nobody knew anything about this lady. It [the pre-admission assessment] says she was an overhead lift and…

**Researcher:** She could stand.

**RCA [10]:** And, she could walk. And, go to the bathroom on her own, completely independent. She does not like to be bothered. Yeah, we had no idea. And, she is very aggressive when you bother her.

In addition to the frustration arising from out-dated or inaccurate information, every study participant who had experience admitting a new resident reported that there were situations when it seemed that a case manager had purposefully omitted information about a resident to ensure that a “match” would be made. In these instances, the first facility with a bed would be expected to accept the resident. According to the study participants, the information that was most consistently omitted by the case managers was the level of risk arising from a prospective resident’s aggressive or responsive behaviour. A manager described her perception of the process and her concerns about the risks:

**Manager [15]:** They actually omit information, especially around responsive behaviours.

**Researcher:** Oh? They actually don’t let you know?

**Manager [15]:** No. They don’t let us know.

**Researcher:** So…because they don’t want you to say “no” to the admission?

**Manager [15]:** That’s right.

**Researcher:** So, you’re actually getting aggressive residents without knowing it?

**Manager [15]:** Yeah, and everyone’s being put at risk. The care aides are put at risk for their personal safety. I think the residents are put at risk because we may not be able to
keep them safe from themselves, or they put our other residents at risk, and I think both…[the Health Authority] and the facility have a liability risk now.

The realization of this risk was experienced by an RCA who described a situation when her arm was nearly broken because a resident had been admitted without sufficient information about his unique care needs:

**Researcher:** So, when a resident is admitted, you’re really just given very basic information—toileting, feeding, transfers?

**RCA [03]:** And even that can be wrong, as you saw.

**Researcher:** Yeah, as we saw. And that’s it. And then otherwise, you’re really going in fairly blind and getting to know that person.

**RCA [03]:** I almost had my arm broken because of it once.

**Researcher:** Yeah?

**RCA [03]:** He was an ex-police officer. He was six foot five, and I’m about five six. He was about 300 pounds, and not fat. He was big. Very, very aggressive. A lot of mental illness. And they said, "Well, you’re one on one with him." And I said, "Why?" And they said, "Oh, well he’s having a bit of difficulty with some of his medications." Not, what medications, what the difficulty was, what the side effect of these medications were. He'd gotten a new medication and he literally had every bad side effect to the medication possible. He had the aggression. He had the rash. He had the fevers. Everything. But I didn't know any of this. And he was sitting in the room, and it was dark and there’s a night-light. So, I turned it on so I could see because it was the evening. It was about nine o’clock, and I went in and I kind of sat next to him, and he was just ripping apart this book. Just…and he looked incredibly angry. And I tried to distract him with something else, but he just, I don’t know how. He just all of a sudden got angry and got my wrist and it was behind my back before I knew what happened. And I was just standing there basically at this man’s mercy, begging him to let go. I called for help but nobody heard
me. They [the other RCAs] were all in [other residents'] rooms. And then something clicked and he let go.

The frequency in which inaccurate or out-dated information about residents was received from the health authorities’ case managers was so problematic that the concern eventually led to the BC Ombudsperson making a recommendation for change.\textsuperscript{14,15} This is likely a reason why several social workers, included in the study, expressed a wish to be consistently able to meet and assess prospective residents so that informed decisions could be made about whether there was a good “match” between a prospective resident and the facility with an available bed. Limited time and resources, combined with the current process, precluded such meetings from occurring. The challenge of making such an important decision with so little information was evident from a study participant’s discussion of the complexities of the decision to admit a new resident:

\begin{quote}
They [the health authorities work together with facility operators to develop a list of standard information about any new resident to be provided to the facility by the health authority a reasonable amount of time before a resident is scheduled to move in” (British Columbia Office of the Ombudsperson, 2012, p. 172).\footnote{14}

The BC Office of the Ombudsperson initiated an investigation in 2008 in response to complaints received about the care that seniors were receiving in their homes and in the community. An initial report was issued in December 2009. A subsequent report was issued in February 2012. This latter report, which addressed residential care, home and community care, home support, and assisted living, included 176 recommendations. Many of those recommendations directed the Ministry of Health to take a leadership role and to provide direction and support to the health authorities to ensure that province-wide standards and processes were in place to ensure that seniors were treated fairly and equitably.\footnote{15}
**Manager [04]:** There are just different requirements for different needs and it’s always shifting, which is part of what makes it really challenging. We often don’t sleep when we’re doing new admissions. I feel so responsible. There’s this new person that’s coming in. It’s their life. It’s their whole family’s life. It’s everyone on the unit. It’s the staff, too. …I always am feeling for the staff, and worried and wondering, “How is this going to work out for everyone?”

The process required that the decision to admit a resident occurred, most often, without any facility staff meeting the resident before her or his arrival at the facility. Thus, everyone involved, including the resident, the family members, the RCF care staff, and the Health Authority case managers relied almost exclusively on the accuracy and effectiveness of an “electronic match.”

**A second disjuncture: The fallacy of choice.** According to the *Home and Community Care Policy Manual* (BCMOH, 2012), the health authorities were required to "establish local service delivery models that will provide clients with access to residential care services within their community or within accessible distance to their community" (6.A. p. 1). This manual also stated that health authorities must "ensure that a client has the opportunity to identify a preferred facility or location" (6.D. p. 1). However, although people in need of residential care were ensured the opportunity to "identify" their first and second choices regarding which RCF they would like to reside in, their choices were not considered when the electronic match was made. This practice was described by a study participant responsible for residents’ admissions:

**Manager [04]:** So, you get to suggest that you want two choices, but the likelihood of you getting one of your choices is very low. It's rare. I think that is clearer for most people now. Nonetheless, some people think that they’re going to get their first choice. And, when I make that phone call [to offer a bed] and say, “I’m not [from the preferred facility],” they’re very surprised. …Because they just assume that if they’ve identified these places that they’re going to get one of those. And, it’s rare. It’s probably extremely
rare in my experience that people get their first choice or second choice. It’s extremely rare because it depends on when the bed comes up and what need is matched.

With the exception of one resident, who was able to pay for a private, non-subsidized room, all of the residents who participated in this study were placed in an RCF that was not one of their choices. The decision to place a loved one into an RCF is extremely difficult for most family members; consequently, being forced to accept placement in an RCF that is not of their choosing can make the transition traumatic:

**Family Member [04]:** Well, it’s upsetting. She ended up going to the hospital and I had her name down for another facility because she had been in the adult day care there and they all knew her. But, this was the one that came up and she had to come here. It’s close, that’s good, and I found some fabulous staff here. But, it was still upsetting. She’s suddenly in a four-bed ward. Everything that she was has been stripped away. There was…she’s got one little picture and a few little things. No chair. She can’t have anything that was part of who she was. And, I found that disturbing. I hated to see her like that. I think it was just as traumatic for us as it was for [resident's name]. I really do. I mean I just felt really strongly. I had envisioned her in the other place where she could have her own room, could have some TV, could have her clothes, pictures, a chair. And I thought, “Well, she could have a phone there,” which she was still able to use. And, so I found it really traumatising. I was just devastated. I thought, "This isn’t what I want for her."

The *Home and Community Care Policy Manual* (2012) stated that clients "will accept the first appropriate bed where the client's preferred facility or location could not be accommodated on admission" (6.C., p 1). Once admitted into the RCF with the first appropriate bed, the residents could request to be transferred to their preferred facility. Historically, once a resident was admitted to an RCF, the likelihood of a transfer being offered to the preferred RCF was extremely small. This trend had changed recently, as explained by a study participant:
Manager [04]: The Health Authority is making an effort. It has been more recent, and I’m not sure, but I have reasons to believe they may have had some coaxing around this. There are transfers occurring now, and for a long period of time, there wasn’t any transfers. Any transfers! I’ve noticed the increased transfers is a trend in the last…since…I’d say the last 10 months or so. Now we’re seeing people that were admitted to another facility that they didn't choose and then they’re coming here within four to five to six months. And so something happened within the process that is allowing that to happen. So, there’s where the choice piece is honoured within the system.

The majority of residents admitted to an RCF have some form of cognitive impairment and all who are admitted to publicly subsidized facilities in BC have complex care needs (BCMOH, 2012). As a result, transition to and between RCFs was often difficult for the resident and the family members. Consequently, even though requests for transfer were being accommodated, some family members would choose to not accept a transfer once the resident was settled into the initial RCF. The family members may conclude that a transfer was not in the best interest of the resident. This was explained by a family member:

Family Member [11]: So, it’s a 45-minute drive to visit her because it was the first available bed. But, in the end, I think that, for her, she’s probably in a very, very good facility. Just…at first, I wondered if her name ever came up for a bed in her own community, would I move her? It would certainly be easier on us, but harder on her. So, we probably won’t…

The extent to which the electronic matches dictated where a resident would be admitted was unexpected. For example, if a resident had been living in a facility in a private-pay bed and then required a subsidized bed (because payment was no longer possible), the resident would be required to accept the first available bed, even if it was not in the facility that had already been established as “home.” A study participant reported:
Family Member [02]: We got to select this facility because we could pay privately, but after two years the money ran out and so we knew we had to transition from private pay to government subsidized. And, because of the first available bed policy she was almost forced to move…it was really frustrating.

Researcher: Really?

Family Member [02]: Yeah. What made it less frustrating was that the executive staff at [Facility #1] really went to bat for us and…got in touch with the case manager and said, “You know, we have a bed available.” “But, it’s not the first available bed” was what the case manager kept saying.

Researcher: So, were they going to actually discharge her to a different facility?

Family Member [02]: Well, yes, and they could have. They had every right to do that under the first available bed policy. But both [the Director of Care and the admissions clerk at Facility #1] kept saying, “But we have a single bed.” I learned to not call it a private room. “We have a single bed available, and it’s the first available bed in our facility.” And the Health Authority would say, “Yes, but it’s not the first available bed in the system.” We fought and eventually we got to stay here. But, not everybody has a family that can advocate for them. And, I worry about what happens to them.

Without exception, the managers who participated in this study opined that the first appropriate bed policy negatively affected the admission process because it was harmful to the development of the important relationship between the facility and the resident and their family members. For example:

Manager [17]: It's awful because they arrive angry because this wasn't their first or second choice. This wasn't where they wanted to go, and they blame you for that. So, we start off in a horrible position right off the bat. The resident is angry and the family is angry and we're doing our best.
**A third disjuncture: Time is of the essence.** The Access to Residential Care Policy required that, once a bed was offered, the prospective resident had 48 hours to not only accept, but take occupancy. This part of the policy put tremendous pressure on family members, as explained by a participant:

**Family Member [10]:** They called at 3:30 [PM] and they wanted her here [at the RCF] at 10:30 [AM] the next morning.

**Researcher:** She was going to be moved in?

**Family Member [10]:** I had been to seminars that the Alzheimer’s resource centre put on about transition to residential care and I had been told, "Get the bag ready because when the phone call comes you’re going to have to move."

**Researcher:** So, they let you know, "Have the bag packed." It’s kind of like a pregnancy. [Laughs]

**Family Member [10]:** Yes, yes, that’s right. But, it’s one of those things. It’s like your emergency kit, you never get to it. Right? I got off the phone and I was in a bit of a whirlwind. I didn’t know what to do, where to start. How I am going to look after mom, look after myself, get dinner, get her ready for bed, get everything ready and have her up and out here [the RCF] by 10:30 the next day? I just couldn’t do it. I was at the end of my rope with my care giving.

Time was of the essence during every admission—for the residents and their family members, as well as the staff responsible for the admission. There was great pressure on all of the RCFs, regardless of ownership status, to ensure that empty beds were filled as quickly as possible. An empty bed was a bed that was not generating revenue, as explained by a study participant:

**Manager [05]:** Our budget is impacted because I cannot get this person in fast enough. That’s just the reality. We lose money when we don’t have someone in those beds. So,
there’s all this pressure. It’s sort of that mix between meeting the needs of the resident and family and yet, I always feel like we’re losing money, we’re losing money, you know, and lost days. I always feel that pressure, and well, I just absorb that.

The pressure to “get the bed filled” may be one of the reasons that residential care institutions provided so little support to healthcare staff members when a resident died. The pressure to quickly fill the bed seemed to be especially difficult for the RCAs because their ability to grieve the death of a resident was curtailed by how quickly, systematically, and almost mechanically the bed was refilled.16 This was expressed by several RCAs:

**RCA [08]:** I mean, we’ve had where somebody dies and an hour later we see the social worker coming down the hall looking at the bed. We’re thinking, "The bed’s not even cold and she [the social worker] is here." But unfortunately, that’s her job and we know that. But, it is hard on us that we’ve cared for this person for a number of years. I think we all kind of have our own little way of dealing with it. You know, there are some people here that will go to every funeral. And some that, you kind of take your time later in the day if you have a little cry or whatever. But, it’s really difficult sometimes. And, if you have the bed filled again so quickly – yeah – it's hard.

**Researcher:** Because you are experiencing loss and yet now, when they die–now you are supposed to remove yourself completely. You are supposed to be a professional. You are a caregiver and now you are on to the next, this is your job. But, when they [the residents] are here, they want you to…

**RCA [08]:** Your heart is supposed to be right on the table, yeah.

Because of the pressure to fill vacant beds quickly, the death of a resident produced a long list of tasks to be accomplished. In response, the RCF administrators that advocated for the

16 The death of a resident was typically why a bed became available.
provision of person-centred care, inadvertently and perhaps unwittingly, required their care staff members to switch promptly from person-centred care, during a resident's life, to task-oriented care when that resident died. This was explained by a team leader:

**Team Leader [06]:** It’s just, get through, get through. Call the funeral home. Get them going. Phone the family. Get the belongings out because we’ve got another one [resident] coming tomorrow. [laughs] Sometimes we say, "Can we just have a day, you know, to get over the fact that we’ve lost this person and then worry about the bed?" And [they respond], "No, no, there’s numbers."

**A fourth disjuncture: Welcome to your new home—please sign here.** The system in place, as a result of the first appropriate bed policy, enabled and demanded that residents’ admissions proceeded very quickly, once a match had been made. An unintended consequence of this was that residents arrived at the selected RCF without a pre-admission assessment:

**Manager [11]:** Sometimes, we have gotten the admission summary after the person has been admitted because they [the case managers and RCF social workers] are just—again, they’re jammed up. It’s not that nobody wants us to have that information or that they’re not doing their job. They’re just overwhelmed.

The result was that paperwork became the focus on admission day, rather than the person and the personal and emotional aspects of being admitted. Many staff members acknowledged that focussing primarily on paperwork was not conducive to creating positive relationships with new residents and their family members. For example:

**Manager [04]:** All the paper work is very time-consuming and, you know, it’s the beginning of our relationship with this family and this person. And, we want to have conversations with them and we want to…. But, I know we need to build those relationships. And, it’s huge. They have all this range of emotions. It’s a process for them as well, and a huge transition. So, to just honour that, and make space to start processing that…. But, I...we often can't.
The family members of Facilities #2 and #3 talked extensively about how stressful and confusing admission day had been for them. For example:

**Family Member [11]:** The day we brought mum, we kind of got off to a rocky start, I guess. We were shown to her room, and there was a couple of minutes of paperwork and then…

**Researcher:** And then?

**Family Member [11]:** …we were left. And, my husband and I, we just had no idea what to do. So, after we put mum’s things away, we sat around for a while. We sat out in the living room, but no one introduced us to any of the healthcare workers or the other residents. So, we just kind of sat in a corner, quite lost, for an hour or so. And finally, I think, my husband went out and asked someone, “What do we do next?”

Every family member interviewed from Facilities #2 and #3 indicated that the staff were so focused on completing the paperwork that their need for information about what to expect in this new "home" for their loved one was lost in the shuffle. In addition, they indicated that the average amount of time they had with the admitting care staff member was approximately 15 to 20 minutes:

**Family Member [07]:** Yeah. I would say it might have been 15 and definitely no more than 20 minutes that we had with the RN who did the admission.

Other family members described their frustration that the questions asked on admission day were directed solely by the forms, instead of by what they believed the staff needed to know about their loved one. For example:

**Researcher:** So, there wasn’t really a formal way for you to be able to sit down with the staff and talk about all those little things that really enable care?

**Family Member [10]:** No. Not where somebody said, “[Nellie] come and sit down with us and tell us all about all the little things that we need to know to look after your mom.”
Family Member [08]: They didn’t ask about who mom is now and what her requirements are now. I thought at that point in time, that was more of an issue. Who was she? What were her expectations? How did she deal with people and people deal with her? Because everybody’s an individual, even with dementia. And, that was never discussed. So, I found the hurriedness, the "sign the papers here" and "hurry up, just give me the signature" was…shocking. And, you really weren’t given any orientation either. You were passed some papers, but there wasn’t a huge amount of information as to what happens in the facility.

The pressure to refill the beds, compounded by the RCFs not having the capacity to store a body once a person had died, led to a form being completed on admission day that detailed the new resident’s funeral arrangements. Every family member interviewed were taken aback by being asked this question on admission day, a day when most were doing their best to cope with the adjustment of placing a loved one in an RCF. For example:

Family Member [07]: Nothing about it is easy. Right? And, [my father] told me afterwards... ‘course he never tells me these things at the time, he tells me afterwards...that from the time we put mom’s name on a list to say that she needed to be put into a facility, he was just dreading the phone every time it rang because he was sure it was going to be them phoning and that he was then going to have to put her into the car and drive her to a facility and essentially drop her off.

Researcher: And take her...

Family Member [07]: And that was just killing him. And yet, I remember the nurse who admitted us saying to us on that day, "We need you to tell us which funeral home you want to work with." Like that information was really critical. We had to give that to her that day. And I said, "Yeah [chuckles], haven’t thought that one through" and how about if we get back to you on that?

Researcher: On day one?
Family Member [07]: Right, on admission day. Right at the top it’s, "We’ve got to have that." And, it’s like, "OK, we’ll give that some thought and I’ll get back to you." …and [they reply], "We’ll need that quickly!" Well, from there on [the social worker] was on to Dad, and every time she saw him, it was always, "We need that information. We need that information."

A common theme of the care staff members was that paperwork had begun to usurp human relationships. Rather than focusing on the people and the emotional aspects of being admitted (none of which was included in the documents completed on admission day), the care staff involved in the admission process were absorbed with responding to and creating textual documents.

A central tenet of person-centred care is that it is provided with respect and deference to the care recipient’s unique needs and preferences (Fazio, 2008). The admission process that occurred as a result of the first appropriate bed policy starkly contrasted with the provision of this philosophy of care. Given the unintended consequences of this policy, the RCF personnel were unable to spend sufficient time and effort to ensure that person-centred care was offered at a critical moment, when relationships were being first formed, during the admission process. The need was expressed by many participants.

Manager [11]: And, just, I also feel that there needs to be more time spent with helping a family to transition with their loved one into the facility. There is nothing built into any orientation. We were told when we got the new orientation package, which has more information, that the average time it takes is four hours. Yet, that’s expected to be done in the same busy day when you don’t have an admission. So, how can you truly do a full assessment? Make the family feel comfortable? Label the belongings? …If it takes that much time of your day? It’s feasibly impossible.

Because Facilities #2 and #3 did not commit resources to support the admission process (e.g., dedicated staff time and supplies) it was not possible to provide a thorough admission
orientation or to conduct a full assessment of newly admitted residents. Facility #1, on the other hand, had an administrator who recognized the need and committed significant resources to ensure that residents, their family members, and the care staff had positive experiences on the day of admission. As explained previously, the administrator trained selected RCAs to be involved in the admission process, released them from their regular duties (and replaced them with casual staff), and enabled them to give four hours of undivided attention to the new resident and family members. Providing this amount of time enabled the RCAs to conduct a thorough assessment (often with the family members present) so that they could obtain information related to the particular care needs of the residents. In addition, she made available a briefcase that contained the resources required for a successful admission. The briefcase and the admission process were described by an RCA:

**RCA [01]:** Plus, we’ve got our million-dollar case—it’s a silver case. It’s got all of our information for the resident. When I come back from my break, at 9:45 [AM] or something like that, I try and get the case and do a bit of stuff before they [the resident and family] come—because there’s a few things that you can do to get more prepared so that when they come you’re just open, greeting them, you know, taking their coat, giving them tea, coffee, whatever, that sort of stuff, rather than just flipping through papers and trying to label this and label that. So, they come in and we usually get them a washbasin and all their essential needs that we provide, and label it with their name and put it in the bathroom and label their closet. And, we have a checklist of all the things that we’re required to do. A two-page checklist: introduce yourself, introduce the roommates and the staff, give them a tour, you know, label their dentures, label their eyeglasses...all the things that we need to do.

Without exception, the family members of residents of this facility described their experience of admission day as being positive—even those who did not select the facility as their first or second choice. For example, one family member described how the admission process
helped to create a positive relationship between her mother and the facility, thereby easing the emotional burden of having made the decision to place her in an RCF:

**Family Member [02]:** So, we chose [Facility #1] because we wanted to make sure she had a private room to herself, and the only way we could get into that situation was as a private paying patient. It was with a great sense of relief that my mother went to this care facility. This particular facility made us feel welcome right from the very beginning. It felt more like a family place than anything else. So, there was a sense of relief, and there was a sense that in this case, my mother was in a very secure place, and that she was made to feel welcome, and that she was being treated respectfully. …I can’t think of any other word to use other than there was a sense of relief.

This commitment to train the RCAs for the admission process, to ensure that they had access to all necessary supplies to do an admission well, and to give them the time to dedicate their attention to the needs of the new resident and family members helped to ensure that the provision of person-centred care remained the focus, despite the Access to Residential Care Policy, which unintentionally, yet systematically, eroded it.

**The RAI-MDSv2.0: Home and community care classification tools project.** In 2002, the Ministry of Health mandated the full implementation of the RAI-MDSv2.0 in every RCF in the province. According to the 2002 Performance Agreement, the purpose of the implementation of this comprehensive assessment tool was to ensure that "the health authorities could identify the needs of home and community care clients and develop care plans to ensure these clients receive an appropriate level of care in an appropriate setting" (p. 16). Significant resources were expended for this expectation to be met. Unfortunately, uncovering data about the healthcare
funds allocated to it was very challenging. The senior managers of the study RCFs indicated that many hundreds of thousands of dollars were spent on the MDS-RAI v2.0 implementation. As previously described, this assessment tool had a dramatic impact on what and how residents’ care information was obtained, where it was stored, and who had access to it.

_The positive aspects of RAI-MDSv2.0 assessment instrument._ According to the literature, the RAI-MDSv2.0 is composed of clinical instruments that trigger individualized, targeted care planning efforts through the use of multidisciplinary, standardized assessment protocols (Hirdes et al., 2000). This assessment is aimed to bring together the diverse perspectives of the multidisciplinary team members and facilitate the development of a comprehensive care plan designed to meet residents' unique and individualized care needs. These positive aspects were described by an administrator:

_Administrator [03]:_ So my understanding of it was to have a standardized approach to assessing people and having the ability to use that information to help plan for healthcare services. So, while it does take time away from the clinician to do this, I would argue that formal assessments on a regular basis help identify changes in people’s conditions sooner. And, the principles are sound in that you want feedback from the whole multidisciplinary team. You want to make sure that it’s not just a point in time, that it’s based on data gathered over a couple weeks through observations.

17 Although I conducted several searches on the internet and enquired in multiple interviews (to both managers and administrators) I was unable to obtain information about the costs associated with the implementation of the MDS-RAI 2.0.
One participant, who used the data collected from the RAI-MDSv2.0 at a national level for research purposes, described how the implementation of this geriatric assessment tool was potentially beneficial for all levels of the care process:

**Administrator [04]:** The grander purpose is to apply a complex geriatric assessment to a person under care so that information can be used to benefit ideally all levels of a care process, from the care planning decision, at the front line, through to improving, understanding quality and processes at the facility level. And, it can be used to look at funding issues at the facility level as well. At the policy level, those data can get assembled and aggregated across jurisdictions, across countries, to understand in a comparable way what happens when people are under care and to understand their characteristics and to compare in an apples to apples way what is happening in terms of both promises and outcomes.

**A disjuncture: Who is using these data?** The professed practical worth and applicability of the RAI-MDSv2.0 seemed to be largely dependent upon who used the data and for what purposes. The individuals who were closest to the actual point of care deemed the data to be least useful and those individuals furthest away from the residents deemed it to be the most useful. For example, the residents, family members, and RCAs did not have practical access to the care plans generated from these assessments; consequently, the application of the data into care practices was limited, at best. Furthermore, most of the study RCAs found that the implementation of these assessment tools had negatively affected the exchange of residents’ care information because it required them to use checkmarks and numbers to communicate their residents’ needs:

**RCA [16]:** I think we need progress notes in there, instead of all these numbers. If you read them they say, "Oh, this person’s a 3, this person’s a 2, this person’s a 1." What does that mean? Stop using numbers…[especially] when it’s done improperly. We should be
using progress notes. This person was restless, this person was crying out, they were saying this word…. Why this word?

A study participant who was an instructor at a local college where RCAs were trained and who also worked as a casual RN in RCFs concurred with this RCA. She feared that important information was lost because of the required format for documentation:

**Manager [04]:** We teach them [the RCAs] subjective and objective data collection, and assessments, and how to verbalise that and how to put it into professional wording. Yet, when they get the RAI MDS, they have to then guess. “OK, if I observed this and the resident said this, which one?”

**Researcher:** Which “ticky box” or number does that fit into?

**Manager [04]:** Yes and then it doesn’t [fit]. So, then it gets lost because it’s left blank.

Several RCAs opined that documenting residents’ care needs in the RAI-MDSv2.0 actually put residents at risk because they were unsure if the RNs or LPNs ever referred to the RAI flow sheets. For example:

**RCA [01]:** But, I know there is a part, if you’ve witnessed a red rash somewhere, or a sore or a skin tear or something like that, you’re to mark it off. But, I don’t even know if the nurses go through and check that so I don’t understand why we even put it on there [the RAI-MDSv2.0 flow sheets].

**Researcher:** Again, you don’t really know where the information on this sheet of paper is going?

**RCA [01]:** Yeah, because I could write down that the person has a skin tear, but who’s actually going to read this? It could be three weeks from now, when that skin tear’s already healed. Because right now I’m going to go and tell the nurse and the nurse is going to put something on it and she’s going to document it where she needs to. So, why am I writing this down here?
This RCA’s expressed concern was credible; the majority of the study LPNs and RNs acknowledged that they rarely, if ever, referred to the RAI-MDSv2.0 flow sheets for residents’ care information. Every study LPN indicated that, although they were required to fill out the RAI-MDSv2.0 assessments, they did not use the information that was produced. For example:

**Team Leader [04]**: Um, I don’t use them [the RAI-MDSv2.0 flow sheets and assessments]. No. And, that comes down to the seven-day observation tools, again. They come and go. I don’t even notice.

Furthermore, the majority of the study RNs did not trust the data collected in the RAI-MDSv2.0 because they believed that the quality of the data was poor. One RN indicated that the quality of the data was likely influenced by several factors and expressed ethical concerns over what to do about it:

**Researcher**: And, how do you feel the quality of the data is from the observation sheets that the care aides are filling out?

**Manager [04]**: [Laughs] Oh dear. Well, again it depends on whether the care aide has had the education and the knowledge that they take from it. The interest that they have in it. Do they feel good about their job? Are they feeling valued or are they just copying what “so-and-so” put down yesterday? So, the information that is actually put on there, I find is so varied and I know that…“No, this isn’t accurate information about the person that they’re talking about.” But again, are you obligated to put in that documentation or do you change it? Do you alter it? It’s so skewed that it’s…. And, then I’ve had team leaders and managers just say to me “well just copy what was in the last four months just so we can get it done. We have to get it done. We have to get it done.” And, they want all of the RNs to be able to do the RAI. They want all of us to be comfortable with it. Fair enough, but we're already max[imiz]ed in our workday. So, newer staff are listening to that and saying, "Well, if I don’t do any, then I’m going to lose my job. So, I’ll just put in something. Something’s better than nothing.” But, the information’s not accurate. So, if
we’re not inputting accurate information, then when it goes to the “higher-ups”…what's it
going to do?

Several RNs were openly frustrated that nursing resources had been diverted from direct
care to implement and sustain the RAI-MDSv2.0. A casual RN expressed her belief that the
quality of care was suffering as a result:

**Manager [04]:** So, I’ve actually gone away from filling it [the RAI-MDSv2.0] out.
Again, because I’m focused on supporting the staff more than supporting the RAI. And,
the care aides, some of them are commenting to that exact fact. “We don’t need the paper
pushers, we want more support. We want somebody to go to, somebody that will listen to
us.” And, they have such a passion for the residents that they care for that some of them
have brought tears to my eyes before because “thank god you’re here today because if
you weren’t here, this has been going on for two weeks and nobody’s even looked at it
yet and so-and-so’s going to die because nobody’s looked at it.” And, these are residents
that have been in there four or five years that they know are deteriorating but nothing’s
being done.

Another RN indicated that using computerized documentation to share care-related
information was not as effective as in-person, group discussions (e.g., huddles) and that care staff
members did not need a computer to tell them a resident's health condition was changing:

**Manager [11]:** OK, so I’ve said that I thought that the responsive rounds and the
palliative rounds are great. Because they involve everybody, and they get a chance, in
real time, to address issues. And, the reason the care plans are so out of date is because all
the time people used to spend working on the care plans, they are now working on the
RAIs. It’s awful. And, the RAI sounds great in theory, it really does. But it…it…all it
does is gets in my way. It gets in my way.

**Researcher:** So, it doesn't help you in any way?

**Manager [11]:** Well, they say that it gives you, you know, it’ll say–a significant status
change will come up in the readings. But, we always know if somebody’s changing. We
don’t need the computer to tell us that somebody is changing. We can see they’re declining.

Another nurse indicated that the focus on being “paper compliant” took away time that could be used in caring for residents and responding to their needs:

**Team Leader [01]:** And, then that would free up a lot of time to be able to be a nurse. I think.

**Researcher:** And, define: “be a nurse.”

**Team Leader [01]:** I think just being more there for the resident. Being a nurse is being able to be there for your patient. And being able to...because you’re always running past them and they’re like, “Oh, nurse!” And, you’re like, “Yeah, I can’t, I’ve got to run, sorry.” I wish I could stop then and be like, “OK, what’s your issue, what’s wrong?” Because all of these things that we come up with, like, “Oh this person’s aggressive, this person’s calling out, this person needs to be toileted all the time....” Well, we don’t have time to really address all those things. And, if we had time, those things might not happen.

Having found that the nursing staff members rarely used the data to inform their care, in any of the study RCFs, I further queried the staff members who played key roles during residents’ admissions. Most of these informants also disregarded much of the information found in the RAI-MDSv2.0. For example:

**Manager [04]:** I don’t do anything on the RAI. I didn’t even know there was a special section for [my discipline]. Even, I have to admit, the RAIs that come to us...that we review...I usually have a quick look and then I read all the little—you know at the end, where they can add comments....

**Researcher:** Where they actually write?

**Manager [04]:** Yeah, where they actually write, and that’s what I read because that actually is contextualized, that has meaning to me. The other stuff—I mean, sometimes I’ll
look to see…but it’s just “ticky boxes”…it’s worse than people on paper. [laughs] “Ticky boxes” are worse than that!

In addition to assisting with care planning, the RAI-MDSv2.0 also included outcomes scales to report specific areas of concern that the staff may have had about a resident (e.g., the assessment results of the depressive rating scale, pain scale, self-performance hierarchy scale, pressure ulcer risk scale, aggressive behaviour scale, or index of social engagement). This information was then used to develop outcome indicators for the facility (e.g., rates of falls, depression, behavioural symptoms, urinary tract infections, decubitus ulcers, or bowel and bladder incontinence), which could be used to measure the quality of the care provided. I asked the managers of the study facilities whether they used these data to modify or inform the care provided. For several reasons, the managers reported that they did not use the data from the RAI-MDSv2.0. First, they indicated that they did not use the data because they had not received training on the application of the instruments:

**Manager [14]:** The only education I have is the education that I sought out myself when they first started rolling it [the RAI-MDS] out. So it’s…I don’t know, I can see the potential of it, but I don’t understand it well enough to make any use of it.

A second reason they gave for not using the data was that the number of metrics associated with the quality indicators was overwhelming:

**Manager [14]:** Well, we get them [the RAI quality indicators]. I just look at one quarter, put it in the action plan, and I don’t review it again until the next quarter because I don’t really care. You know what I mean? In our company, we were told, the number one rule
for us now is three is the maximum [quality initiatives\textsuperscript{18}] that we can do. They said, "We prefer two, but we’ll allow three, if we figure you can handle the other two." That’s the maximum. The very next month we get our RAI quality plan – 18 metrics on it. This year, there’s like 26. I told my boss’s boss, “There’s no way that this [implementing quality initiatives to address each metric] is going to happen. I’m not gonna’ do it. No one is going to do it. We’ll all tell you, ‘Yes, we’re going to do it,’ but no one is going to do it because it’s overwhelming.” I can’t even look at it now, I get a headache.

This manager also indicated that she did not need a computer program to tell her to respond to the care needs of the residents or the education and training needs of the care staff:

**Manager [14]:** See, this is the other piece that really frustrates me. So, what the RAI really is, is a snapshot in time about what your [RCF resident] population is. One of the RAI metrics is increasing incontinence. Right? That’s one of the metrics that we’re looking at right now. So, since the RAI tells us we have worsening incontinence, now we’re required to actually plan around this stuff. Well, nobody can actually tell me what new kind of plan to put in place. [They’ll say,] "Well you could do…training. You know, toileting." Well, what do you think we do? I don’t need a program to tell me that. That’s what we do!

Another manager indicated that she was overwhelmed by the data reports generated by the RAI and discussed her concerns regarding both the quality of the data and the way they were being used:

**Manager [15]:** I find it so overwhelming that I don’t look at it myself until I’m forced to pull a report to discuss. And, my frustration is that they’re making—the upper Health Authority elements—are making huge, significant decisions on where we’re going, what

\textsuperscript{18} Initiatives with the aim of improving accountability, quality and performance in a specific aspect of care (e.g., decreasing resident falls).
we’re doing, staffing models, all sorts of things, based on the RAI information. And, accreditation and quality councils...they are all using this too.

**Researcher:** Yes?

**Manager [15]:** And the RAI information is not being correctly collected. So, for instance, we just had an evaluation done–we are ages behind. [The RAI coordinators] are saying to us, "Just come in and build false data. Just come in and fill in the blank because the system doesn’t let you get–if you fall behind it doesn’t let you get caught up.” So, I’m now getting workload in to create false data, just fill in the blanks, so we can try and get on top of it again, but it’s an add-on piece of work versus an informed piece of work.

This manager's concerns about the use of these data for accreditation purposes and by the quality councils to measure the quality of care were shared by other senior administrators.\(^{19}\) The licensing officers indicated that they too were depending more heavily on the RAI data for their inspections:

**Administrator [11]:** [Before the RAI], the director of care would be beside me. I would be having these conversations, a bunch of: “What does this mean?” and “I see you’ve got this here, but not over here.” We would have those conversations. But then, from what I understand now, the licensing officer goes in, sits in front of a computer, goes through the RAI, usually just left by themselves, and…we’re not so much looking at the deep content, we’re not…analyzing the content, but we’re looking to make sure all the pieces are there.

\(^{19}\) In 2008, the British Columbia Patient Safety and Quality Council was created by the provincial government to enhance patient safety, reduce errors, promote transparency and identify best practices to improve patient care.
In addition to the data being used to evaluate quality standard performance, they also were used by senior administrators from within the health authorities to make decisions regarding the allocation of resources for residential care services:

**Administrator [03]:** Well, I have some practical examples of how we use the data to try to help make decisions around quality care initiatives. We saw that some of the data was starting to indicate an increase in pressure ulcers and wounds so that led us to making some investments around wound care. We look at it to better understand what is the prevalence of things like dementia and the prevalence of antipsychotic medications that are being prescribed without an underlying diagnosis. So, all of that helps get a better sense of what’s going on. So, for me in a kind of program planning level, or a strategic level, it helps me see some of the trends and understand some of the emerging issues so we can better plan for our clientele in the future.

I interviewed an individual who used the RAI-MDSv2.0 data once it was submitted to the Canadian Institute for Health Information (CIHI), for research purposes. This participant described CIHI's relationship with interRAI and then explained why he was confident about the quality of the data:

**Administrator [04]:** CIHI plays a data monitoring and quality control role, so they are the active recipients of the data. They [CIHI] have a national repository, they maintain standards for the actual data elements themselves, so there is an agreement between interRAI, who hold intellectual property on the instrument, and CIHI, and it’s a beneficial one both ways. And yes, I hear the anecdotes, how somebody wrote down the wrong things once, [but] I’m looking at a dataset of 100,000 observations and I’m thinking,

20 The Canadian Institute for Health Information (CIHI), created in 1994, maintains pan-Canadian databases that enable jurisdictions to compare data. CIHI also produces data analyses related to health and health care in Canada. About 80% of its annual revenue is granted by the Federal Government.
“Well, how many of the 100,000 did that influence?” And, if it was 5%, 2%? You know, these anecdotes tend to tarnish...because of a single inaccuracy...it’s like the whole thing is bad if one thing is bad. Now, when we look at the data in, as a whole, again, for secondary research purposes, they stand up pretty well. The associations that you would expect to see are there. And, that’s why I am saying, I can often live with some small amount of imprecision...because I know that the people who are the most impaired are being recorded that way and the people that are the least impaired are being recorded that way, and I take some of the [other] things with a grain of salt.

The more a person could influence where resources were being spent in the RCFs (e.g., senior administrators, licensing officers, accreditation surveyors, policy makers, and researchers), the greater value they placed on the RAI-MDSv2.0 data. This was significant because nursing resources were diverted from the point of care when the RAI-MDSv2.0 was implemented, as one administrator explained in answer to my question about the true "cost" of the implementation of the instrument:

**Administrator [03]:** So, yes, they’ve diverted potential nursing resources primarily away from doing front line care to having people do the MDS coordinator role. And then, they have to maintain the competency of everyone who’s using the tool. So, there’s lots of administrative work in using the tool at a facility level.

**Researcher:** This is a huge investment and the government mandated it across the board. Has anyone asked the question, "Are we getting our money’s worth? Or is it worth the value?"

**Administrator [03]:** That’s a good question. I don’t know if anybody’s done a cost-benefit or a money analysis of it.

Without exception, the study participants who worked inside the RCFs expressed a belief that the benefits were not worth the costs of implementing the RAI-MDSv2.0.
A second disjuncture: Why are we really doing this? In addition to being used for assessment, care planning, and quality improvement, the RAI-MDSv2.0 could be used for funding purposes through the application of Resource Utilization Groups (RUGs). According to the CIHI RAI-MDSv2.0 resource manual (2006), RUGs are used to group residents into similar categories based on residents’ clinical and resource-utilization characteristics. The classification scheme can be used to "understand the facility population and to help management make decisions as to type and numbers of staff required, and how to distribute resources to specific clinical areas" (p. 6). However, the RAI-MDSv2.0 coordinators conveyed that the primary purpose of RAI-MDSv2.0 was to provide an interdisciplinary assessment of residents’ care needs and to aid the development of individualized care plans. They also reported that the RAI-MDSv2.0 was not developed as a workload measurement tool and that, if used, the RUGS should be considered a secondary aspect of the tool. A regional RAI coordinator, who was responsible for the implementation of the RAI-MDSv2.0 in many RCFs, informed me that it was not a workload measurement tool:

Manager [03]: It’s not the workload tool that staff actually initially thought it might be. Many staff are coming and saying, “We thought this was going to show an increase in workload and we’re all for it because we thought we would get more funding because it’s a workload tool.” But, very clearly, it’s not a workload tool.

Senior administrators admitted, however, that they spoke of the potential for the tool to lead to better staffing levels when the RAI-MDSv2.0 was initially introduced. They indicated

21 The Resource Utilization Groups (RUGS) were developed, in the USA, as a case-mix measure, which has been validated for use in many countries (Fries, Schneider, Gavazzi, Burke, & Cornelius, 1994).
that they did this to assist the managers in obtaining "buy-in" from the RCAs during the roll out of the assessment package. This message “stuck” in the minds of the RCAs; the majority indicated that they were informed that the MDS-RAIv2.0 was a workload measurement tool and that, if completed properly, it could lead to increases in staffing levels. For example:

**RCA [03]:** We were told it was to assess the workload on the unit so that more staff could be brought in if it was needed, and whatnot. I have yet to see more staff. I have seen staff removed so we have less staff.

**Researcher:** And, do you think that impacted the care workers’ opinion of the tool and their use of it?

**RCA [03]:** Yes. There are people that just won’t do them. It’s a waste of time. Why should I fill anything out that is not doing anything to help a resident or myself?

Other RCAs expressed frustration because the tool did not measure or assess everything that they did during a work shift. This frustration, combined with a lack of confidence in the tool's ability to improve staffing levels or residents’ care, was expressed by an RCA:

**RCA [20]:** But, it doesn’t cover everything. It doesn’t cover how many times a person has been toileted in a day. It doesn’t cover if they have had a shower that day, how many times the bed had to be changed that day for that resident. There are all kinds of things. So, to me, it’s not an adequate tool for this.

**Researcher:** It’s not an adequate workload measure?

**RCA [20]:** Yeah, well it’s definitely not that. And, it’s supposed to benefit the resident. But, if things are being copied from the day before because of time factors, and there are short cuts being taken, that can’t happen.

Despite these concerns, the study participants unanimously stated that, although it is not yet the case in BC, they were certain that it would be used for funding purposes sometime in the
future. This belief was confirmed by a senior administrator in her response to a question about why she believed that the Ministry had mandated the implementation of the RAI-MDSv2.0:

**Researcher:** Can you tell me why the Ministry of Health mandated the implementation of the RAI?

**Administrator [02]:** No. I don’t know. Other than that it is pretty much a standard through much of the western world. It is a standard in most of the provinces in Canada and I can imagine, you know, it does provide better data to the Ministry for whatever planning funding activities that they would be doing, that they had passed.

**Researcher:** How do you use it?

**Administrator [02]:** How do I use it?

**Researcher:** Yeah.

**Administrator [02]:** I have recently started looking at the case-mix index numbers. Not to make the [funding] decisions but more out of–

**Researcher:** Interest?

**Administrator [02]:** Interest. It will lead to [funding] decisions someday, but it’s not there yet. Both over concerns of quality of data and really having the confidence to know what is the right way to move forward. So, we will be talking to people in Ontario about what they’ve done because they are adjusting funding based on case-mix index or some of those numbers. Um, I think we need to get there because we have facilities with much more complex, heavy workload residents than others and we need to–

**Researcher:** Adjust based on the…

**Administrator [02]:** Adjust the funding based on that. I mean, it’s just not reasonable to ask people to take on heavier workload residents without reimbursing them the cost they're incurring to do that. So, I don’t think it’s a punitive thing to look at those case-mix index numbers. It’s just an equity thing. And, right now, we get a lot of push back from
facilities not wanting to take the heavier care clients. Well, that’s reasonable. We don’t pay you any more to take the heavier than the light one.

**Researcher**: No, and they don’t get increased staffing when they take them so..

**Administrator [02]**: No, they increase nothing.

However, another participant, who had extensive experience with the RAI-MDS, explained why case-mix indexes, such as those found in the RAI-MDSv2.0, were not intended to be used to increase funding, but instead were used in the allocation of limited pre-determined resources:

**Administrator [04]**: The Ministry is always mindful of their budgets, and they know that the operators [RCFs] are always looking for more [funds]. And, unfortunately, sometimes a system like the MDS, when it comes in, is sold with that promise [increased funding], but in fact—and this is always a metaphor you need to put up front when these systems are put in place—the amount of funding that is available is a big pie. And, all that these systems do is tell you how to allocate the pie. But, the size of the pie is a political determination, and is ultimately about what budgets are available. The MDS, when properly implemented, would tell you the fairest way to divvy up that pie so that the care is as fair as it can be, across all the homes [RCFs]. And, so the reality is when any case-mix system is introduced, the homes that did very well under the previous system lose, and the homes that didn’t do so well gain. And, so goes the statement that the losers are winners and the winners are losers under any case-mix implementation.

In an attempt to ensure that the RAI-MDSv2.0 data were as accurate as possible, the manager of Facility #1 created a permanent part-time position for an LPN, who was solely responsible for the completion of the detailed RAI-MDSv2.0 assessments, the creation of the care plans, and for submitting these data to the Health Authority and CIHI. Unfortunately, however, these very detailed assessments and care plans were kept on a computer and were not accessed by any of the care staff in the facility; rather, they were used primarily to demonstrate compliance with the regulations and standards:
**Team Leader [08]:** The best way to think of this care plan, and as awful as it sounds, because we’re going to base this eventually on funding—this is our receipt for what we say we do here.

This "receipt" likely contained the most accurate RAI-MDSv2.0 data that I observed;\(^{22}\) however, it did not inform care practices and did not assist in the transfer of residents’ care information within the facility. Nonetheless, if the RAI-MDSv2.0 is to be used for funding purposes and resource allocation, it would be easy to argue that an accurate and detailed creation of a "receipt" for services may provide the most honest reflection of the true purpose of the implementation of the RAI-MDSv2.0 across Canada.

**Summary and Reflections**

Access to information is essential to the provision of person-centred care. So too is the creation of trusting, mutually respectful and responsive relationships. The regionalization of health care in BC led to the enactment of key boss texts that affected both the provision of care and creating of relationships in RCFs across BC. The boss texts I reviewed were activated in response to the Performance Agreements—the texts that outlined the Government’s expectations for the delivery of patient services, health outcomes, and healthcare spending.

The Performance Agreements mandated that each health authority produce balanced budgets. However, because of the centralization of administrative and financial systems, the RCFs’ managers had little if any power to influence decisions regarding where and how to achieve the required fiscal retrenchment and restraint. Thus, the power structures embedded in these large health authorities led to the RCFs’ managers becoming disempowered middle

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\(^{22}\) This assertion was based on the focused time and attention she placed on the completion of the RAI-MDS.
managers who often felt they lacked authority to actively respond to the needs of their care staff. In addition, the emphasis on standardization within the authorities caused the managers to spend the majority of their time responding to corporate initiatives designed to meet extensive regulatory standards. Thus, the social organization within the RCFs led to an inadvertent creation of closed gates of communication, which in turn, eroded the trust and damaged the relationships between the managers and the staff who reported to them.

Second, the Performance Agreements led to the enactment of the Residential Care Access Policy. This policy required that seniors in urgent need of residential care would accept the first appropriate bed offered to them, within 48 hours of an electronic match being made. As a result, residents were admitted to RCFs with little if any individualized care information being transmitted.

Finally, the Performance Agreements mandated the implementation of the RAI-MDSv2.0 in every RCF in BC. The implementation of these assessment instruments dramatically affected how and what care information was obtained and how it was shared within the RCFs. Without exception, the study care staff members and managers expressed a belief that the diversion of nursing resources from the front line to the completion of this assessment tool negatively affected the exchange of care information and the provision of care. They also expressed concerns about how the data from these instruments were used by people in positions of power within the health authorities and the Government.
Person-centered care has been described as a care philosophy in which a positive relationship is established that respects the care recipient’s preferences and life history, honours that person’s identity, enables her or his engagement in meaningful activity, and encourages an overall sense of well-being (Fazio, 2008). The attainment of the goal of increasing the provision of person-centered care is considered by many to be essential to both the quality of care and quality of life of people residing in residential care facilities (RCF), especially those who have Alzheimer disease or a related form of dementia (Brooker, 2007; Fazio, 2008; Kitwood, 1997; Talerico, O'Brien, & Swafford, 2003). Unfortunately, a review of the literature indicates that meaningful improvements in the provision of person-centred care in RCFs have been largely unrealized, despite significant effort to alter practice (Doty, Koren, & Sturla, 2008; Miller, Miller, Jung, Sterns, Clark, & Mor, 2010). This study was conducted to improve our understanding of how the social organization of care within RCFs supports or inhibits the provision of person-centred care.

RCF care staff, managers, and senior administrators are required to be in compliance with multiple regulations, policies, and expectations while simultaneously considering the dynamic and unique needs of the residents for whom they are responsible. These regulations and policies come in the form of institutional, replicable texts that are created to direct the textually mediated care work conducted in RCFs. To date, no study has systematically evaluated the influence of RCFs’ replicable institutional texts on the provision of person-centred care. This study addressed that gap by investigating the textually-mediated work processes within selected RCFs, and
revealed points of disjuncture between the actual, embodied work practices of the resident care aides (RCAs) and the governing processes that influence them.

In this study, I sought to answer the following questions:

1. What are the primary institutional texts that influence RCAs in their day-to-day work?
2. How do textually mediated work processes influence the provision of person-centred care in RCFs?
3. How is the work of RCAs socially organized in RCFs?

This chapter first presents a synthesis of the research findings followed by a discussion of the link discovered between the presence of empowered leaders and RCAs’ quality of work-life and care—a link that is postulated to be essential to the provision of person-centred care. I then examine both the theoretical and policy implications of the findings. I conclude the chapter by addressing the study’s limitations and provide some considerations for future directions and research.

**A Synthesis of the Research Findings**

Although they were observed to provide between 80% and 90% of the direct care to residents, in all of the sites studied, the RCAs lacked practical access to the majority of institutional texts that contained specific information relevant to the residents’ care needs and preferences (e.g., assessments, care plans, and care conference reports). Practical access to the institutional texts that contained individualized care-related information was largely dependent on one’s job classification. The regulated healthcare professionals (e.g., licensed practical nurses, registered nurses, dieticians, and occupational therapists) frequently accessed these texts to provide and receive information relevant to their residents’ care. The RCAs, on the other hand,
primarily received and shared this information orally and mostly informally. As a result, two microsystems of care emerged, based on these distinct information exchange formats.

I represented these microsystems of care as being divided by a “fence” with the RCAs, family members, and residents on one side of the fence and the regulated health professionals and management on the other. On the side where the regulated care staff were situated, the care work was highly textually mediated; here the adage, "If it's not documented, it didn't happen," reigned supreme. On the other side, the individualized information and intricacies about the care work provided by the RCAs (i.e., not just what they did, but how they successfully accomplished their work) was not captured in written form. As a result, the knowledge they held about each resident's idiosyncrasies, which was gained from their close proximity and familiarity, was not captured nor shared by any of the formal institutional texts. Instead, the sharing of this information, which could mean the difference between successfully and safely providing care to a resident or not, was predominantly accomplished through informal, oral exchanges.

Due to the unstructured nature of these exchanges, access to this information was largely dependent upon the quality of the working relationships both between and within the microsystems of care. Without exception, the RCAs indicated that the quality of their working relationships had the most significant impact on their ability to gain access to essential resident-care information, and on their resilience, as they faced the day-to-day challenges of providing care to residents. Consequently, the work of the RCAs was largely socially mediated, something that was not formally acknowledged within the highly textually mediated institutions within which they worked.

Having found these distinct microsystems of care, I began to look for “gates” in the fence through which information was able to pass, and the direction(s) in which it passed. I determined
whether the “gates” were: (a) closed when they needed to be open (i.e., there was no practical access to the information); (b) open with one-way and “bottom-up” flow (i.e., the information flowed only from the RCAs to the regulated health professionals) with no reciprocal information flowing back to them; (c) open with one-way and “top-down” flow (i.e., the information flowed only from the regulated healthcare professionals to the RCAs) with no reciprocal information flowing from them; or (d) open with two-way flow (i.e., the information flowed easily between the Microsystems of care). With this fence simile in mind, I mapped the flow of resident-care information between the RCAs and the other members of the healthcare team for each of the three study RCFs. The creation of these maps informed the subsequent data collection and analysis and provided a visual representation of some of the key findings.

Research question #1: What are the primary institutional texts that influence RCAs’ day-to-day care work. The only institutional texts that were purposefully developed and implemented to enable RCAs to have practical access to residents’ care information were the Activities of Daily Living (ADL) care plans found in the residents' rooms. These texts contained resident-care information that was distilled from the detailed, RAI-MDS care plans to the most basic bodily care information. However, in the three study RCFs, these texts were not regularly updated, causing the RCAs to view the information found within them as largely untrustworthy. Consequently, by approximately three months following a resident's admission, the RCAs, in all three RCFs, had stopped referring to these texts for care information. Thus, the residents' assessments and care plans, which were developed specifically to organize and prescribe their care, exerted little, if any, influence on the RCAs’ daily care practices. This finding is consistent with the literature that has suggested that care plans do not guide the daily care provided in RCFs (Adams-Wendling, Piamjariyakul, Bott, & Taunton, 2008; Daly, Buckwalter, & Maas, 2002;
Dellefield, 2006; Kontos, Miller, & Mitchell, 2009; Schnelle, Bates-Jensen, Chu, & Simmons, 2004; Taunton, Swagerty, Smith, Lasseter, & Lee, 2004), yet the RAI-MDS care plan remains one of the primary means by which the quality of care is evaluated within these institutions (Dellefield, 2006; Hirdes, 2006).

Of significance, all of the RCAs had practical access to only two resident-care-related institutional texts that were regularly and systematically updated. These texts were the residents' bowel lists (describing the type of bowel care required) and bath lists (identifying the residents’ scheduled time for bathing). The exception to this finding was noted at Facility #2, where the RCAs also had access to the residents' social histories—an institutional text associated with residents’ care needs, which the RCAs deemed vital to the provision of person-centred care. However, the RCAs in the other two facilities did not have practical access to these texts. Consequently, the bath and bowel lists were the primary institutional texts containing residents’ care information that all RCAs referred to during the course of their day-to-day care work. For access to other care information, the RCAs relied almost exclusively on the oral exchange of information. Additionally, the recording of residents' bowel movements was the only care information documented by the RCAs that was systematically reviewed by the regulated professional staff and used to plan daily care routines.

The key institutional texts related to residents’ care in RCFs exert little if any positive influence on the provision of person-centred care. Empowered leaders and reciprocating teammates, when present, combined with the RCAs' personal values, beliefs, knowledge, and experience in providing care, were substantially more influential on the provision of person-centred care than were any of the institutional texts (e.g., assessments and care plans).
The finding that RCAs have practical access to very limited information about residents’ care provides important insight into how the care work is socially organized in RCFs. It also provides tangible evidence of how extremely limited the RCAs' "true" role is within the care team (i.e., the ensuing message is that their role is to keep the residents' bowels moving regularly and their bodies clean). This institutional process shapes the work experience of the RCAs and likely contributes to their belief that regulated health professionals see them only as "professional ass wipers." This finding furthers our understanding of why, despite the rhetoric heard in many RCFs that RCAs are the “eyes and ears” of care, RCAs continue to feel undervalued, underappreciated, disrespected, and dismissed (Anderson et al., 2005; Bowers, Esmond, & Jacobson, 2003; Caspar & O'Rourke, 2008; Lloyd, Schneider, Scales, Bailey, & Jones, 2011). And, most important, it highlights that although they provide most of the care for RCF residents, the RCAs are provided with limited information and limited opportunity to learn about the specific needs and desires of residents. This institutional process largely negates the possibility of person-centred care.

**Research question #2: How do textually mediated work processes influence the provision of person-centred care?** The mandated organizational focus on regulatory compliance has deeply entrenched the textually mediated work processes in RCFs. Some researchers have asserted that this focus has produced a "paper compliance culture" and resulted in the unintended consequence of diminished attention being paid to residents' quality of life (Kane, 1990; Kane, 2003; Kontos, Miller, & Mitchell, 2009). Ensuring regulatory compliance requires significant amounts of time and resources spent on producing documented evidence of care and care quality; thus, regulatory demands have redirected the regulated health professionals and managers from propinquity to the residents’ living quarters and into administrative offices.
where they spend a significant portion of their day working on computers. Accordingly, the concentrated focus on regulatory compliance resulted in relatively few opportunities for in-person, oral exchanges of information between the RCAs and their team leaders, nursing managers, and facility managers.

In all of the facilities studied, the organizational systems, which mandated the written exchange of information, did not support a structured (i.e., formal or regularly scheduled), two-way exchange of information within or between the Microsystems of care. As a result, in addition to lacking practical access to relevant institutional texts, the majority of the RCAs also lacked the opportunity for in-person communication about residents’ care needs and for organizational information exchange with: (a) other RCAs (having instead to catch them “on the fly” or before or after their shifts), (b) their team leaders (having access to them only in brief, one-way information exchanges during a shift report or “on the fly,” when the nurses were delivering medications to the residents), (c) their nursing supervisors, and (d) their managers. This finding adds to the body of research that demonstrates that, although it is their preferred method of information exchange, RCAs are rarely provided structured opportunities to share verbally their knowledge of residents’ care needs, with each other or with the regulated health professionals in the facility (Anderson et al., 2005; Colon-Emeric et al., 2006; Kontos, Miller, & Mitchell, 2009; Lloyd, Schneider, Scales, Bailey, & Jones, 2011; Tauton, Swagerty, Smith, Lasseter, & Lee, 2004).

The focus on paper compliance and the primacy placed on formal institutional texts have had the unintended consequence of subjugating the experiential and tacit knowledge of formal care givers in RCFs. The emphasis placed on paper compliance and the subsequent subjugation of the experiential knowledge of these formal care givers can be traced to two key boss texts
used in RCFs: (a) the “first appropriate bed” policy and (b) the RAI-MDS v2.0. Each of these texts has influenced how and what information is gathered and exchanged in RCFs, and has therefore had a significant impact on the provision of person-centred care.

**The first appropriate bed policy.** As a result of the “first appropriate bed” policy, established by the provincial government, the amount, type, and timeliness of services provided to seniors in need of residential care is largely dependent upon the results of a standardized, computerized assessment carried out by a case manager of the relevant health authority to determine whether the eligibility criteria are met. The information gathered from the assessment process is entered into a database and subsequently used to create "electronic matches" between the senior's assessed needs and available beds in RCFs within the authority. This assessment dictates the amount and type of information about a resident that the RCFs receive prior to the resident's admission, which has led to a substantial reduction in individualized care information being made available.

The activation of the computerized assessment process has caused clinicians to focus primarily on the individual items and coding conventions, resulting in a preoccupation with the text, rather than the person's social history and unique care needs or the appropriate service planning required to meet those needs (Hawes, Fries, James, & Guihan, 2007). Due to this highly textually-mediated process, the matches between RCFs and prospective residents are made with little if any consideration of the residents' and their family members' preferences. Thus, some of the outcomes that result from this policy are in direct opposition to the provision of person-centred care.

**The RAI-MDS v2.0.** A central tenet of person-centred care is that it is individualized and based on the care recipient’s unique needs, preferences, and life history (Fazio, 2008).
Accordingly, the provision of this type of care is largely dependent upon caregivers' access to information about the person to whom they are providing care. Access to this individualized information is in turn dependent on effective information exchange and collaboration among healthcare team members. The RAI-MDS v2.0 does not require that interviews be held with residents and has been criticized for its lack of attention to residents' preferences and quality of life (Kane et al., 2003). The activation of the RAI-MDS v2.0 also has compromised communication and limited information exchange between RCAs and their team leaders. Consequently, the mandated implementation of the RAI-MDS v2.0 has adversely affected the provision of person-centred care in RCFs.

This result is especially significant because, as reflected in my findings, the RAI-MDS has been shown to have additional limitations, including questionable reliability and validity in the evaluation of everyday conditions (i.e., when used by staff who have not been suitably trained in its use) and an inability to accurately reflect the actual processes and quality of care across different RCFs (Bates-Jensen et al., 2003; Cadogan, Schnelle, Yamamoto-Mitani, Cabrera, & Simmons, 2004; Crooks, Schnelle, Ouslander, & McNeses, 1995; Hill-Westmoreland, & Gruber-Baldini, 2005; Rahman & Applebaum, 2009; Schnelle, Bates-Jensen, Chu, & Simmons, 2004; Zisselman, Warren, Cutillo-Schmitter, & Denman, 2002).

**Research question #3: How is the work of RCAs socially organized in RCFs?** As a result of the social organization of the work carried out in the participating RCFs, the RCAs did not have practical access to written information about the residents’ care nor did they have access to their teammates, team leaders, nursing supervisors, or managers for focussed, in-person, care information exchange. These closed gates of communication ultimately resulted in the exclusion of RCAs’ involvement in care and organizational decision-making. Accordingly,
the social organization of the care provided in the RCFs represented a systematic devaluing of the very knowledge and skills that the institutions depended upon for the provision of care.

Similar to other studies, the RCAs’ unique and important understanding of residents’ care needs was often found to be excluded from the residents’ care plans, and they felt unable to influence the organizational decisions that determined the care provided (Kontos, Miller, & Mitchell, 2009; Parmelee, Bowen, Brown, & Huff, 2009; Taunton, Swagerty, Smith, Lasseter, & Lee, 2004). This consistent finding has been attributed to professional stratification as well as low levels of interdisciplinary respect, communication, and collaboration among RCAs and regulated health professionals (Bowers, Esmond, & Jacobson, 2003; Colon-Emeric et al., 2006; Kemper at al., 2008; Kontos et al., 2009).

Because of the social organization of care delivery, the RCAs relied primarily on supportive teammates to receive and share essential information and turned to their individual experiences, knowledge, and values to accomplish their work successfully and safely. This finding adds to the growing body of literature that has shown that, as a result of being excluded from formal assessment and care planning exercises, and not being directly supervised by regulated health professionals at the bedside, RCAs primarily use team sharing (e.g., discussions with healthcare team members about residents’ care) combined with their occupation-specific tacit knowledge and interpretative abilities to make daily care decisions (Anderson, Wendler, & Congdon, 1998; Janes, Sidani, Cott, & Rappolt, 2008; Kontos, Miller, & Mitchell, 2009; Kontos & Naglie, 2009).

**Concluding Remarks and Implications**

This exploration of the social organization of work in RCFs elucidated some of the institutional processes that ensure that RCAs remain at the lowest level of a well-established and
ingrained hierarchy. The stratification found when examining care staff members' access to information provided an interesting and somewhat disturbing representation of how deeply entrenched this hierarchy is. For true culture change to occur, leaders in these institutions must actively minimize the negative effects of this hierarchy. An important first step would be to create open gates of communication and to enable the RCAs to position themselves on the same "side of the fence" as the regulated health professionals through active and empowered participation in residents’ care activities, including assessment, care planning, and quality improvement initiatives. Until RCAs are actively included in these formal care processes, their important and significant vantage point regarding the health and wellbeing of RCF residents will remain an untapped resource that is essential to the residents’ quality of care and quality of life.

Discussion: The Empowerment Pyramid for Person-Centred Care

Having found that the institutional texts exerted little if any positive influence on the provision of person-centred care, I focused on those factors that did contribute beneficially to care delivery in the RCFs. I acknowledge that the intention of an institutional ethnography is to enable the individuals under study to find their own solutions to the uncovered disjunctures found in their institutions. However, to move forward (i.e., not become completely dispirited by my findings), I needed to engage in some solution seeking. Therefore, I applied a pragmatic approach, which is outcome focused and primarily concerned with what works (Garrett, 2007). Based on my findings regarding "what works" to improve care practices in RCFs, I elucidated a model—the Empowerment Pyramid for Person-Centred Care. This model provides a conceptualized understanding of the key factors that positively influence the provision of person-centred care in RCFs. These factors include: empowered leaders, trust, reciprocity, resilience,
and quality of work-life. The factors and the proposed associations between them are depicted in Figure 9.1.

**Figure 9.1: Empowerment Pyramid for Person-Centred Care**

Empowered leaders. The care work in RCFs is socially organized to ensure that RCAs remain at the lowest level of a well-established and ingrained hierarchy. As a result, the study RCAs reported that they felt that they were "at the bottom of the barrel" and that the rest of the care team viewed them as nothing more than "professional ass wipers." However, the presence of leaders who engaged in key leadership behaviours seemed to counteract the negative outcomes of this deeply entrenched social organization of care. These leaders actively engaged in
behaviours that demonstrated the following: (a) responsiveness, (b) respect, and (c) recognition. Of note, the leaders' ability and propensity to engage in these behaviours seemed to be dependent upon the leaders' self-perceived levels of empowerment. It is for this reason that I have characterized these leaders as "empowered leaders."

**Responsiveness.** Empowered leaders were responsive to the needs and concerns of the RCAs. For example, a manager demonstrated responsiveness by appearing on “the floor” to openly discuss a rumour that layoffs were impending. This manager actively responded to the RCAs’ need for direct and open information and to their concerns regarding how the layoffs would affect their work (and that of their colleagues). Another example is when a team leader contacted a resident's physician in response to a concern that an RCA shared with her regarding the level of pain she believed a resident was experiencing. The presence of empowered leaders who were responsive to the RCAs was found to be directly associated with the presence of open, two-way gates of communication that allowed for in-person information exchange between the RCAs and their team leaders, nursing supervisors, and management. This finding made intuitive sense given that the ability of managers and leaders to respond to the needs and concerns of RCAs is first dependent upon whether they know the nature of the RCAs’ concerns and needs.

It is noteworthy that the government’s model of regional healthcare delivery, introduced in the 1990s, significantly affected the autonomy exercised by the RCF managers, which, in turn, influenced their exchange of information with the RCAs. The less empowered the managers and nursing supervisors were in their ability to respond to the needs of their care staff, the less willing and able they were to ensure that their subordinates had access to open, two-way gates of communication. Examples of this behaviour were noted in the managers from Facilities #2 and #3, who predominantly used one-way, written texts for communication purposes (e.g., memos
and mass e-mails). These managers seemed less aware of the needs and concerns of the RCAs and were thus significantly less likely (or able) to respond to them. The resulting closed or one-way gates of communication led to an erosion of trust between the care staff members and these managers, which diminished the quality of their relationships.

The literature is dense with research findings that have underscored how important it is for leaders to stay focused on, and actively respond to, the needs of their team (e.g., Dirks & Ferrin, 2002; Jung & Avolio, 2000; Podsakoff, MacKenzie, Moorman, & Fetter, 1990). The level of responsiveness that leaders demonstrate towards the needs and concerns of their subordinates is directly associated with the cultivation of trust that subordinates feel towards their leaders (Covey, 2006; Kouzes & Posner, 2012; Lencioni, 2005). In addition, when administrators of RCFs fail to attend to employees’ needs, they passively foster cold and impersonal feelings and interactions between care staff members and residents (Sheridan, White, & Fairchild, 1992).

**Recognition.** The empowered leaders actively appreciated the RCAs by recognizing them for work well done. Unfortunately, relatively few leaders consistently provided recognition or appreciation to their subordinates. With very little exception, the RCAs reported that they rarely felt actively appreciated by management for the work they did. In fact, in response to the question, “If you could change one thing about this job, what would it be?” many answered that they wished management would appreciate them more.

Although most employers think that they know how to express appreciation for a job well done, research has shown that employers seldom acknowledge appreciation for their employees’ work, and when they do, it is poorly done (Wiley, 1997). In a study investigating 40 years of survey data regarding employees’ motivators, more than 80 per cent of supervisors claimed that they frequently expressed appreciation to their subordinates, while less than 20 per cent of the
employees reported that their supervisors expressed appreciation more than occasionally (Wiley, 1997). This difference in perception is important because the recognition of a job well done, or full appreciation for work done, is often among the top motivators of employees’ performance (Koch, 1990; Manion, 2003; Stuart, 1992). When reviewing motivational factors for RCAs, Pennington, Scott, and Magilvy (2003) found that recognition and a sense of achievement were most important. They concluded that, to achieve positive outcomes for both RCAs and residents, management needs to become more creative in finding ways to recognize RCAs and to enhance their sense of achievement.

**Respect.** The empowered leaders were respectful of the RCAs' important contributions to the care team. Respect was demonstrated by such things as including the RCAs in residents’ care decision-making (e.g., active participation in admission assessments) and organizational decisions (e.g., active and empowered participation on work-load and work-safe committees). Essentially, these managers demonstrated that they trusted the RCAs' skills, knowledge, and experience and, as a result, provided them with greater levels of autonomy than the traditional hierarchy typically allowed or fostered. As a result, these leaders actively minimized the effects of the hierarchy found in their RCFs by creating open gates of communication and by enabling the RCAs to position themselves on the same “side of the fence” as the regulated health professionals. This findings is important because, when asked what they need and want most, RCAs consistently state that they want to be respected, recognized, and rewarded for providing high-quality care, and to be included in care planning and care conferences (Deutschman, 2001; McGilton, 2002).

**Trust.** High levels of trust between the RCAs and other members of the care team were cultivated when empowered leaders ensured that open gates of communication were present.
This conclusion is consistent with the findings of Gilbert and Tang (1998), who found a strong positive relationship between organizational trust and the nature and extent of organizational communication. They suggested that formal, but even more important, informal access to organizational communication channels enhances organizational trust. Furthermore, distrust in managers by subordinates has been found to be associated with less interaction between the managers and their subordinates. This behaviour seems to reinforce itself because several researchers have suggested that employees will actively minimise their communication with managers whom they distrust (Graen & Schiemann, 1978; O’Reilly & Roberts, 1976; Scandura, Graen, & Novak, 1986). Thus, trust is an essential ingredient of open and meaningful communication within organizations (Muchinsky, 1977; Yeager, 1978).

Distrust in management was observed to be linked to low morale in the RFCs. Specifically, the RCAs who were angry at and distrusted management demonstrated behaviours typically associated with burnout (e.g., highly critical of management, openly frustrated, and negative about their jobs) and provided what some RCAs referred to as "slack" care (i.e., cutting corners to make their jobs easier at the potential expense of residents). Alternatively, greater levels of organizational trust, and trust in management, supported the establishment of supportive and trusting care teams that engaged in reciprocating behaviour. This finding is consistent with the literature that shows that trust is linked to performance and is a key ingredient of cooperative relationships (Scott, 1980; Whitener, Brodt, Korsgaard, & Werner, 1998). When employees trust one another, their effectiveness and job satisfaction are enhanced (Driscoll, 1978; Kegan & Rubenstein, 1973).

**Reciprocity.** Without exception, the RCAs reported that the presence of supportive work teams made the difference between a "good day" and a "bad day." They stated that with
supportive teammates they could successfully manage the most challenging workplace
adversities they encountered. Reciprocity (i.e., the exchange of mutual support and assistance)
emerged as a key feature of supportive work teams. Blau (1964) suggested that these social
exchanges are valued primarily because they are symbols of high quality, trusting relationships.

The tendency to reciprocate has received considerable theoretical attention as a strong
motivator in both interactive contexts in general and labour interactions in particular
(Dufwenberg & Kirchsteiger, 2004; Fehr & Falk, 2002; Rabin 1993). In general, research has
shown that positive, beneficial actions (e.g., empowered leadership behaviour) directed at
employees contribute to the establishment of high-quality exchange relationships (Barr &
Serneels, 2009; Dansereau, Graen, & Haga, 1975; Konovsky & Pugh, 1994; Rhoades &
Eisenberger, 2002; Shore & Wayne, 1993). For example, Settoon (1986) found that desired,
reciprocal work behaviour (both that which conformed with and that which extended beyond
what was specified in the employment contract) was associated with the nature of the
relationship between supervisors and their subordinates. Settoon (1986) also found that the more
the relationships or exchanges between supervisors and subordinates were based on mutual trust
and loyalty, interpersonal affect, and respect for each other, the better a subordinate's
performance in terms of reciprocal citizenship behaviour (i.e., behaviour that aided the
subordinate and other coworkers, albeit not part of the subordinate's required duties). Settoon,
Bennett, and Liden (1996) added to this evidence by demonstrating that when both leader-
member (i.e., leader-subordinate) exchange and perceived organizational support were examined
within the same study, leader-member exchange had a stronger association with citizenship
behaviour than did perceived organizational support.
Research has also shown that the absence of reciprocating behaviour and trust in a work place is associated with a lack of resilience and poor health status. For example, Suzuki, Takao, Subramaniam, Komatsu, Doi, and Kawachi (2010) found that workers \((n = 1,147)\) reporting individual-level mistrust and lack of reciprocity had approximately double the odds of poor health even after controlling for differences in sex, age, occupation, educational attainment, smoking status, alcohol use, levels of physical activity, body mass index, and presence of chronic diseases.

**Resilience.** In the current study, reciprocity was found to strengthen the RCAs' resilience in their day-to-day work as they coped with common workplace adversities. This is an important finding because the care work that RCAs engage in, on a daily basis, is physically and emotionally demanding. Throughout the course of a regular shift, they must provide the most intimate of care to individuals with highly complex needs. Much of the work that they do is unpleasant and unmentionable in our society (e.g., the cleaning of the genital and rectal areas and bowel care, including the administration of enemas and suppositories). In addition, they face challenges associated with occupational health and safety issues (e.g., the risk related to working with residents who physically resist care and heavy lifting), staffing (e.g., shortages and unreasonable staff-to-resident ratios), access to appropriate supplies to accomplish their tasks (e.g., inadequate supply of linens, transfer belts, and slings for mechanical lifts), and the experience of grief caused by the death of a resident. The RCAs of all three facilities were regularly exposed to these and other forms of adversity; consequently, their ability to remain resilient was essential to sustaining the quality of care they provided.

Jackson, Firtko, and Edenborough (2007) reviewed the literature related to personal resilience as a strategy for responding to workplace adversity. They described resilience as “the
ability of an individual to adjust to adversity, maintain equilibrium, retain some sense of control over their environment, and continue to move on in a positive manner" (p. 3). Overall, the research suggests that resilience has significant implications for job-related attitudes, including satisfaction, commitment, engagement, organizational citizenship, diminishment of cynicism and undesirable behaviour, including absenteeism and deviance (e.g., actively disregarding rules and regulations) (Avey, Patera, & West, 2006; Avey, Wernsing, & Luthans, 2008; Larson & Luthans, 2006; Luthans, Avolio, Avey, & Norman, 2007; Youssef & Luthans, 2007). These findings point to the important role that resilience plays in shaping individuals’ appraisals of, and reactions to, their work experiences and thus, the quality of their work-life.

Quality of work-life leading to quality of care. The quality of the study RCAs' work life was largely dependent upon the presence of empowered leaders and the resulting work-place relationships these leaders helped to create. Positive work-place relationships seemed to enable greater resilience. The more resilient the RCAs felt in the face of work-place adversities, the more likely they were to engage in care practices that were demonstrably responsive to their residents’ needs. Accordingly, the presence of empowered leaders exerted a significant influence on the RCAs' quality of work-life, which was directly associated with the quality of care they provided.

These conclusions are supported by the work of Bishop, Weinberg, Leutz, Dossa, Pfefferle, and Zincavage (2008) who demonstrated that RCAs who had supervisors that respected and relied upon their knowledge of residents’ care needs experienced more job satisfaction and were more likely to express an elevated sense of responsibility toward the residents. Bishop et al. (2008) concluded that residents’ satisfaction with their relationships with the nursing staff was related to the proportion of RCAs on the residents’ unit who indicated that
they had a positive relationship with their supervisors. These findings are consistent with those of Rader and Semradek (2003), who concluded that the best way to ensure that RCAs respect residents’ rights and listen to their preferences is for managers to ensure that RCAs are respected and that their decision-making roles are supported. Tellis-Nayak (2007) reiterated these assertions; she concluded that supportive managers who create person-centred workplaces enable caregivers to actively engage in the provision of person-centred care, thereby improving residents’ quality of life.

Bowers, Esmond, and Jacobson (2003) found that it was not necessarily the hard work or poor pay that caused RCAs to leave their jobs; rather, it was the way in which they were treated by their employers (i.e., feeling dismissed or insignificant as a result of organizational policy and practices). This finding is important given that several studies of the quality of work-life and quality of care in RFCs have revealed that there is an association between lower absenteeism and turnover rates and greater job satisfaction and important outcomes such as improved performance, enhanced care provision, and corresponding improvements in residents’ satisfaction (Brannon, Zinn, Mor, & Davis, 2002; Brannon, Barry, Kemper, Schreiner, & Vasey, 2007; Eaton, 2001; Ejaz, Noelker, Menne, & Bagaka’s, 2008; Morgan & Konrad, 2008).

Many authors have proposed that improving the quality of healthcare employees’ work life may ultimately lead to improvements in the quality of care they provide (Eaton, 2000; Eisenberg, Bowman, & Foster, 2001; Stone, Dawson, & Harahan, 2003). According to Eisenberg, Bowman, and Foster (2001) a healthy workplace is one where employees, the providers of care, are able to deliver high quality care and where employees’ health and residents’ care quality are mutually supportive. Thus, they contended that the physical and emotional health of healthcare employees
fosters quality care and that being able to deliver high-quality care in turn fosters employee health.

To summarize, in this study, empowered management, nursing supervisors, and team leaders: (a) responded to the needs and concerns of RCAs, (b) appreciated the RCAs and recognized them for a job well done, and (c) demonstrated respect of the RCAs’ knowledge and skills (e.g., by expanding their roles on the care teams with activities such as admission assessment and work-load committee). These empowered leaders cultivated organizational trust, which in turn cultivated the presence of supportive, reciprocating care teams. This essential teamwork enabled the RCAs to remain more resilient as they faced common workplace adversities. Finally, the responsiveness of the leaders within the organization, to the needs and concerns of the RCAs, was observed to be reflective of the RCAs’ level of responsiveness to the needs and concerns of the residents and their family members. Accordingly, the RCAs' quality of work-life was directly associated with the quality of care provided. When the Empowerment pyramid for person-centred care model was presented to the study participants at information sessions scheduled for the sharing of some of the research findings, the study participants, who represented all levels of the organizational hierarchy, overwhelmingly indicated that it accurately depicted some of the key factors that influence the provision of person-centred care in RCFs.

**Theoretical Implications: Why Leaders Need Access to Structural Empowerment and RCAs Need to Experience Self Determination**

**Structural empowerment.** Kanter’s (1979) *Theory of Structural Empowerment* suggests that individuals’ attitudes and behaviour are shaped primarily in response to their positions within an organization; consequently, personality predispositions are seen as less influential on behaviour than are situations that arise because of one’s position within the organization. Central
to an individual’s position is her or his access to both formal and informal power. *Formal power* is derived from positions that are relevant to key organizational goals, allow discretion, and provide recognition. In contrast, *informal power* is derived from the quality of alliances and relationships with people in the organization. Accordingly, informal power is a measure of the quality of interprofessional relationships within one’s work setting.

According to Kanter (1979), the *structure of power* denotes access to three lines of power—lines of supply (i.e., an individual’s ability to exert influence outward and bring needed and valued resources into the organization), lines of information (i.e., timely access to information about organizational decisions and policy changes that may directly or indirectly affect one’s organizational domain), and lines of support (i.e., guidance and feedback received from subordinates, peers, and supervisors to enhance effectiveness) (Laschinger, 1996). Kanter (1979) proposed that the best way to make ineffective individuals more productive is not by training or replacing them, but by making structural changes in the organization that enable them to have access to empowerment structures (e.g., access to resources, access to support, and increased control over working conditions and flexibility). Having access to these empowerment structures in an organization is postulated to empower people to effectively and constructively contribute to the attainment of the organization’s goals (Kanter, 1979).

The study findings lend support to Kanter’s (1979) theory, which, when applied to the current context, would predict that, if RCAs have appreciable access to informal power (i.e., supportive and responsive workplace relationships) and appropriate lines of power (i.e., resources, support, and information), then they would be more empowered to contribute constructively and effectively to the achievement of high quality, person-centred care, the organizational goal. However, it is important to note that the findings also indicate that any
change must begin with determining whether the facility managers, nursing supervisors, and team leaders have access to structural empowerment (i.e., the leaders must have appreciable access to the resources required to enact respect, recognition, and responsiveness to the needs of RCAs, other providers, residents, and families). Consistent with Kanter's theory, the leaders' ability to share power was found to be dependent upon their own access to it. Kanter (1979) proposed that individuals who have access to empowerment structures motivate and empower others by sharing those sources of power (e.g., engaging in empowered leadership behaviour). Alternatively, individuals in organizations that lack access to such structures see themselves as accountable, yet without power. This, in turn, creates feelings of frustration and failure, which leads them to attempt to reduce other people’s power by exerting dictatorial control over employees below them in the organizational hierarchy. Kanter (1979) stated that the process of getting and giving power is inextricably intertwined and that the most effective way to expand power is to share it.

Kanter's theory is especially beneficial in helping to explain why the managers and leaders in the RFCs who felt the least empowered were also the least likely to engage in empowered leadership behaviour. However, to further our understanding of how the presence of empowered leaders positively influences the lived experiences of RCAs and thus, the actual care practices, we need to turn to self-determination theory as proposed by Ryan and Deci (2000).

**Self-determination theory.** Self-determination theory is a macro-theory of motivation that has received widespread attention in the education, health care, and sports domains (Gagné & Deci, 2005). According to Ryan and Deci (2000), basic psychological need satisfaction is assumed to represent the underlying motivational mechanism that galvanizes and directs people’s behaviour. In self-determination theory, three basic needs are distinguished: the needs
for autonomy, competence, and relatedness. The need for autonomy represents people’s inherent desire to feel volitional, which is accomplished through experiencing a sense of choice and psychological freedom when carrying out an activity (DeCharms, 1968; Deci & Ryan, 2000). The need for competence represents people’s inherent desire to feel effective in their ability to adapt to complex and changing environments (Deci & Ryan, 2000; White, 1959). Competence satisfaction is related to mastery and results in the general, affective experience of effectiveness, whereas competence frustration results in helplessness and a lack of motivation (Deci & Ryan, 2000). The need for relatedness represents people’s inherent propensity to feel connected to others (e.g., be a member of a group and to experience love and care) (Baumeister & Leary, 1995). This need is satisfied when people experience a sense of communion and develop close and intimate relationships with others (Deci & Ryan, 2000).

Self-determination theory considers each of these basic psychological needs to be innate, fundamental propensities, much like biological needs (Deci & Ryan, 2000). Thus, it does not postulate a particular order in which the three needs must be met. Instead, all three needs are considered important for people to thrive. Additionally, according to the theory, people do not need to experience a deficit for the needs to fuel behaviour. Rather, people are attracted to situations in which need satisfaction may occur.

Central to self-determination theory is the distinction between autonomous motivation and controlled motivation (Gagné & Deci, 2005); this distinction is especially significant when the theory is applied to the work environment. Controlled motivation is said to result from experiencing external (i.e., peer pressure, mandated regulatory compliance, and rigid routines) or internal (i.e., guilt and shame) contingencies to conduct a particular behaviour. It is contrasted with autonomous motivation, which is prominent when employees engage in an activity because
they consider it intrinsically interesting or personally valuable (Deci & Ryan, 2000).

Autonomous motivation is conducive to the satisfaction of the three needs and has been found to correlate positively with work-related well-being, optimal performance, persistence, and maintained behaviour change, job satisfaction, positive work-related attitudes, and organizational citizenship (Baard, Deci, & Ryan, 2004; Deci, Ryan, Gagné, Leone, Usunov, & Kornazheva, 2001; Gagné, Koestner, & Zuckerman, 2000; Ilardi, Leone, Kasser, & Ryan, 1993; Kasser, Davey, & Ryan, 1992; Van den Broeck, Vansteenkiste, & De Witte, 2008). Once employees' needs are satisfied, they are likely to feel further energized to actively engage in subsequent need fulfilling activities (Deci & Ryan, 2000).

When employees feel controlled, their need for autonomy is forestalled (Ryan & Deci, 2000). For example, RCAs who are forced to meet a deadline (e.g., having only 15 minutes to provide a resident with morning care because of the requirement that all residents are to be ready for breakfast at 8:00 a.m.) will experience less volition in executing the task. However, despite this pressure, RCAs might manage to satisfy their needs for competence by accomplishing the assigned task within the mandated timeframe. Unfortunately, my observations indicate that this may be one of the ways in which the organizational system reinforces task-oriented behaviour in caregivers. It is important to note, however, that when controlled motivation is used, the satisfaction of all three needs is less likely to occur because pressure to engage in a work activity is rarely accompanied by feelings of autonomy and interpersonal connection (Markland & Tobin, 2010). Research has shown that controlled motivation can lead to diminished overall performance and can negatively affect employees’ well-being (Gagné & Deci, 2005).

Deci, Connell, and Ryan (1989) contended that managerial autonomy support (i.e., leadership behaviour that helps to cultivate autonomous motivation) is critical to positive work
outcomes and employee well-being. Managerial autonomy support is defined by the following leadership behaviour: (1) acknowledging subordinates' perspectives, (2) providing relevant information in a non-controlling way, (3) offering choices, and (3) encouraging self-initiation rather than pressuring subordinates to behave in specific ways. These leadership behaviours are associated with employees being more satisfied with their jobs, having a higher level of trust in corporate management, and displaying positive work-related attitudes (Deci et al., 1989).

When applying self-determination theory to the empowerment pyramid for person-centred care it is clear that the leadership behaviour associated with managerial autonomy support is similar to the empowered leadership behaviour placed on the first level of the pyramid (i.e., encouraging self-initiation and acknowledging perspectives demonstrate respect and offering choices and sharing and receiving information demonstrate responsiveness). Thus, empowered leaders who engage in these behaviours may help RCAs meet their needs for autonomy. Working further up the pyramid, the experience of trust and reciprocity from supportive team members is postulated to help RCAs to meet their needs for relatedness. Finally, the experience of resilience, quality of work, and quality of care may help RCAs meet their needs for competence. It is important to note that both self-determination theory and the empowerment pyramid strongly support the premise that RCAs' ability to thrive in the work place is largely dependent upon the presence of leaders who support their need for autonomy. Thus, empowered leaders provide the foundation of both self-determination theory and the empowerment pyramid, and a strong sense of purpose and satisfaction in one’s work is the outcome of both.

The RCAs' ability to provide person-centred care (which must, by definition, be flexible and adaptive to the unique care needs of residents) is largely dependent upon their experience of autonomous motivation. It is highly likely that the persistent implementation of rigid care
routines, which are based on organizational norms and regulations, rather than residents' needs and preferences, is likely the result of the pervasive use of controlled motivation in RCFs as opposed to autonomous motivation. Finally, if managerial autonomy support is primarily offered only to regulated healthcare staff members (e.g., managers only encourage RNs and/or LPNs to demonstrate initiative, choice, and autonomy at work) and rarely or never offered to RCAs, the result is likely to be a further entrenchment of the hierarchical social organization of care.

**Policy Implications: To Whom Are You Responding?**

Every manager, nursing supervisor, and team leader enrolled in this study spent his or her day diligently responding to individuals’ and administrative needs, demands, and directives. They often finished a work-day feeling as if the list of “things to do” was no shorter than when the day began. However, those leaders that spent a significant portion of their day responding to the needs of the individuals who were below them on the hierarchy frequently engaged with these individuals by asking, "What do you need from me in order to do your job?" The leaders who dedicated time, energy, and resources to asking and then addressing the answers to this vital question more often demonstrated the three empowered leadership behaviours (i.e., responsiveness, respect, and recognition), which seemed to subsequently enable and encourage the RCAs to engage in person-centred care.

Those leaders that spent the majority of their days responding to directives of individuals above them in the hierarchy engaged predominantly in one-way communication, which communicated an unspoken message to the RCAs: "This is what I need from you to help me do my job" (e.g., collecting data and submitting statistics, conducting audits, and ensuring compliance with regulatory requirements). When this one-way, top-down exchange became the dominant discourse between the RCF supervisors and their subordinates, empowerment,
teamwork, and trust were eroded, which negatively affected the provision of person-centred care. Based on these findings, I recommend that closer scrutiny be undertaken of RCFs’ regulations, policies, systems, and directives that result in leaders believing they must focus on responding to institutional texts (i.e., being paper compliant) at the expense of proactively responding to the needs and concerns of the people within the institution.

The primacy of the written information exchange in RCFs must not completely replace or worse, eliminate, the reliance on an oral exchange of information. Formal systems should be implemented to support a structured, oral information exchange within and between the microsystems of care found in RCFs (e.g., team huddles led by RCAs, scheduled two-way afternoon reports between the team leaders and the RCAs) to promote consistent and effective exchange of information relevant to residents’ care.

Finally, clarification of the purpose of the RAI-MDS v2.0 is required. From its inception, the RAI-MDS was intended to serve many purposes: to collect data to inform care planning and to describe the resident population, to generate quality indicators to evaluate RCFs and guide improvement interventions, and to serve as a data source for RCF payment systems and resource allocation. Efforts to use this tool to simultaneously respond to the needs of consumers, RCFs, regulators, funders, and researchers (who can have conflicting demands) undermine the instrument’s manifest functions (i.e., being a reliable and valid comprehensive assessment of residents’ care needs) (Rahman & Applebaum, 2009). For example, requiring RCFs to collect data that can be used to determine funding for their salaries may compromise good data collection practices (e.g., individuals entering incorrect data because it will lead to more revenue for their institutions) (Rahman & Applebaum, 2009). This is especially concerning when it results in poor data that are subsequently used to create and implement plans for residents’ care.
Thus, policy makers and RCF administrators would be wise to narrow the focus and use of this instrument. Determining what is *really* wanted from these data and then ensuring significantly improved data collection processes and appropriate uses for that data are essential.

If the primary purpose of the RAI-MDS v2.0 is for the determination of funding and allocation of resources, then the implementation of the instrument could be dramatically altered (i.e., having one staff member ensure that the data are accurate and acknowledge it as a *receipt* of care, rather than as a *plan* for care that may or may not be enacted). On the other hand, if the primary purpose of the RAI-MDS v2.0 is for interprofessional assessment and care planning for every resident, then ensuring that the *entire* care team (including the RCAs) is directly involved in the implementation and use of the instrument would be important. Until the purpose of the RAI-MDS v2.0 is clearly determined and made transparent, it will continue to be a simple repository of data of questionable quality.

**Limitations and Future Directions**

The findings from this study are limited in their generalizability by various factors. First, this ethnography was conducted in three RCFs located within one of five health authorities. The collection of data from RCFs located in different health authorities, different provinces, or different countries could have produced results leading to different conclusions. Second, whether there were differences in the experiences, opinions, and behaviour of the people who agreed to participate and those who declined to take part could not be ascertained. Third, regardless of my intention to be as objective as possible in my observations and analyses, the lens through which I viewed the data undoubtedly influenced what I saw and how I interpreted it. Had I had different preconceived ideas or experiences, I may have focused my attention and gaze on entirely different elements of the data set.
Despite these limitations, this study adds to the body of knowledge postulating that improving the quality of care for residents in RCFs is directly related to improving the quality of the work life of the RCAs. Consistent with the published literature, my findings indicate that this latter consideration is an area in need of significant attention. I found that the presence of empowered leaders may be beneficial in improving both the RCAs' quality of work-life and the quality of the care they provide. However, this study stopped short of being able to determine and understand all of the factors that support or inhibit the development of empowered leaders in these institutions. Thus, this is an area in need of further investigation.

Having found that RCAs rely primarily on their personal "tool kit" when giving care to residents, evaluation should be undertaken of whether their education and in-service training sessions provide them with the requisite tools to successfully and safely accomplish their work. Taking direction from them in determining the tools in need of provisioning, sharpening, or re-mastering would be an important starting point. This could assist in meeting their needs of both competence and autonomy, which they require during the course of their day-to-day delivery of care to residents.

Finally, the *empowerment pyramid for person-centred care*, which provides a conceptualized understanding of the findings, requires further evaluation. Future research needs to be conducted to determine whether the key factors, and the relationships between them, exert the proposed influence on the provision of high quality, person-centred care in RCFs.

**Summary and Reflection**

Distilling the findings from this dissertation to a manageable concluding chapter was a challenging and necessary exercise. It required that I become very clear in what I could claim to have “found” as a result of the study. I found that access to information is embedded in the social
organization of care in RCFs. I found that, due to the social organization of care, RCAs must primarily rely on each other and on their own knowledge, skills, and beliefs to successfully accomplish their work. I found that many of the institutional, textually mediated work processes negatively influenced the provision of person-centred care. I found that RCAs would benefit from more respect, recognition, and responsiveness from the leaders in the institutions within which they work. I found that the quality of work-life in RCFs is directly related to the quality of care that residents receive.

On a more personal note, I found that I was deeply inspired by the RCAs, at times even humbled. I found that some of my preconceived ideas about how to "fix" these institutions were false. I found that I learned much more from this experience than can ever be encapsulated here. And finally, I found that, after dedicating over five years of my life to this research, I am ever more passionate in my desire to make a difference in the lives of RCAs and the residents they care for. I am hopeful that this study may provide the first step in helping achieve that goal.
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Appendices

Appendix A: Study Information Sheet and Consent

Study Information Document

Title: The Influence of Institutional Texts on the Provision of Person-Centred Care in Long-Term Care Settings

Student Researcher: Sienna Caspar
Contact Information: Phone (***) ***-****
                      e-mail ****@*****

You are being invited to take part in this research study because you are a professional care provider in a long-term care (LTC) facility. Your participation is voluntary, so it is up to you to decide whether to take part in this study. Before you decide, it is important for you to understand what the research involves. This study information sheet will tell you about the study, why the research is being done, and what is required of you, should you decide to participate in the study. If you do decide to take part in this study, you are still free to withdraw at any time and without giving any reasons for your decision. If you do not wish to participate, you do not have to provide any reason for your decision not to participate. Additionally, if you do not take part in this study or if you decide to withdraw at any time, it will have no effect upon your employment and your decision will be maintained in confidence. Please take time to read the following information carefully before you decide.

WHO IS CONDUCTING THE STUDY?

The study is being conducted by Sienna Caspar as part of her requirement for the completion of her Doctor of Philosophy in the Interdisciplinary Studies Graduate Program at University of British Columbia.

BACKGROUND

Canada’s population is aging, which may lead to an increased demand for LTC services and the decreased availability of formal caregivers. This is likely to cause the work within LTC settings to become even more physically and emotionally demanding. In light of these trends, the need to increase our understanding of organizational processes of LTC facilities that enable or impede formal caregivers to provide high quality, person-centred care has never been more important.

WHAT IS THE PURPOSE OF THE STUDY?

The purpose of this study is to learn how LTC facilities can create an environment that helps care staff members provide high quality, person-centred care. This study will investigate the influence of organizational practices and processes on care staffs’ ability to provide person-centred care. Results of this study may enable the development of system-wide changes to policies, procedures, and practice guidelines that support care members in meeting the organizational goal of providing person-centred care.

WHO CAN PARTICIPATE IN THE STUDY?

If you are a care aide, registered nurse, licensed practical nurse, manager, recreation staff member, physiotherapist, occupational therapist or dietician who is currently working in a permanent part-time or full-time position in this long-term care facility and you are proficient in English you can participate in this study.

WHO SHOULD NOT PARTICIPATE IN THE STUDY?
If you are not proficient in English you should not participate in this study.

DO I HAVE TO PARTICIPATE?
No, participation is voluntary and no care staff member is required to participate.

WHAT DOES THE STUDY INVOLVE?
As a participant of this study, you will be asked to allow the researcher to shadow you during the course of your regular work day. To ensure that the privacy and rights of the residents are respected, the researcher will not request to be present when personal care is provided to the residents. Rather, the researcher will only ask to observe your interactions with residents, family, members, and other staff members in common areas of the facility. Verbal permission to observe your interaction will be sought from residents and other people you interact with in the performance of your duties. The notes taken by the researcher during the participant observation will be transcribed for data analysis. Following the job-shadowing, you will be asked to participate in a conversation with the researcher. These conversations will take approximately 1 hour each and will occur during your regular work hours. To ensure that your participation in this interview does not impact your work day or the work day of your co-workers, you will be covered by a casual staff member while you participate in the interview with the researcher.

WHAT WOULD I HAVE TO DO?
If you agree to participate you will allow the researcher to observe you while you are performing your everyday work, caring for residents in the LTC facility. Following this, you will participate in a conversation of approximately one hour in length with the researcher. During this conversation you will be asked to describe your experiences (e.g., your activities and responsibilities during a typical day) working in a LTC facility. The researcher is interested in exploring and understanding the aspects of your work environment that support and hinder your ability to provide the best possible care that you can.

WHAT ARE THE POSSIBLE HARMs OF PARTICIPATING?
There is a minimal social risk. Your co-workers will be aware that you are participating in this study during the job shadowing and also when your duties are being covered by a casual staff member while you participate in the 1-hour conversation with the researcher.

WHAT ARE THE BENEFITS OF PARTICIPATING?
There are no direct benefits or compensation for participants. However, you may find it useful or interesting to reflect on your work experiences. In addition to this, it is hoped that the information learned from this study can be used in the future to develop system-wide changes that may positively influence both quality of care and quality of work-life in LTC settings.

WILL MY TAKING PART IN THIS STUDY BE KEPT CONFIDENTIAL?
You will be asked to provide a code name (a pseudonym) for yourself that will be attached to the field notes of the observation period and to your individual interview. All identifying information will be suppressed and only your code name will be used by the researcher when she writes about or discusses the results of this study. All notes, tapes, and transcripts will be secured in a locked filing cabinet in the researcher’s home. The record connecting your real name and code name will be kept in a locked secured cupboard separate from the other research data. Only the researcher will have access to this information. All material will be destroyed after 5 years.

WILL I BE PAID TO PARTICIPATE IN THIS STUDY?
As a thanks for your participation you will be given a $45 gift certificate following your interview.
WHAT HAPPENS IF I DECIDE TO WITHDRAW MY CONSENT TO PARTICIPATE?

Your participation in this research is entirely voluntary. You may choose to withdraw from the study at any point during the study. You may also ask to have your data removed from the study at any time and destroyed.

WHAT HAPPENS AFTER THE STUDY IS FINISHED?

The study results will be made available to you and will be submitted for publication as a PhD thesis. After publication of the thesis, the results will be disseminated through the submission of research articles to scientific journals and presentation proposals sent to scientific conferences.

WHO DO I CONTACT IF I HAVE QUESTIONS ABOUT THE STUDY DURING MY PARTICIPATION?

If you have any questions or desire further information about this study before or during participation, you can contact Sienna Caspar at (***) ***-**** or ****@*****

WHO DO I CONTACT IF I HAVE ANY QUESTIONS OR CONCERNS ABOUT MY RIGHTS AS A PARTICIPANT IN THIS STUDY?

If you have any concerns about your rights as a research participant and/or your experiences while participating in this study, please contact the UBC Behavioural Research Ethics Board by phone: 604-827-5114 or by e-mail: nadia.rad@ors.ubc.ca.

SUBJECT CONSENT TO PARTICIPATE

I have read and understand this consent form, and I volunteer to participate in this research study. I understand that I will receive a copy of this form. I voluntarily choose to participate, but I understand that my consent does not take away any legal rights in the case of negligence or other legal fault of anyone who is involved in this study. I further understand that nothing in this consent form is intended to replace any applicable Federal, Provincial, or local laws.

Participant's Name (Printed or Typed):
Date:

Participant's Signature:
Date:

Principal Investigator’s Signature:
Date:

Signature of Person Obtaining Consent:
Date:
Letter of Initial Contact

RE: Upcoming study at [Facility #1]

Study Title: The Influence of Institutional Texts on the Provision of Person-Centred Care in Long-Term Care Settings

Sienna Caspar is a doctoral (PhD) student at the University of British Columbia (UBC). She is doing a study to learn how to create a working environment that helps care staff provide the best possible care to residents. To accomplish this, Sienna will be spending time at [Facility #1] to learn more about what it is like to work in a long-term care facility. She will be watching the care staff as they go about their regular day-to-day work activities. However, she will never ask to be present or make observations when private or intimate care is provided to residents such as assistance with toileting, taking a bath, or getting dressed. Most observations will be made in public spaces in the facility or in residents’ rooms when care staff members are assisting with non-private care. She will take notes as she watches so that she can remember what she sees. Residents’ names will never be included in any of her notes nor will any identifying information about residents be obtained. These observations will not affect daily routines.

Sienna will also be interviewing some of the residents, staff, administrators, and family members to learn more about what it is like to live and work in a long-term care facility. 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 completely voluntary.

Study Information Documents are available at [Facility #1]. You can ask questions about this study at any time. If you have any questions or would like to learn more about the study please do not hesitate to contact Sienna Caspar at (***)***-**** or ****@**** or one of her dissertation supervisors:

Co-supervisor: Dr. Pamela Ratner, FCAHS, RN, UBC
School of Nursing (***)*** ****

Co-supervisor: Dr. Alison Phinney, RN, UBC
School of Nursing (***) *** ****
Appendix C: Study Information Document

THE UNIVERSITY OF BRITISH COLUMBIA

Study Information Document
Title: The Influence of Institutional Texts on the Provision of Person-Centred Care in Long-Term Care Settings

WHO IS CONDUCTING THE STUDY?

The study is being conducted by Sienna Caspar as part of her requirement for the completion of her Doctor of Philosophy in the Interdisciplinary Studies Graduate Program at University of British Columbia.

Student Researcher: Sienna Caspar   Phone (***) ***-**** e-mail**************
Primary Investigator: Pamela Ratner, PhD (***) ***-**** e-mail ************

BACKGROUND

Canada’s population is aging, which may lead to an increased demand for LTC services and the decreased availability of formal caregivers. This is likely to cause the work within LTC settings to become even more physically and emotionally demanding. In light of these trends, the need to increase our understanding of organizational processes of LTC facilities that enable or impede formal caregivers to provide high quality, person-centred care has never been more important.

WHAT IS THE PURPOSE OF THE STUDY?

The purpose of this study is to learn how LTC facilities can create an environment that helps care staff members provide high quality, person-centred care. This study will investigate the influence of organizational practices and processes on care staffs’ ability to provide person-centred care. Results of this study may enable the development of system-wide changes to policies, procedures, and practice guidelines that support care members in meeting the organizational goal of providing person-centred care.

WHO CAN PARTICIPATE IN THE STUDY?

1. If you are a resident living in this long-term care facility and you are proficient in English you can participate in this study.
2. If you are a registered nurse, licensed practical nurse, manager, administrator, recreation staff member, physiotherapist, occupational therapist, dietician or support staff member who is currently working in a permanent part-time or full-
time position in this long-term care facility and you are proficient in English you can participate in this study.

3. If you are a friend or family member of a resident who lives in this long-term care facility and you are proficient in English you can participate in this study.

**DO I HAVE TO PARTICIPATE?**

No, participation is voluntary and no one is required to participate.

**WHAT DOES THE STUDY INVOLVE?**

The study involves observations of care staff members as they go about their day-to-day work practices followed by interviews with some staff members of the facility and some residents and family members.

**WHAT ARE THE POSSIBLE HARMs OF PARTICIPATING?**

There is a minimal social risk. The staff, managers, and other family members may be aware that you are participating in this study during observational periods or while you participate in the 1-hour conversation with the researcher.

**WHAT ARE THE BENEFITS OF PARTICIPATING?**

There are no direct benefits or compensation for participants. However, you may find it useful or interesting to reflect on your experiences with the student researcher. In addition to this, it is hoped that the information learned from this study can be used in the future to develop system-wide changes that may positively influence both quality of care and quality of work-life in LTC settings.

**WILL MY TAKING PART IN THIS STUDY BE KEPT CONFIDENTIAL?**

Because this research is taking place in a residential environment and observations and interviews will occur on site, it will be difficult to maintain complete anonymity about participation. In order to maintain confidentiality, you will be asked to provide a code name (a pseudonym or made up name) for yourself that will be attached to your individual interview. All identifying information will be suppressed and only your code name will be used by the researcher when she writes about or discusses the results of this study. All notes, tapes, and transcripts will be secured in a locked filing cabinet in the researcher’s office and data will be kept on computers that are password protected. Only Sienna, her doctoral committee, and analysis group will have access to the data. The record connecting your real name and code name will be kept in a locked secured cupboard separate from the other research data. Only Sienna will have access to this information. The data will be kept for a minimum of five years in accordance with the University of British Columbia research policy.
WHAT HAPPENS IF I DECIDE TO WITHDRAW MY CONSENT TO PARTICIPATE?

Your participation in this research is entirely voluntary. You may choose to withdraw from the study at any point during the study. You may also ask to have your data removed from the study at any time and destroyed.

WHAT HAPPENS AFTER THE STUDY IS FINISHED?

The study results will be made available to you and will be submitted for publication as a PhD thesis. After publication of the thesis, the results will be disseminated through the submission of research articles to scientific journals and presentation proposals sent to scientific conferences.

WHO DO I CONTACT IF I HAVE QUESTIONS ABOUT THE STUDY DURING MY PARTICIPATION?

If you have any questions or desire further information about this study before or during participation, you can contact Sienna Caspar at (***) ***-****

WHO DO I CONTACT IF I HAVE ANY QUESTIONS OR CONCERNS ABOUT MY RIGHTS AS A PARTICIPANT IN THIS STUDY?

If you have any concerns about your rights as a research participant and/or your experiences while participating in this study, please contact the Research Subject Information Line in the UBC Office of Research Services at the University of British Columbia at 604-822-8598.
Appendix D: Proxy Consent For Participant Observation

THE UNIVERSITY OF BRITISH COLUMBIA

School of Nursing
T201- 2211 Wesbrook Mall
Vancouver, BC Canada
V6T 2B5
Tel: (604) 822-7417
Fax: (604) 822-7466

Proxy Consent for Participant Observation

Study Title: The Influence of Institutional Texts on the Provision of Person-Centred Care in Long-Term Care Settings

Student Researcher: Sienna Caspar (***)***.**** or ****@*****

Please complete this form below and return it directly to Sienna Caspar using the self-addressed stamped envelope provided. No one but Sienna will know what you decided. This decision is up to you, and no one will be upset, and nothing will happen if you don’t sign this paper or if you change your mind later.

I read the Introductory Letter and the Study Information Documents dated March 15, 2012 and understand what this study is about.

I understand that I can change my mind at any time.

I agree to allow (resident’s name)_______________to participate by being observed when care staff members are attending to his/her needs.

Your signature: ____________________________ Date ____________

Your printed name: __________________________ Date ____________

Researcher’s Signature________________________ Date___________
Appendix E: Participant Observation Consent Form: Resident

THE UNIVERSITY OF BRITISH COLUMBIA
School of Nursing
T201- 2211 Wesbrook Mall
Vancouver, B.C. Canada V6T 2B5
Tel: (604) 822-7417
Fax: (604) 822-7466

Participant Observation Consent and Assent Form: Residents

The Influence of Institutional Texts on the Provision of Person-Centred Care in Long-Term Care Settings

Student Researcher: Sienna Caspar (***-**** e-mail***********)
Primary Investigator: Pamela Ratner, PhD (***-**** e-mail ***********)

Sienna Caspar is a doctoral student at the University of British Columbia. She is doing a study to learn about how the work of care staff in long-term care settings is socially organized. She is asking you to participate in her study because she is requesting that she be able to observe the care staff as they engage in their regular day-to-day work activities.

If you agree to be in her study, Sienna asks that you allow her to observe your caregivers as they attend to your needs and interact with you during the course of their regular work-day. Sienna will never ask to be present or make observations when private or intimate care is provided to you such as assistance with toileting, taking a bath, or getting dressed. Most observations will be made in public spaces in the facility where you live or in your room when your caregivers are assisting you with non-private care. Sienna will take notes as she watches so that she can remember what she sees. Your name will not be included in any of her notes nor will any identifying information about you be obtained.

You can ask questions about this study at any time. If you decide at any time that you do not want to be observed while your caregiver is assisting you, you can ask Sienna to stop and to leave.

If you sign this paper, it means that you understand the contents of this letter and that you want to be in the study. If you don’t want to be in the study, don’t sign this paper. Being in the study is up to you, and no one will be upset, and nothing will happen if you don’t sign this paper or if you change your mind later.

Your signature: ____________________________ Date ____________

Your printed name: ____________________________ Date ____________

Signature of person obtaining consent: ______________ Date ____________
Appendix F: Regional Daily Care Record

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Regional Resident Daily Care Record

Month: Year: 2011

**Nutritional Intake**

- G – Good (75% or more of meal)
- M – Moderate (50%-75%)
- F – Fair (25%-50% of meal)
- P – Poor (less than 25% of meal)
- R – Refused
- C-Off unit
- TF – Tube Feed
- NPO – Nothing by mouth
- L – Liquids only

**Skin Condition**

- N – Skin healthy/intact
- A – Abrasions
- L – Lesions/blisters
- B – Bruises
- R – Rashes
- S – Skin Tears or Cuts
- D – Dressing intact
- N/O – Not Observed
- X – Skin reddened but intact

**Restraints (Specify)** Refer to Physical/Mechanical Restraint Monitoring Form

- [ ] __________________________

**Safety Devices** (Check all that apply)

Note any changes to the safety device information in the progress notes and write PN above your initials

- [ ] Low Bed
- [ ] Roam Alert
- [ ] Bed Alarm
- [ ] Front closing seat belt
- [ ] Chair Alarm
- [ ] Other: ______________

- [ ] Call Bell within reach
- [ ] Side Rails

**Date:**

Initial below to confirm that care was provided as per the Care Plan and the information on Nutritional Intake, Skin Conditions and Restraints/Safety Devices is correct and that devices (bed/chair alarms, Roam Alert) are working properly.

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<td>b) Asks Repetitive questions</td>
<td>c) Makes Repetitive Verbalizations</td>
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MOOD BEHAVIOR: Code: Y=Yes N-No S=Slept (ALL shift) OP=On Pass H=Hospital
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<td>or less, than usual; getting up earlier than</td>
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<tr>
<td>normal &amp; unable to fall back asleep</td>
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<tr>
<td>l) Sad, pained, worried facial expression</td>
<td>N</td>
<td>D</td>
<td>E</td>
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<tr>
<td>m) Crying/tearful</td>
<td>N</td>
<td>D</td>
<td>E</td>
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<tr>
<td>n) Has Repetitive physical movements</td>
<td>N</td>
<td>D</td>
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<tr>
<td>1. E.g. pacing, hand wringing, restlessness,</td>
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<tr>
<td>fidgeting, picking, rocking, tapping, rubbing, etc.</td>
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<tr>
<td>o) Stops or is less involved in activities of</td>
<td>N</td>
<td>D</td>
<td>E</td>
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<tr>
<td>interest</td>
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<tr>
<td>1. E.g. the resident has stopped doing things</td>
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<td>they used to do or stopped going to events/</td>
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<tr>
<td>places they used to go</td>
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<tr>
<td>IS THIS NEW FOR THIS RESIDENT?</td>
<td>N</td>
<td>D</td>
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<tr>
<td>p) Reduced social interaction</td>
<td>N</td>
<td>D</td>
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<tr>
<td>1. E.g. the resident is less involved in</td>
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<tr>
<td>activities, less talkative, spending more time</td>
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<tr>
<td>alone</td>
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<tr>
<td>IS THIS NEW FOR THIS RESIDENT?</td>
<td>N</td>
<td>D</td>
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</table>

Covenant Health St. Joseph's Edmonton
RR# RM
DOB: PHN: Dr. ADM

383
Appendix G: RAI-MDS 7 Day Tracking

Regional RAI MDS 7 Day Tracking Tool

Unless otherwise stated code:
Y (YES); N (NO) or S (Slept all shift)

<table>
<thead>
<tr>
<th>DATE:</th>
<th>DAY 1</th>
<th>DAY 2</th>
<th>DAY 3</th>
<th>DAY 4</th>
<th>DAY 5</th>
<th>DAY 6</th>
<th>DAY 7</th>
</tr>
</thead>
<tbody>
<tr>
<td>B5 Delirium/Thinking/Awareness</td>
<td>N</td>
<td>D</td>
<td>E</td>
<td>N</td>
<td>D</td>
<td>E</td>
<td>N</td>
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<tr>
<td>Easily distracted (gets side tracked)</td>
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<tr>
<td>Altered perception / awareness</td>
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<tr>
<td>Episodes of disorganized speech</td>
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<tr>
<td>Restlessness (physical or “calling out”)</td>
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<tr>
<td>Lethargy (sluggish)</td>
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<tr>
<td>Mental function varies through the shift</td>
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<tr>
<td>E4 Behaviour/Symptoms</td>
<td>N</td>
<td>D</td>
<td>E</td>
<td>N</td>
<td>D</td>
<td>E</td>
<td>N</td>
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<tr>
<td>Wandering behaviour</td>
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<tr>
<td>Verbally Abusive</td>
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<tr>
<td>Physically abusive</td>
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<tr>
<td>Socially inappropriate or disruptive</td>
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<tr>
<td>Resists Care</td>
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<tr>
<td>Behaviour easily altered</td>
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<tr>
<td>G2 Bathing: A</td>
<td>N</td>
<td>D</td>
<td>E</td>
<td>N</td>
<td>D</td>
<td>E</td>
<td>N</td>
</tr>
<tr>
<td>What the resident did for self: Enter number:</td>
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<tr>
<td>0- resident is independent once set up</td>
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<tr>
<td>1- supervision, encourage, cueing</td>
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<tr>
<td>2- physical help with transfer only</td>
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<tr>
<td>3- physical help with any part of bathing</td>
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<tr>
<td>4- resident doesn’t help at all</td>
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<tr>
<td>8- activity did not happen</td>
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</tr>
<tr>
<td>G2 Bathing: B</td>
<td>N</td>
<td>D</td>
<td>E</td>
<td>N</td>
<td>D</td>
<td>E</td>
<td>N</td>
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<tr>
<td>What the staff provided: Enter number:</td>
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<tr>
<td>0- no set up/physical help</td>
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<tr>
<td>1- set up help only</td>
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<tr>
<td>2- one person physical assist</td>
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<td>3- two or more person physical assist</td>
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<tr>
<td>8- activity did not happen</td>
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<tr>
<td>N1 Time Awake</td>
<td>D</td>
<td>E</td>
<td>D</td>
<td>E</td>
<td>D</td>
<td>E</td>
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<tr>
<td>Slept/napped longer than 1 hour in the:</td>
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<tr>
<td>Morning (Once up for the day – 1200h)</td>
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<tr>
<td>Afternoon (1200-1700h)</td>
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<tr>
<td>Evening (from 1700 till bed)</td>
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<tr>
<td>N2 Time Involved in Activities</td>
<td>N</td>
<td>D</td>
<td>E</td>
<td>N</td>
<td>D</td>
<td>E</td>
<td>N</td>
</tr>
<tr>
<td>Spends time in leisure activities, pursues own interests</td>
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<tr>
<td>Code (C) for CLYSIS / (W) for WOUND</td>
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<tr>
<td>Kardex and Care Plan Reviewed</td>
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</table>

PRINT name & designation | | | | |
INITIALS | | | | |

Revised: April 2011
### Regional RAI MDS 7 Day Tracking Tool

#### Column A: Resident Performance
- **0-** No help or Supervision needed
- **1-** Supervision, encouragement or cuing needed
- **2-** Limited Assistance- Resident involved, non weight bearing support provided.
- **3-** Physical assistance needed- resident dependent but able to help
- **4-** Total Dependence- resident did not participate
- **8-** Activity did not happen

#### Column B: Support Provided
- **0-** Independent - No help but supervision, cueing, encouragement may be needed.
- **1-** Set up help only
- **2-** 1 person physical assist
- **3-** 2 or more person physical assist.
- **8-** Activity did not happen

<table>
<thead>
<tr>
<th>GIA Activities of Daily Living</th>
<th>DATE</th>
<th>DAY 1</th>
<th>DAY 2</th>
<th>DAY 3</th>
<th>DAY 4</th>
<th>DAY 5</th>
<th>DAY 6</th>
<th>DAY 7</th>
</tr>
</thead>
<tbody>
<tr>
<td>Help needed to move in bed</td>
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<tr>
<td>(turn side to side, sitting up &amp; lying down)</td>
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<tr>
<td>Help needed to transfer</td>
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<tr>
<td>To and from the bed/ chair/ standing.</td>
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<tr>
<td>(Does not include transfer to/from toilet/shower/tub)</td>
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<tr>
<td>Help needed to walk</td>
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<tr>
<td>(in room)</td>
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<tr>
<td>Help needed to walk</td>
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<tr>
<td>(in corridor/ hallway on the unit)</td>
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<tr>
<td>Locomotion On Unit</td>
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<tr>
<td>How the resident moves about the room/ unit (walking, scooter wheelchair, geri chair etc.)</td>
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<tr>
<td>Locomotion Off Unit</td>
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<tr>
<td>How the resident moves off the unit (walking, scooter wheelchair, geri chair etc.)</td>
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<td>Help needed to dress/undress</td>
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<tr>
<td>Help needed to eat/ drink</td>
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<tr>
<td>How the resident eats and drinks regardless of skill, includes TUBE FEED</td>
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<tr>
<td>Help needed to use the toilet/ commode/ incontinence products</td>
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<tr>
<td>Includes transfers to the toilet commode, bedpan, urinal, change incontinent product, empty catheters, ostomies, per-icare, and adjusting clothes</td>
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<tr>
<td>Help needed to perform personal hygiene</td>
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<tr>
<td>Does not include shower/tub/ full bed bath</td>
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</tbody>
</table>

**Initials**
- **N**
- **D**
- **E**

Revised April 2011