POWER AND INTERESTS AT WORK: A STUDY OF THERAPEUTIC RECREATION PROGRAM PLANNING IN RESIDENTIAL CARE

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ABSTRACT

The purpose of this study was to develop a deeper understanding of how and why therapeutic recreation (TR) programs are planned in an extended care residential facility and the influence of the context, power and interests on planning. The TR literature does not adequately address the complex context of TR planning practice in residential care and does not help recreation therapists (RTs) understand how to ethically navigate through the power and interests that influence planning.

A combination of qualitative research methods including interviews, observations and document analysis were used in this case study, located in the Fraser Valley, British Columbia, Canada. Practicing RTs and their TR Manager were interviewed two to three times each. Three monthly planning meetings and one TR business meeting were observed and recorded and one TR job action planning meeting was recorded.

The RTs held strong beliefs about the purpose of TR and its role in contributing to the quality of life of people living in residential care. Organizational, professional, and personal power and interests influenced RTs’ planning practice and were important factors in the RTs program planning decisions, whom they involved in making those decisions and thus whose interests were served.

The impact of other stakeholders on the RTs planning practice was evident in the study. To competently engage in the sociopolitical activities of planning, the RTs were aware of who was involved in their planning practice (e.g., nurses, care aides, housekeepers, food service workers, volunteers, and family members) and who should be involved more (e.g., isolated and lower cognitive functioning residents). In addition, the RTs utilized several definably different tactics in planning situations involving power issues. Depending upon the circumstances, the
power of the stakeholder and the personal style of the individual, the RTs engaged in reasoning, consulting, networking, appealing, bargaining, counteracting and pressuring.

Incorporating the concepts and theories about planning from the adult education literature, a more robust question-based framework for TR is suggested that applies the contextual, sociopolitical and ethical elements of planning to the richly technical and theoretical Leisure Ability Model. Recommendations for practice and for further research are offered.
# TABLE OF CONTENTS

Abstract .......................................................................................................................... ii
Table of Contents ........................................................................................................... iv
List of Tables .................................................................................................................. vii
List of Figures ............................................................................................................... vii
Acknowledgements ...................................................................................................... viii

## Chapter One – Introduction ....................................................................................... 1
  Purpose of the Study ..................................................................................................... 3
  Context of the Study ..................................................................................................... 6
  Significance of the Study ............................................................................................. 11
  Research Questions ..................................................................................................... 12
  Structure of the Thesis ................................................................................................. 12

## Chapter Two – Review of Relevant Literature ........................................................... 14
  Therapeutic Recreation Literature .............................................................................. 14
  Leisure Ability Model ................................................................................................. 15
  Health Promotion/Health Protection Model ............................................................. 21
  Therapeutic Recreation Service Delivery and Outcome Models ......................... 24
  Optimizing Lifelong Health Through Therapeutic Recreation Model ................. 26
  TR Models and Theories of Practice .......................................................................... 27
  Adult Education Program Planning Literature ...................................................... 28
  Cervero and Wilson’s Negotiation Theory of Planning ........................................... 30
  Sork’s Planning Framework ......................................................................................... 38
  Caffarella’s Interactive Model of Program Planning .............................................. 45
  Adult Education Planning Theory Summary ........................................................... 52
  Summary ...................................................................................................................... 53

## Chapter Three – Research Methodology ................................................................. 55
  My Background as a Researcher/Recreation Therapist ......................................... 55
  Selecting the Research Site ......................................................................................... 56
  The Site ....................................................................................................................... 57
  Participant Selection .................................................................................................. 58
  Data Collection and Analysis ..................................................................................... 61
  Interviews ................................................................................................................... 62
  Documents ............................................................................................................... 65
  Participant Observation .............................................................................................. 66
  Analysis ....................................................................................................................... 67
  Quality of the Data ...................................................................................................... 69
  Limitations of the Study ............................................................................................. 71
  Summary ...................................................................................................................... 71

## Chapter Four – Results .............................................................................................. 73
  How Does the Context of Extended Care Influence TR Planning Practice? ........... 73
  Environmental Influences on Planning ..................................................................... 74
  Residential Care Access and Demand ..................................................................... 74
  Changes in the Labour Legislation ............................................................................ 75
  Job Action .................................................................................................................. 76
  Provincial Government Imposed Collective Agreement ....................................... 77
  Influenza Outbreaks ................................................................................................. 77
  Organizational Influences on Planning ...................................................................... 78
<table>
<thead>
<tr>
<th>Human Influences on Planning</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>The Residents</td>
<td>101</td>
</tr>
<tr>
<td>Family Members</td>
<td>104</td>
</tr>
<tr>
<td>Funders</td>
<td>105</td>
</tr>
<tr>
<td>Management Staff</td>
<td>106</td>
</tr>
<tr>
<td>Nursing Staff</td>
<td>107</td>
</tr>
<tr>
<td>Doctors</td>
<td>110</td>
</tr>
<tr>
<td>Support Staff</td>
<td>111</td>
</tr>
<tr>
<td>Other Staff Members</td>
<td>111</td>
</tr>
<tr>
<td>Volunteers</td>
<td>112</td>
</tr>
</tbody>
</table>

How and Why Do RTs Plan Programs in Extended Care? ............................................... 112
What Do RTs Believe About the Purpose of TR in Extended Care? ................................... 113
   Improving Residents’ Quality of Life ................................................................. 115
   Helping Residents Overcome Challenges to Participation ........................................ 117
   Providing Opportunities for Choice and Self-determination .................................... 118
   Resident Centred Care .............................................................................................. 120
   Providing Opportunities to Participate in Past Leisure Interests ............................. 121
   Promoting Residents’ Right to Recreation .............................................................. 122
   Promoting a Holistic Approach .................................................................................. 123
   Promoting a Homelike Environment ............................................................................ 124
   Creating Opportunities for Family Involvement ...................................................... 126
   Promoting a Sense of Self Worth .............................................................................. 127
   Easing Transition into the Facility ............................................................................. 128
How and Why Were Programs Chosen to be Offered? ......................................................... 128
   Meeting the Needs and Interests of Residents ......................................................... 129
   Other Reasons Why Programs Were Planned ............................................................ 131
How do Power and Interests Influence the Planning Process? ........................................... 133
   Shaping Needs ............................................................................................................ 134
   Setting Agendas ......................................................................................................... 135
   Determining Populations Served ................................................................................ 136
   Making Decisions ....................................................................................................... 138
   Allocating Resources ............................................................................................... 139
   Choosing Who Benefits from the Program .................................................................. 140
What Tactics do RTs use to Plan Programs? .......................................................... 141
   Reasoning .................................................................................................................... 142
   Consulting ................................................................................................................... 144
   Appealing .................................................................................................................... 146
   Networking .................................................................................................................. 148
   Bargaining .................................................................................................................... 150
   Pressuring ................................................................................................................... 152
   Counteracting ............................................................................................................. 152
Summary ......................................................................................................................... 153

Chapter Five – Discussion ................................................................................................. 155
   The Influence of the Environment and the Organization ............................................ 156
     Holistic or Medical? .................................................................................................. 157
     The Organizational Structure and Hierarchy ......................................................... 158
     Meta-Negotiations about the Physical Structure of the Facility ............................... 159
     Traditional Activities versus Therapeutic Recreation Programs ........................... 160
Beliefs and Ethics .............................................................................................................. 162
   Quality of Life – Rhetoric or Reality? ........................................................................ 162
   Holistic Care or Professional Recognition? ............................................................... 164
# Chapter Six – Summary, Conclusions and Recommendations

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Summary of the Research</td>
<td>188</td>
</tr>
<tr>
<td>Conclusions</td>
<td>190</td>
</tr>
<tr>
<td>How Does the Context of Extended Care Influence Planning Practice?</td>
<td>190</td>
</tr>
<tr>
<td>How and Why Do RTs Plan Programs in Extended Care?</td>
<td>193</td>
</tr>
<tr>
<td>How Do Power and Interests Influence Planning Practice?</td>
<td>194</td>
</tr>
<tr>
<td>What Tactics Do RTs Use When Planning Programs and Why?</td>
<td>194</td>
</tr>
<tr>
<td>How Well Do Current Program Planning Models Help to Guide RTs?</td>
<td>194</td>
</tr>
<tr>
<td>Recommendations for Future Research</td>
<td>195</td>
</tr>
<tr>
<td>Recommendations for Practice</td>
<td>196</td>
</tr>
<tr>
<td>Recommendations for TR Educators</td>
<td>196</td>
</tr>
<tr>
<td>Recommendations for TR Professional Associations</td>
<td>197</td>
</tr>
<tr>
<td>Recommendations for Practicing RTs</td>
<td>197</td>
</tr>
<tr>
<td>Closing Comments</td>
<td>197</td>
</tr>
<tr>
<td>Appendix A – Letter of Initial Contact</td>
<td>199</td>
</tr>
<tr>
<td>Appendix B – Consent Form</td>
<td>201</td>
</tr>
<tr>
<td>Appendix C – Interview 1 Protocol</td>
<td>203</td>
</tr>
<tr>
<td>Appendix D – Interview 2 Protocol</td>
<td>204</td>
</tr>
<tr>
<td>Appendix E – B.C. Therapeutic Recreation Association Code of Ethics Belief Statement of Recreation Therapists</td>
<td>205</td>
</tr>
<tr>
<td>Appendix F – Therapeutic Recreation Program Codes</td>
<td>207</td>
</tr>
<tr>
<td>Appendix G – Quality of Life Model</td>
<td>208</td>
</tr>
<tr>
<td>References</td>
<td>210</td>
</tr>
</tbody>
</table>
LIST OF TABLES

Table 1: Categories of Organizational Factors ................................................................. 49
Table 2: Demographic Characteristics of Research Participants ........................................... 60
Table 3: Functional Cognition Level of Research Site Residents ........................................ 103

LIST OF FIGURES

Figure 1: Caffarella's Interactive Model of Program Planning ............................................... 46
Figure 2: Recreation Therapy Staffing per 50 Residents in Extended Care Facilities with
Greater than 200 Residents ................................................................................................. 58
Figure 3: Beliefs about the Purpose of TR ........................................................................... 114
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CHAPTER ONE

INTRODUCTION

Since 1980, I have worked as a recreation therapist (RT) with adults living in residential care due to a variety of mental and physical challenges. Primarily I have planned and organized therapeutic recreation (TR) programs for clients (also referred to as residents in residential care settings), aged 75 years and older, living in extended care residential facilities. Similar to RTs working in other residential care facilities, my practice has been guided by therapeutic recreation\(^1\) theories of practice (Austin, 1997, 1998; Gunn & Peterson, 1978; Peterson & Stumbo, 2004; Sylvester et al., 2001; Van Andel, 1998; Voelkl, Carruthers, & Hawkins, 1997).

TR models of practice and their foundational theories have guided me in assessing, planning, implementing and evaluating programs for clients. However, despite the philosophical and technical strengths of the TR models, they do not adequately address the complex context of TR planning – particularly in residential care settings. Consequently, throughout my practice I have experienced the frustration of conflicting demands on how and what programs I arrange. For example, the plans I would set for a resident who wished to participate in community swimming every week would or would not come to fruition depending upon many factors. The TR literature guided me in how to assess the needs of clients, analyze the activity, identify barriers the clients may face, and how to develop strategies for skill development and/or adaptations that would enable the client to overcome any barriers and participate in a community

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\(^1\) There are many definitions of “therapeutic recreation.” For the purpose of my research, I refer to Sylvester, Voelkl, and Ellis’ \(2001\) definition:

Therapeutic recreation is defined as a service that uses the modalities of activity therapy, education, and recreation to promote the health and well-being of persons who require specialized care because of illness, disability, or social condition. Furthermore, recognizing the potential of leisure for contributing to the quality of life of all people, therapeutic recreation facilitates leisure opportunities as an integral component of comprehensive care. (p. 17)
swimming program. However, despite my efforts, the client’s ability to participate would also be influenced by other factors such as the facility resources available, the nursing schedule, the labour contract, the volunteer’s interest and skills, the traditions of the facility, and/or the administrator’s attitude.

Although the prevalent TR models include an analysis of the impact of context on program planning with regards to identifying community resources and client barriers to leisure participation, they overlook the sociopolitical impact and influence of the environmental, organizational, and human elements of the context (Caffarella, 2002). Furthermore, in an effort to professionalize therapeutic recreation services, Canadian RTs have embraced the American, technically-oriented treatment models of planning at the expense of models that incorporate a more holistic, comprehensive view of planning. Pedlar et al. (2001) argue that therapeutic recreation has adopted “the medical model and a concomitant ‘treatment outcome’ philosophy. Focusing on treatment-outcomes has tended to diminish many of the beneficial characteristics of leisure (Hemingway, 1986; Lakey, 1996; Mobily, 1996; Sylvester, 1998)” (p. 16). Likewise, RTs working in residential care have attempted to fit their practice into the ‘medical’ model. However, due to the personal and organizational power and interests inherent in the context, this technical, medical framework has not provided RTs with the guidance necessary for practice in residential care facilities. Coyle (1998) argues that the emphasis in residential care should be on empowering clients to take control of their lives versus being recipients of clinical services. Similarly, in the interest of fostering residents’ freedom of choice and empowerment, the TR treatment-oriented models, could benefit from the inclusion of an analysis of the power and interests influencing planning.
However, if RTs are to facilitate residents’ efforts to experience independence and as meaningful a quality of life as possible, RTs need to be challenged to move beyond the clinical models and towards models that comprehensively guide how to plan responsibly in a context rife with competing personal and organizational interests and powers. To do this though, RTs need models that include consideration of the influence of the context and the interests and powers that impact planning. Consequently, I was interested in researching how recreation therapists working in extended care plan programs in the face of complex organizational contexts so that I might be able to contribute to TR practice in residential care by developing a more comprehensive planning framework.

**Purpose of the Study**

The purpose of this research was to develop a deeper understanding of how personal and organization power and interests and the residential care context influenced how programs were planned, how RTs negotiated power and interests in residential care, and subsequently reveal areas for improvement in practice. I wanted to study how and why therapeutic recreation programs are planned in residential care facilities and how the prevalent therapeutic recreation program planning models and their underlying theories apply, do not apply, and/or could be developed to better apply to planning practice within this context.

This thesis discusses three closely interrelated but nonetheless distinct concepts: theories, models, and frameworks. Theories provide the underlying explanatory system for planning while models attempt to represent a preferred method of planning by describing the components of practice and how they connect and work together in order that other planners can copy or imitate this ‘exemplary’ method (Austin, 1997). Sork and Caffarella (1989) describe the purpose of a planning model as “a tool used to help understand and to bring order to a complex decision-
making process” (p. 234). In comparison, a framework is not defined in terms of a specific design that must be copied, but more generally as a description of a structure or a system. In summary, theories attempt to explain the principles of a phenomenon, models attempt to describe the technical and practical structure of a phenomenon, and frameworks attempt to describe the conceptual structure of a phenomenon. It is important for models and frameworks to be based upon a valid and tested theoretical foundation. In addition, Voelkl et al. argue (1997) that a good practice model is built upon experience but reflects the reality (i.e., constraints and opportunities) of current practice.

On the basis of my experience, I believe that the TR theories and models that are being taught in education programs are too de-contextualized. Although TR theorists (Austin, 1998; Gunn & Peterson, 1978; Stumbo & Peterson, 1998; Van Andel, 1998; Wilhite, Keller, & Caldwell, 1999) propose that RTs can play an important role in facilitating residents’ achievement of leisure participation, they do not adequately discuss the impact of power, interests and context on the planning process. Research on the role of these factors may provide a clearer description and analysis of TR program planning in residential care. I wanted to build upon existing TR theory and models by developing a framework for practice that incorporates an analysis of the impact of power, interests and context and promotes ethical, responsible planning practice.

In her “interactive model of program planning” Caffarella (2002) explores the importance of understanding the context. She writes,

Organizations are constantly changing. Political and economic climates are ever-fluctuating, and sometimes even volatile. There is a growing diversity among people who plan and attend education and training programs. Discerning the context, which is both a skill and an art, is a major component that planners address as they design educational programs. (p. 59)

In their work on adult education program planning, Cervero and Wilson (1994a) argue that “adult educators always plan programs in contexts defined by a concrete set of power relationships and associated interests. These concepts (power and interests) and their relationship structure planners’ action in planning practice” (p. 119). Similarly, Sork (2000) argues that to be effective, planners need to be “aware of the role of power, ideology, and interests and how these interact when people work collectively to make decisions about intentions and actions” (p. 177).

In like manner, as will be discussed in the following section, residential care organizations are undergoing rapid change and the diversity of the people who work and live in residential care is increasing. Therefore, RTs must be skilled at discerning the context.

Sork (2000) argues that

Studies of planning more often reveal a complex web of conflicting interests and priorities that are difficult or impossible to reconcile. This creates a significant challenge for planners because we have few conflict-based models or theories of planning to provide insights and suggest strategies (p. 177).

Utilizing adult education program planning theory I want to advance TR theory and practice by developing a framework that goes beyond the technical elements and includes the contextual, sociopolitical (e.g., power and interests) and ethical elements of planning.
Context of the Study

Caffarella (2002) defines the program planning context “as the human, organizational, and environmental factors that affect decisions planners make about programs” (p. 59). The context of this research site can similarly be described according to these three elements.

The organizational factors influencing this site included the physical, sociopolitical, and administrative structures – that is, the context of residential care. The term “residential care” refers to facilities for people who need access to health care professionals 24 hours a day, seven days a week (Ministry of Health Services & British Columbia Housing Management Corporation, 2003). I conducted my research at a 300 bed “extended care” \(^2\) residential care facility. It is part of an urban acute care organization (given the pseudonym, Pacific Memorial Hospital), which is in turn part of the Fraser Health Authority, which reports to the Provincial Minister of Health.

In 2002 there were approximately 25,000 Independent Living beds for seniors in BC (which includes supportive living, assisted living, and residential care beds) \(^3\). As of August 2002 there were 93 Independent Living facilities and 7,660 Independent Living beds in the Fraser Health Authority (Fraser Health Authority, 2003, p. 39). Approximately 34% of these residents,

\(^2\) Prior to 2003, residents’ care needs in BC were categorized as Intermediate Care 1, 2, and 3 (IC1, 2 or 3) and Extended Care. The new 2003 BC Independent Living Program continuum of care categorizes residents’ care needs as “Independent Housing with Support”, “Assisted Living” and “Residential Care.” The Ministry of Health Services (2003) argues that “many residents assessed at IC1 and 2 and even some at higher levels do not need to live in residential care” but that these residents will be more suitably accommodated in either “supportive housing” or “assisted living” housing (Ministry of Health Services & British Columbia Housing Management Corporation, 2003, p. 9).
In “Supportive/Independent Living” units, housekeeping, laundry, and meals are provided as well as 24-hour emergency response. “Assisted Living” facilities provide the same services as Supportive Living, as well as scheduled and non-scheduled personal care. The Ministry continues to explain that “those who need access to constant professional care will continue to be accommodated in residential care facilities. This level of need is called “complex care” (Ministry of Health Services & British Columbia Housing Management Corporation, 2003, p. 9). Therefore, today’s equivalent of the historical category of “extended care” is “complex care” and it was within this changing organizational context that I conducted my research. For the purposes of this research I will use the term “extended care.”

\(^3\) See footnote #2 above for explanation of “supportive living”, “assisted living”, and “residential care.”
or 2,584, were categorized as requiring “residential care” (Fraser Health Authority). The majority of residents were female (approximately 65%) and were over the age of 75 (approximately 86%). In 2002, there were 85,902 seniors aged 75 years and older living in the Fraser Health region. In comparison, there were 262,668 seniors aged 75 years and older in all of BC.

The Fraser Health Authority estimates that approximately 1 in every 10 seniors aged 75 years and older living in the Fraser Health Authority region lived in a facility in 2002 (Fraser Health Authority, p. 40). By the year 2027, the projected population of seniors aged 75 years and older living in the Fraser Health region will be approximately 190,940 (Fraser Health Authority, p. 9). If the rate of admission to complex/extended care continues to be 34% of 1 in 10 seniors, by 2027 there will be approximately 6,492 complex care residents in the Fraser Health Authority and approximately 20,000 complex care residents in BC. The changing criteria for admission to complex care, and the increasing demand for residential services, calls for research that will address the changing and complex context of TR practice and that will provide RTs with direction and ideas for improving their practice.

The “human” factors influencing the context of this study included the residents of the EC facility, the TR staff who planned and organized the programs, family members, hospital administrators and managers, community members, volunteers, and the “interdisciplinary” team members who worked with the RTs (e.g., nurses, doctors, care aides, occupational therapists, chaplains, music therapists, housekeepers, maintenance workers, food service workers, social workers, pharmacists, etc.).
Besides requiring 24-hour access to health care support, to be eligible for *extended* or *complex care*, a person must be physically, cognitively, and/or behaviourally challenged (Ministry of Health Services, 2002). In my fourteen years of experience working in large urban extended care facilities, all of the residents required a wheelchair for their daily mobility, although some were able to walk with the assistance of two people. In addition, all of the residents required assistance with their daily grooming and bathing, and many needed assistance to eat. Many of the residents experienced some form of memory loss, dementia, and/or inability to follow directions. However, some residents were very cognitively able, for example capable of playing bridge or learning to use a computer.

As noted above, there are many other people who may influence the planning practice of the RTs. Residents and their family members are increasingly demanding more say in how and where they live as they age. The patient who believes that the doctor or medical professional "knows best" is rapidly being replaced by the astute, informed resident who wants to participate in determining how his or her own care needs are met. The influence of the above mentioned stakeholders was explored indirectly, within the context of their relationship to the RTs. Although researching the planning practice of RTs from the perspective of the various stakeholders would provide valuable information and insight into the practice of RTs, it was beyond the scope of this study.

The context of this study site can also be explored from the viewpoint of the wider political "environmental factors" that impact planning practice in residential care. Since the BC Liberals were elected in a landslide majority in 2001 (77 of 79 seats in the provincial legislature),

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*See footnote #2 above for explanation of "extended" or "complex" care.*
health care has undergone a number of significant changes which have affected recreation therapy services and residential care. As noted above, the access criteria for long term care have been revised, changing the nature of the services as well as who can receive them. As a result, only people with the greatest physical and cognitive challenges are admitted to residential care and the increased care needs of the residents have correspondingly increased the workload for the care staff, which has not experienced any increases in staffing. Several long term care facilities have been closed, the residents transferred to different facilities, and some staff laid-off.

In addition, the budgets for residential care have been reduced, and the provisions of the collective agreements negotiated by health care workers have been unilaterally changed by the government. Specifically, the government has frozen health care budgets, thereby forcing health authorities to cut staff, services and programs in order to meet the increased costs of wages, supplies, and equipment. Furthermore, the Liberal’s introduced Bill 29 on January 28th, 2001, that amongst other things over-turned the “no contracting-out” provisions in various collective agreements. The Liberals then informed the health authorities that they now had Bill 29 as a tool for cutting costs – by contracting out services. Subsequently, hospitals and residential care facilities started contracting out, not only the support services of housekeeping, laundry and food services, but also nursing and recreation services. Since Bill 29 was introduced, over 5,000 health care workers have been laid off and many more are expected to lose their jobs as a result of contracting-out.

For example, there had been several changes to the staffing at the extended care facility where I worked until 2002. In April 2002, my position as senior recreation therapist (supervisor) was eliminated, as well as the positions of three part-time recreation staff. Next, in the summer of 2002, eleven of the registered nurses (RNs) were given displacement notices and they were
replaced with licensed practical nurses (LPNs). The dozen housekeeping staff were next to be laid off in the summer of 2003 as their work was contracted-out. Subsequently, on September 11th, 2003, the remaining five recreation staff were informed that their positions were being eliminated and that they were going to be replaced by rehabilitation aides, reporting to the occupational therapist (OT) and physiotherapist (PT). When presenting the news of this latest change, the manager argued that extended care was following the lead of other facilities by focusing more on rehabilitation versus recreation. This argument has not been substantiated by any evidence of other facilities making similar changes. Further study, which is beyond the scope of this thesis, is needed to determine the driving factors behind all of these changes in health care. However, a surface examination reveals that all of the changes have resulted in the creation of positions that require less education and training and subsequently cost the employer less. Regardless of the influencing factors, the changes in health care have greatly impacted how, why and what programs are being planned in residential care.

The acute care organization within which my extended care research site was located had contracted-out housekeeping and security services and had re-organized the food service department. In addition, 60 extended care beds were closed in 2002, resulting in resident relocations and staff lay-offs. Although there had not been further cuts to the TR staff, the threat of lay-offs was always present as the staff were aware of cuts and contracting-out at other facilities.

These changes have resulted in increased instability and anxiety amongst all health care workers. Some residential care facilities staff decided to decertify themselves as members of a union in an attempt to avoid contracting-out, resulting in additional changes to labour-management relations. The repercussions of these changes on residential care and the practice of
RTs can only be estimated as health care teams are in a constant flux, working relationships are disrupted, roles are changed, jobs are contracted out, and staff are distracted by the uncertainty of their employment.

**Significance of the Study**

Why is it important to study the program planning practice of recreation therapists working in residential care facilities? First, residential care organizations are rapidly changing as residents' needs are becoming more complex and diverse. Second, the TR literature does not adequately address the complex context of TR planning – particularly in residential care settings. Third, TR models of practice do not include any guidance for RTs on how to navigate through the sociopolitical and ethical issues prevalent in their planning contexts. In this time of health care cuts to staff and programs, Yang and Cervero's (2001) argument that "ignoring political realities can be fatal to a programme and even to the person who is responsible for the programme" (p. 290) is very pertinent to RTs, their TR programs, and the residents who access them. Increased understanding of the power and influence techniques and styles and their relationship with political contexts will increase RTs understanding and ability to practice more strategically and responsibly.

Finally, my experience has shown that the provision of therapeutic recreation services for individuals living in residential care facilities is central to the residents' experiencing some quality of life in their remaining days. However, there has not been any research conducted in BC on the planning of TR programs in any context, let alone in the context of residential care. As we all grow older (hopefully), it is important to establish the value of recreation therapy and to encourage RTs to reflect upon and improve their practice so that we too may enjoy a quality leisure lifestyle if we end our days in residential care.
Research Questions

Based on my experience as a recreation therapist and my review of the literature I decided to explore the following research questions:

1. How does the context of extended care influence planning practice? What organizational (e.g., structural, political and cultural), environmental, and human, factors influence planning practice?

2. How and why do RTs plan programs in extended care? That is, what do RTs believe about the purpose of TR in extended care and how are programs chosen to be offered?

3. How do organizational, professional, and personal power and interests influence RTs planning practice in extended care? That is, how are needs shaped, agendas set, populations determined, decisions made, resources allocated and residents chosen?

4. What do RTs know and do – what tactics do they use when planning programs (e.g., reasoning, consulting, appealing, networking, bargaining, pressuring, counteracting, negotiating) and why (i.e., what are they attempting to change)?

(See the Appendix C and D for more detailed interview questions related to these research questions.)

Structure of the Thesis

In Chapter Two I review the therapeutic recreation literature to identify a conceptual framework for the practice of TR and gaps in the literature. Next, I review the adult education program planning literature to identify a theoretical framework that is useful and appropriate for analyzing program planning in therapeutic recreation practice in residential care. I review empirical studies that link power, interests and context with planning and I consider how personal and organizational power and interests shape TR practice.
In Chapter Three I describe the research methodology and strategies used in this study. I discuss the research site, research participants, data sources, data collection, data analysis and limitations of the study. In Chapter Four the results of the research are discussed beginning with a review of how the context of extended care influences TR planning practice. Next, I describe the participants' beliefs about the purpose of TR. Following this I discuss how decisions are made about which programs are offered, how power and interests influence planning, and what tactics RTs use to alter power relationships and other factors that frame their practice.

In Chapter Five, the results are analyzed and interpreted to explain how power, interests and the sociopolitical context influences planning. Next, I suggest features of a more robust planning framework for TR. Chapter Six begins with a summary of the study followed by conclusions and then recommendations for future TR research and practice.
CHAPTER TWO

REVIEW OF RELEVANT LITERATURE

In this section, the principal theories and models referred to in the practice of therapeutic recreation will be discussed. Following this, the adult education program planning literature will be reviewed to identify a conceptual framework that is useful for analyzing therapeutic recreation program planning practice in residential care.

Therapeutic Recreation Literature

Sylvester et al. (2001) argue that therapeutic recreation models should provide RTs with direction on how to plan and implement programs as well as a theoretical basis for each component of the model. The models discussed in this section include the Leisure Ability Model (Gunn & Peterson, 1978; Peterson & Stumbo, 2000, 2004; Stumbo & Peterson, 1998), the Health Protection and Health Promotion Model (Austin, 1998), the Therapeutic Recreation Service Delivery and Outcome Models (Van Andel, 1998), and the Optimizing Lifelong Health Through Therapeutic Recreation Model (Wilhite et al., 1999).

The Leisure Ability Model has been the dominant model in TR since Gunn and Peterson (1978) published their book. The other models noted above have recently gained more attention in the TR literature and therefore are included in this review. The “recreation” literature (Edginton, Hanson, & Edginton, 1992; Kraus, 1997; Kraus & Shank, 1992; Patterson, 1987) that focuses on community recreation and issues of inclusion and integration could also usefully inform TR practice but for the purposes and limits of this research project they will not be included in this literature review.
Leisure Ability Model

The most influential therapeutic model being taught and used in therapeutic recreation is the Leisure Ability Model (LAM) (Gunn & Peterson, 1978; Peterson & Stumbo, 2000, 2004; Stumbo & Peterson, 1998). The first assumption of the LAM is that “every human being needs, wants, and deserves leisure” (Peterson & Stumbo, 2004, p. 35). The second assumption is that due to the presence of their disabilities and/or illnesses, individuals with a disability and/or illness encounter more severe and frequent barriers to enjoying a full and satisfying leisure lifestyle than other people. Thus the purpose of TR services is to “facilitate the development, maintenance and expression of an appropriate leisure lifestyle” for people with barriers to leisure (p. 38).

Peterson and Stumbo argue that to be competent and successful RTs must have a well-grounded understanding of TR theory, TR content, TR service planning, delivery and evaluation, and typical client needs and characteristics. The theoretical concepts that direct the planning of TR programs are the concepts of learned helplessness, intrinsic motivation, locus of control, choice, and optimal or “flow” experience. For example, Peterson and Stumbo (2000) argue that the role of the RT is to help clients regain their sense of personal control and causation and thereby reverse the effects of learned helplessness. These can be achieved “through the specific provision of functional interventions, leisure education, and recreation participation services, which teach specific skills, knowledge and abilities” (Peterson & Stumbo, p. 11). RTs help clients build skills by providing them with activities that increase their leisure competencies and sense of control so that they will, as a result, have more leisure options to choose from.

“Optimal” or “flow” leisure experiences refer to those situations where the challenge of an activity is matched to the skill level of the participant so that “the individual is most able to
achieve a state of concentration and energy expenditure that Csikszentmihalyi (1990) has labelled "flow" (Peterson & Stumbo, p. 13).

Peterson and Stumbo explain that there are three content areas of TR service that clients move through on a continuum, although these components can overlap. The LAM model's three content areas or service components are:

1. treatment (renamed functional intervention in 2000)
2. leisure education
3. recreation participation (Peterson & Stumbo, 2000).

_Treatment_ or _Functional Intervention_ services refer to skill building interventions that focus on the client's physical, social, emotional, and/or cognitive needs – with the aim of developing the client's skills so that they are able to become fully involved in leisure pursuits. For example, one client may need to learn anger management strategies to successfully participate in a group activity; whereas another client may need to develop the physical strength and skills to participate in a bowling program. In this stage of the Leisure Ability Model, the RT has primary control regarding the content of the interventions, although the client should be encouraged to exercise as much autonomy as possible.

_Leisure Education_ focuses on the client attaining leisure related attitudes, social interaction skills, and knowledge of leisure resources, activities, and skills. For example, clients may work with RTs to identify the barriers preventing their participation in a particular leisure activity so that they may then develop plans for overcoming or circumventing these barriers.

_Recreation Participation_ activities are structured programs, usually organized and implemented by the RT, that enable the client to experience enjoyment as well as practice their leisure related skills. The client is more responsible for his or her experience, receiving minimal
support from the RT. The ultimate goal of the LAM is for the client to independently participate in freely chosen leisure activities. However, the rationale for the recreation participation component varies depending upon the context. In residential care, where total independence is unlikely due to the limited abilities of the clients, more support is provided by the RT.

Clients may require and receive services in one or all of the components. Although the model is sequentially designed (i.e., clients progress from step 1 to 2 to 3), clients may also move back and forth between the steps. Client and therapist control of decision-making is placed along a continuum with the RT having the greatest control during the early functional intervention stage, and the client assuming more control as they move along the continuum towards independent recreation participation. Although the ultimate goal is for clients to achieve independent leisure participation, this is beyond the parameters of this model.

*Planning elements.* The authors (Peterson & Stumbo, 2000) separate the service components of TR (described in the Leisure Ability Model) from the process and procedures of planning TR service delivery (described in their Therapeutic Recreation Accountability Model or TRAM).\(^5\) The TRAM describes a sequential systematically designed process for providing a comprehensive TR service and includes the following eight elements:

1. Comprehensive and specific program design
2. Activity analysis, selection and modification
3. Protocols or clinical practice guidelines
4. Client assessment plans
5. Intervention programs and client documentation

\(^5\) For the purposes of this paper because the service and process components, although separated, support each other, the Therapeutic Recreation Accountability Model (TRAM) and the Leisurability Model (LAM) will be referred to throughout this paper as one model – as the LAM.
6. Program evaluation and program outcomes

7. Client evaluation and client outcomes

8. Quality improvement and efficacy research (Peterson & Stumbo, p. 95 - 100).

In their book, Peterson and Stumbo (2004) devote a chapter to each of these elements, but for the purpose of this research, only the first step, a comprehensive and specific program design, will be examined in detail. The purpose of this first step is to determine the direction of the TR department by gathering data about the organization and client group, followed by prioritizing and deciding which programs will best meet client needs, and then creating implementation and evaluation plans that will ensure that the right programs are provided. The steps described for comprehensive program planning are:

1. Analysis – researching the client population and their leisure needs

   Five areas of analysis are identified including:
   
   • the community (e.g., resources in the community)
   • the agency (e.g., mandate of the facility, including staff, facility, and fiscal resources)
   • the client population (e.g., demographics, needs, characteristics, etc)
   • the TR department (e.g., TR department philosophy, RT credentials)
   • the TR profession (e.g., conferences, continuing professional education, resources)

2. Conceptualization – identifying and developing the program’s statement of purpose and the program’s goals

3. Investigation – identifying the components or programs that will meet the stated goals

4. Determination – selecting specific programs

5. Specific program design – planning the details of a specific program, including objectives, performance measures, implementation description, and evaluation plan.
Critique of the Leisure Ability Model. The Leisure Ability Model’s strengths are its logical and clear presentation of each component and its detailed explanation of the technical steps required for each task. Peterson and Stumbo’s (2004) text provides RTs with excellent examples on how to assess and document clients’ clinical needs, how to write treatment and diagnostic protocols, how to analyze and select activities and how to design a program plan. The elements are defined in conceptual terms (e.g., ‘conceptualization’ versus ‘goal setting’, and ‘investigation’ versus ‘defining objectives’), which encourages RTs to consider alternative methods of planning – not a limited set of techniques.

However, the treatment focus of the LAM is problematic for application in residential care facilities for several reasons. First, the model is based on development of a non-disabled adult learner and therefore may have substantial weaknesses in its conceptual foundation, especially when applied to older adults with progressive disabilities (e.g., Alzheimer’s, Parkinson’s) or with complex long-term medical needs (e.g., hemiplegia, congestive heart failure). Second, the foundational concepts, learned helplessness and locus of control, underestimates the complexity of extended care clients’ lives and the amount of control extended care institutions and staff have over clients’ ability to choose. Furthermore, Bullock (1998) argues that ‘flow’ experiences are not regular, routine occurrences and questions whether they should even be a goal of TR services. Third, the model’s promotion of a treatment focus compromises the holistic quality of leisure and the role of the RT in residential care facilities, which is primarily to promote and facilitate residents’ leisure and recreation lifestyles.

In addition, Peterson and Stumbo’s (2000) assertion that programs should produce client outcomes and focus on a single purpose or need is problematic. Peterson and Stumbo contend that a program should not focus on several needs of a client at once—nor should a program
accommodate clients with different needs. Peterson and Stumbo argue that in the past, RTs have used the approach of serving different client needs within the same program and that this practice restricts the ability of the RT to effectively meet the specific needs of the client. However, due to the scarce resources available in residential care, this practice of focusing on only one need is not practical and may not even be necessary (Sylvester et al., 2001). For example, one client might be referred to a gardening program to re-learn how to garden with one hand after having a stroke resulting in hemiplegia (functional intervention in physical abilities), whereas another client might be participating to learn a new leisure activity (leisure education), and a third might voluntarily participate because they enjoy gardening (recreation participation). Sylvester et al. (2001) also argue that the use of recreation activities to develop function abilities may result in “an overemphasis on instrumental outcomes at the expense of intrinsic benefits, such as enjoyment, friendship, and creativity” (p. 87). The LAM focuses on treatment and the role of the RT as therapist, whereas within the extended care residential context the RT must also assume the role of the facility planner, responsible for democratically planning programs for the “residential care community.”

Most importantly for this study, the model’s technical focus also does not address the issue of planning programs in a complex context where power and interests influence RTs’ daily practice. In addition, the theoretical foundation of the model includes reference to fostering personal control and causation but does not include theories about advocating for clients living in a political organization. The absence of any reference to the ethical and sociopolitical context is problematic for several reasons. First, it does not acknowledge that there are multiple conflicting interests that impact planning and furthermore it does not provide a lens for examining whose interests count or whose interests are being met. Second, the model ignores the relationship of
power to planning and does not help RTs to determine the power relationships within the organization, or to anticipate sources of support and potential obstacles to planning. The model also neglects to provide RTs with tactics for influencing power relationships necessary to achieve their planning goals for the residents.

*Health Promotion/Health Protection Model*

Austin’s Health Promotion/Health Protection Model (HP/HP) is also widely referred to in the literature and Austin suggests that it is an alternative to the LAM. Austin argues that the purpose of therapeutic recreation is “to assist persons to recover following threats to health (health protection) and to achieve as high a level of health as possible (health promotion)” (1998, p. 110). Austin’s model focuses more on achieving optimal health versus an optimal leisure lifestyle.

The model is based on the concepts of a humanistic perspective, high-level wellness, and stabilization and actualization tendencies. The humanistic perspective views individuals as being responsible for their own well being and health and being active versus passive participants in their health. Additionally, this perspective assumes that people are both affected by their environment and are affecting their environment. High-level wellness focuses on enhancing the physical, social, and cognitive health of the individual as compared to the traditional medical model focus on treating the disease. Hence, Austin argues that high-level wellness focuses holistically on the health of the whole person. Stabilization tendencies drive us to adapt and cope with changes and stress and actualization tendencies motivate us to maintain and improve our health. Health as a concept “encompasses both coping adaptively and growing and becoming” (Austin, 1998, p. 111).
Austin also draws upon therapeutic recreation, recreation, leisure, psychology, nursing and health literature to develop his model. Austin defines recreation as “more than activity [it is] commonly linked with being restorative, offering refreshment or re-creation for participants” (1997, p. 147). Leisure is “the intrinsically motivated, self-determined nature of participation, coupled with the match between ability and challenges” (Austin, p. 149). The characteristics of leisure, freedom, intrinsic motivation and self-determination, are considered to be important factors in promoting health.

Austin’s (1998) Health Promotion/Health Protection Model is very similar to the Leisure Ability Model in that it portrays client and RT control on a continuum – with the RTs’ control being greatest during the initial prescriptive/treatment stages and the client’s control expanding as the model moves through the continuum to independent leisure participation. Austin’s continuum ranges from poor health on one end to optimal health on the other and clients may need and receive any of the following three components at any time:

1. Prescriptive activities
2. Recreation
3. Leisure

Austin argues that the RT should direct the prescriptive activities because clients have a temporary feeling of loss of control and helplessness over their well being. Austin does not give a specific definition of what prescriptive activities are. Once clients are involved in activities, Austin argues that they can envision themselves regaining control and improving their health. Consequently, he argues, clients will then start to take more control of their leisure. Although, the title of this service is different, Austin’s prescriptive activities component is very similar to the functional intervention stage of the LAM.
Recreation is described as being a ‘restorative’ activity through which clients continue to stabilize and regain their health equilibrium. At this stage, clients learn new skills, attitudes and experience increased self-esteem as they successfully engage in recreation activities. Austin encourages RTs to let the client take as much control over their choices as possible. Although this component appears to have a broader scope, ‘recreation’ is similar to the leisure education stage of the LAM.

Leisure is described as “a means to self-actualization” and growth (as compared to recreation which is more restorative) (Austin, 1998, p. 114). Similar to the LAM’s recreation participation stage, the client takes responsibility for his or her own health and well being during leisure.

Planning elements. Austin describes the traditional planning process as a cyclical, orderly process including assessment, planning, implementation, and evaluation. Austin contends that “the therapeutic recreation process provides a systematic method of problem solving through a progression of steps” (1996, p. 151). Although Austin includes brief references to several standardized assessment tools, he provides minimal detail on how RTs should conduct the other planning steps.

Critique of the HP/HP model. Although Austin argues that his model can be useful for any clients with challenges, he clearly limits its use to clinical treatment purposes only, which is extremely problematic for its application in residential care. Austin (1998) argues “that ‘therapeutic recreation’ should be reserved for the clinical application of recreation and leisure and not be used to describe the provision of recreation services for persons who require special accommodations because of unique needs they have due to some physical, cognitive or psychological disability” (p. 143). That is, the model’s clinical focus excludes programs that
have a leisure or enjoyment focus instead of a treatment focus. Then, Austin contradictorily
states that the model is based on holistic principles that treat the whole person (high-level
wellness), not just the disease.

Similar to the arguments about the treatment focus of the LAM, the HP/HP model’s
clinical focus limits its utility in residential care settings. Sylvester (2001) suggests that:

When health is the sole aim of therapeutic recreation, services may become narrowly
utilitarian, diminishing the broader values of leisure, such as autonomy, community, and
self-determination. As such, the subjective, expressive, and associational aspects of
leisure that allow high levels of freedom and intrinsic motivation, promote the exercise of
capabilities, and help to form social connections may not receive adequate attention in a
model limited to health. (p. 91)

As argued above, this model’s narrow focus on treatment and the role of the RT as therapist,
limits the practice of RTs working in residential care, who must also be educators, leaders,
facilitators, community planners as well as programmers and who therefore need a
comprehensive model of planning that illuminates the complexity of the planning process and
the personal and organizational power and interests that influence planning. Most importantly, as
was also argued about the LAM, this model’s technical focus does not address the issue of
planning programs in a politically-complex context, where power and interests influence RTs’
daily practice.

**Therapeutic Recreation Service Delivery and Outcome Models**

Van Andel (1998) draws upon psychology, leisure and recreation, and rehabilitation
literature in the development of his two related models for TR service. The first, the Therapeutic
Recreation (TR) Service Delivery Model outlines four types of services that RTs provide.
Similar to the above models, the components of the TR Service Delivery Model: diagnosis/needs
assessment, treatment/rehabilitation, education, and prevention/health promotion, are presented
on a continuum with the RT’s control greatest during the initial assessment/treatment stages and client’s control expanding as the model moves through the continuum to health promoting activities wherein the client experiences a healthy lifestyle. Van Andel does not describe any program planning steps but indicates in his case study example a process of assessment, goal identification, and individual intervention planning. Van Andel’s model differs slightly in its description of its scope of service but it is substantially the same as the Leisure Ability Model.

Van Andel’s (1998) second model, the Therapeutic Recreation Outcome Model, focuses on three potential outcomes for clients including health status, quality of life, and functional capabilities. Health status is related to specific functional domains that need to be addressed to achieve optimal wellness. The functional domains are: cognitive/mental function, psychological/emotional function, physical function, spiritual function, social function, and leisure function. Van Andel argues that maximum functional capacity in all domains is essential for optimal quality of life and wellness. Quality of life refers to the client’s spiritual and psychological well-being and Van Andel views this outcome as the one that RTs have the greatest potential of influencing.

Van Andel (1998) argues that the models can be adjusted for residential care settings where the RT is more likely to emphasize structured activities and leisure experiences. The models’ application to residential care practice is strengthened by its focus on the quality of life and the importance of leisure. However, Van Andel does not clearly explain how this adjustment is to be made. While Van Andel’s models expand the scope of therapeutic recreation services to more fully embrace leisure, greater conceptualization and development of the planning process is needed. Additionally, Van Andel’s argument that maximum functional capacity in all domains is necessary for optimal quality of life is problematic for clients with chronic or progressive
disabilities who are unable to achieve this definition of success. Sylvester (2001) suggests “that although an individual may have impairments in one domain he or she may still be capable of experiencing a high level of wellness” (p. 94). Furthermore, as was repeated in the critique of the two prior models, this model overlooks the personal and organizational power and interests inherent in planning practice and consequently does not provide RTs with direction on how to plan, organize or implement interventions within the socio-politically complex context of the residential care facility.

Optimizing Lifelong Health Through Therapeutic Recreation Model

The Optimizing Lifelong Health Through Therapeutic Recreation (OLH-TR) model (Wilhite et al., 1999) conceptualizes TR service as being “based on the assumed need for intervention with the intent of influencing the individual’s personal and/or leisure function (Wilhite & Keller, 1992)” (p. 98). This non-linear model is based on developmental psychology theory and consists of four elements: selecting, optimizing, compensating and evaluating. The basic principles of the model are that a healthy leisure lifestyle increases well being; that well being is advanced by strengthening individual client’s opportunities and resources; and that individuals are responsible for adapting and changing with the circumstances. In the model, the RT works through the service components with clients using a systematic process including assessment, program planning, implementation, and evaluation. Focus is on the client selecting their preferred activity and on the client evaluating their experience.

A strength of the OLH-TR model (Wilhite et al., 1999) is that it acknowledges that individuals with disabilities can experience health and well being. Similarly it recognizes that independent leisure functioning is not always feasible or desirable for some clients and that dependency or interdependency may also be appropriate. This is particularly true for complex
care residents with chronic or progressive disabling conditions, such as a resident with dementia who needs physical and/or verbal cueing to participate in a gardening program. Furthermore, the OLH-TR model promotes clients’ involvement and control in decision-making, although this can be problematic for extended care residents who are dependent on others for making decisions. Another strength of the model for its application in residential care is its emphasis on leisure. However, although the model conceptually recognizes the unique needs of residential care, it does not provide the RT with any technical guidance on how to plan, organize or implement interventions. Similarly, the model includes some analysis of societal and environmental impacts on resources, opportunities and on health and well being, but it does not provide RTs with any guidance on how to understand and interpret the planning context, nor how to plan in the face of conflicting interests and demands. Furthermore, its focus on accommodation “may foster passive acceptance on the part of clients instead of environmental change that accommodates individual leisure abilities” (Sylvester et al., 2001, p. 102).

**TR Models and Theories of Practice**

The above models all include theories of leisure, highlighting the importance of freedom of choice, self-determination and enjoyment. However, these models primarily provide RTs with guidance on how to work as a treatment-oriented therapist, and do not provide RTs with any guidance on how to facilitate democratic planning processes necessary for organizing recreation and leisure opportunities that promote satisfaction, enjoyment and a better quality of life for residential care clients. Because of the technical-medical focus, the process of designing and planning therapeutic recreation programs is, similar to the traditional process of planning educational programs, conceptualized as a systematic, rational procedure, which starts from assessing needs, to setting objectives, to organizing learning components and activities, and ends
with evaluating learning outcomes (Yang & Cervero, 2001). However, as Yang and Cervero
argue, “the practice of program planning rarely follows a linear progression as assumed by linear
The dominance of the technically focused treatment models of planning has consequently limited
RTs’ understanding of their practice to technical elements and disregarded the sociopolitical
context within which planning occurs. The above models overlook the conflicting interests,
power relationships and negotiations that shape planning and do not address the ethical dilemmas
RTs encounter when negotiating interests and power relationships, nor the corresponding
responsibilities arising from their decisions.

Although the above TR models contain many useful elements, their treatment-oriented
focus is insufficient for the complexity of the context of TR practice in residential care settings.
The treatment models do not help the RT negotiate conflicting interests and power relationships
in his or her attempt to provide residents with a meaningful quality of life. As I discuss in the
next section, TR theory could be usefully informed by adult education program planning theory
that includes strategies for understanding the context and the sociopolitical and ethical
dimensions of planning.

**Adult Education Program Planning Literature**

Cervero and Wilson and their colleagues have conducted extensive research on the
impact of context on planning, including personal and organizational power and interests. In this
section I will examine the theoretical work of Cervero and Wilson, Sork, and Caffarella
authors have developed models and frameworks that include the sociopolitical context.
Cervero and Wilson were among the first in the field of adult education to argue that planning practice is “a social activity in which the only way to plan responsibly is to act politically” (1994a, p. 117). Their point is that planners are always engaged in negotiating how programs will be planned. Planning programs involves meetings, telephone calls, informal discussions, memos, and formal documents between the various stakeholders who have an interest in what gets planned and for whom. To competently engage in these “social activities” of planning, planners need to be aware of who is and who should be involved in planning practice (requiring analysis of the context and the learners) and how to engage with stakeholders already included in the process, and how to foster the engagement of stakeholders who should be included. In residential care, RTs similarly need to be aware of who should be involved in planning. If RTs followed the strictures of the TR models previously discussed, they would attempt to implement a program plan based solely on the assessed needs of the individual resident. While this practice is ideal, it does not address the reality that the RT also must negotiate the program plan with the residents as a group, with family members, volunteers, nurses, resident care attendants, doctors, occupational therapists, housekeepers, administrators and other members of the health care team. (Gunn & Peterson, 1978; Wilhite et al., 1999).

However, Cervero and Wilson’s work is primarily focused on the sociopolitical elements of planning and does not include the technical elements of planning. Subsequently, Sork has developed a framework for planning that usefully conceptualizes planning as being interactively technical, sociopolitical and ethical. Sork (2000) argues that the “politically aware planner is aware of the role of power, ideology, and interests and how these interact when people work collectively to make decisions about intentions and actions” (p. 177). However, the planner should not only know how to analyze the interests and power dynamics inherent in planning
situations, but also how to respond strategically to them. As Sork notes, Cervero and Wilson have demonstrated that planning practice is not a neutral activity, but is an activity filled with conflicting interests and needs that requires sociopolitical strategies in order to attempt to successfully plan and develop programs. Sork’s question-based framework is useful for focusing research questions examining all three areas of planning practice. However, Sork’s framework does not provide sufficient detailed direction for program planners to implement in their practice.

Caffarella’s interactive model of planning draws upon the work of Sork and Cervero and Wilson, but provides a more detailed model for planning practice. Caffarella’s (2002) interactive model provides detailed information on twelve tasks involved in planning, including chapters on “discerning the context” and “building a base of support” – both focused on the sociopolitical elements of planning. However, Caffarella’s model is better understood after having first examined the work of Sork and Cervero and Wilson. Although these authors include the work of many other theorists, the research and writings of Cervero and Wilson, Sork, and Caffarella encapsulate my experience as an RT and I believe can usefully inform and guide TR theories and models of practice. In the following sections I will discuss their work in detail.

*Cervero and Wilson’s Negotiation Theory of Planning*

I have found that Cervero and Wilson’s depiction of planning as a social activity resonates with my experiences planning programs. Cervero and Wilson and their colleagues (Carter, 1996; Hendricks, 1996; MacLean, 1996; McDonald, 1996) have illustrated that planning is more than a technical process. Their arguments about the dominating impact of technical rational theories of planning on our conceptions of practice have challenged planners to rethink their practice.
Wilson and Cervero (2001) argue that planning practice must be viewed not as a technical activity, but relationally, as a social activity that is “embedded in and constitutive of wider social settings” (p. 2). Carter’s (1996) work illustrates how poorly traditional technical planning models represent planning practice. Carter argues that what planning models overlook is “what the stakeholders bring to the table, such as expressed or implied interests, varying and unequal amounts of power, different skill levels and access to resources, and various social and professional relationships and roles” (p. 28).

Hendricks’ (1996) study of the politics of planning in a college nursing education program also confirms Cervero and Wilson’s argument that planning is a dynamic process comprised of power relationships, negotiations, and ethical issues. Similarly, MacLean’s (1996) findings of the conflictual purposes inherent in planning medical continuing education programs affirms the gap been prescriptive planning theories and actual practice and supports the call for planning theories that include the sociopolitical and ethical elements of planning. I would argue that Wilson and Cervero have successfully expanded the discourse of planning to legitimately include social political dimensions of planning.

Interests. Cervero and Wilson (1994a; 1994b) argue that the social activity of planning is made up of the conflicting and consensual interests of the many stakeholders in the program planning process (learners, teachers, planners, institutional leaders, and the affected public). Cervero and Wilson (1998a) draw upon Habermas’ (1971) critical theory and Morgan’s (1986) organizational theory and define interests as “a complex set of predispositions, goals, values, desires and expectations that lead people to act in certain ways and to position themselves in a particular manner when confronted with situations in which they must act” (Cervero & Wilson, p. 140).
Furthermore, Cervero and Wilson (1994a) argue that three types of interests are prevalent in planning practice—expressed interests, ideal interests and real interests. Utilizing Isaac’s (1987) work Cervero and Wilson explain that expressed interests are “the ‘revealed preferences’ [that] are actively held by particular people in the planning process’ (Isaac, 1987, p. 96)” (p. 124). Ideal interests are those that are best for a person and “‘are a function of a person’s ethical beliefs’ (Isaac, 1987, p. 107) [and they] are the purposes to which planners should ascribe” (p. 124, italics in original). Last, real interests are implicit and habitual and reflect the actual purposes and norms elemental to planners’ practices. Cervero and Wilson clarify that “practicing based on real interests does not necessarily mean that a planner believes that those interests should prevail [but that] they are norms that govern practice in a particular institutional setting” (p. 126). Wilson and Cervero (1996a) argue that educators need to examine whose interests are being served and that “the central responsibility of planners is to determine whose interests they will negotiate in the planning process” (p. 42).

In TR planning practice in a residential care facility, the needs of the client are the ascribed focus of planning practice. However, conflict often arises between the interests of various clients, planners, volunteers, and other health care team members and RTs must routinely make ethical choices regarding which clients will be served and when. For example, practice has found that the morning hours are usually the best time for programs for clients because this is when they are generally more alert and energetic. However, when planning for a group of 50 clients, the RT can only see perhaps 8 to 10 clients in one morning, and therefore must choose whom they will and will not see. The RT might take into consideration such factors as the clients’ ability to participate in afternoon or evening programs, overall participation rate in all programs, their health status, their bath schedule, and/or the number of family or friends visiting
the client, when deciding whose interests they will serve and when. As noted above, structural factors impact whose needs are addressed and how.

**Power.** Interests are framed and shaped by the variety of power relationships (socially systematic and socially ad hoc) within and external to the organization. Wilson and Cervero utilize Morgan’s (1986) work on power in organizations in their argument about the role of power in planning. Morgan describes the daily practices of negotiation and coalition building in organizations as stemming from the diversity of interests found within the organization. When peoples’ interests are contrary, conflict arises, and “power is the medium through which conflicts of interest are ultimately resolved” (Morgan, p. 158). Likewise, Wilson and Cervero (1996b) argue that planners negotiate interests and power relationships. Hence, while power may be the medium, sources of power can also be altered to enable people to achieve their interests.

For example, Forester (1989), who has written extensively about community planning, argues that in the process of planning, planners reconstruct the interests and power relationships of others involved in terms of “knowledge (who knows what), consent (who exercises power and who obeys), trust (who cooperates with whom), and the formulation of problems (who focuses on or neglects which problems)” (p. 80). Likewise, Wilson and Cervero (1996b) argue that the structure or context determines planners’ ability to act. Furthermore, power, which is distributed based on the planner’s social, personal and organizational position, can enable planners to act. The political challenge for planners is deciding how to use their power to construct their programs.

**Negotiation.** Planners negotiate with and among both personal and organizational interests as they plan programs (Cervero & Wilson, 1998b). Utilizing the work of Elgström and Riis (1992), Cervero and Wilson expanded their concept of negotiation to include substantive
and meta-negotiations. Substantive negotiations are about the details of the program, that is, what the content of the program should be. In comparison, meta-negotiations refer to “attempts to change power relations and to reach a more favourable negotiatory position in re-opened substantive negotiations” (Elgström & Riis, 1992, p. 105).

In their study of negotiations in planning, Umble et al. (2001) grounded their research in Elgström and Riis’ (1992) theory of frame factors and negotiation and on Cervero and Wilson’s (1994a; 1996; 1998b) negotiation theory of adult education program planning. Umble et al. demonstrated an important distinction between meta-negotiations about power relationships (i.e., influence over the planning process) versus meta-negotiations about conceptual frame factors (i.e., organizational ideology, norms, values, standards) and material frame factors (i.e., resources, funding, personnel, equipment, etc.). Umble et al. utilized a case study research methodology (Yin, 1994) to study a public health continuing education program. The construct validity of their study was strengthened by the use of multiple sources of evidence, including interviews with 40 stakeholders, detailed field observations, and document analysis (Yin, 2003).

Umble et al. (2001) found that “stakeholders whose interests were not being fully met engaged in meta-negotiations to change the power relationships at the planning table and in substantive negotiations to change the content and audience for it” (p. 128). This work by Umble et al. provided useful direction for my research on negotiation in planning practice. Specifically, research regarding the different types of frame factors that the meta-negotiations focus upon (e.g., power relationships, conceptual/ideological frames, material/resource frames) and detailed descriptions of negotiation strategies employed by RTs would provide further guidance to those in the field. For example, their findings demonstrated that historical and organizational relationships created a strong conceptual frame. Similarly, what and how
programs are planned in residential care can be influenced by history and tradition (e.g., “we always have a summer BBQ for residents’ families”) and by organizational relations (e.g., when a physiotherapist position was created in the EC she took over responsibility from the recreation staff for the exercise program). Further exploration of the impact of these frame factors on practice and the tactics planners use to change them, would be useful.

For the purposes of this research project, the application of frame factor and negotiation theory was utilized in the development of the research questions and protocols. The description of the relationships between meta-negotiation and substantive negotiation, and the examples provided illuminating these relationships, helped focus my interviews, observations, and document analysis as well as provided evaluative criteria for the interpretation of the data collected.

*Tactics.* Yang and Cervero (2001; 1998) identified influencing tactics adult educators use in program planning. Yang and Cervero’s study found that power and influence tactics are contingent upon social and political relationships and underlay planning practice. Hence, Yang and Cervero recommend that to be effective, planners need to understand the sociopolitical planning situation and be able to utilize various power and influencing tactics depending upon the situation.

To measure the use of power and influence tactics, Yang and Cervero (1998) asked research participants to recall a recent program that they had been involved in planning and to indicate the effectiveness of different influence and power behaviours. Seven constructs were used to categorize power and influence behaviours: *reasoning, consulting, appealing, networking, bargaining, pressuring,* and *counteracting.* *Reasoning* was defined as a rational strategy, used when power relations are relatively symmetrical and there is consensus on
legitimate interests. The consulting tactic was used when planners needed input and ideas from other planners to identify planning solutions. Appealing was used in situations when the planners had less power than their co-planner. Networking was a tactic used to get the support of other stakeholders who had relevant knowledge or authority. Bargaining was a tactic used when co-planners with symmetrical power bases had conflictual interests to negotiate. The last two tactics, pressuring, or making direct demands of a co-planner, and counteracting, or blocking co-planners efforts, were used when planners had little chance of achieving their interests through other tactics. Yang and Cervero included demographic factors, age, gender, years working as an education or training professional, years working in the current organization and years working in the current position in the organization.

Yang and Cervero (2001) followed up their 1998 research by further clustering the above-mentioned tactics into four power and influence styles (bystanders, tacticians, ingratiators and shotguns) and their findings confirmed that these styles could be identified from the organizational political process (p. 292-293). The bystanders took a passive role in their organizations, the tacticians favoured rational strategies such as reasoning and consulting, and the ingratiators used a more interpersonal approach and preferred appealing and bargaining tactics, while the shot guns were more competitive using pressuring, counteracting, networking and bargaining tactics. In addition, planners’ “conflicting interests” and “power base” were variables used to assess the organization context (Yang & Cervero, p. 291). Yang et al. used French and Raven’s (1959) conceptualization of power bases to define and measure the concept. French and Raven’s five interpersonal bases of power are: “legitimate, reward, coercive, expert, and referent” (Yang & Cervero, p. 291).
Mabry and Wilson (2001) asked what do successful programmers know and do – what tactics and strategies do they use? They argued that “understanding the practical negotiation strategies employed by adult educators could be instrumental in improving the program planning practice” (p. 2). Furthermore, they found that the tactics planners’ used depended upon the planners’ perceptions of how much power the stakeholders could use in the situation and the amount of involvement the planners wanted from the stakeholders in the planning process. For example, if the planner did not want a particular stakeholder influencing or involved in the planning process, the planner used tactics such as *circumvention* to reduce the stakeholders’ involvement. Additionally, Mabry and Wilson found that “planners had strongly held notions of not only what needed to be done, but also how it should be done” (p. 2). As a result, the planners’ used tactical strategies, including *appealing, exchanging, pressuring, consulting,* and *avoiding* to maintain and/or to transform power relationships. In other words, planners used both substantive and meta-negotiations to correspondingly negotiate the elements of specific programs as well as the relationships of power or who would be included or excluded in such negotiations.

McDonald’s (1996) study of knowledge and empowerment issues within a community-based education program also describes several strategies for countering and diffusing power relationships including nurturing other significant players, failing to take action when it would be counterproductive to do so, and using an ‘expert’ position to exert influence. Another strategy used to empower participants in the planning process was researching different stakeholders’ views in order to gain a better understanding of their perspective on issues so that the planner could help the stakeholder express themselves during meetings. Additionally, McDonald attempted to redistribute power at meetings by using shared leadership. Similarly, within the
residential care context, the RT may reconstruct the power relationships of the individual clients by advocating and supporting those clients' voices that may not otherwise be heard (i.e., because they have advanced dementia, or are marginalized because of their race or language).

Wilson and Cervero (2001) note that “we cannot change what we don’t see [and therefore] we need a new way to see in order to act to address injustices of the world” (p. 4). Consequently, we need to bring “great visibility to the political and ethical choices, contractions and consequences of adult education [in order to be able to] better understand how to create educational practices, programs, and policies that provide opportunities for people to develop and exercise more control over their social, cultural, economic and political lives.” (Wilson & Cervero, p. 4). Therefore, in order to develop better understanding of the sociopolitical and ethical elements in practice, we need more research and studies on this topic.

*Sork’s Planning Framework*

In this section, Sork’s (2000) framework for planning will be explored. Sork proposes a “question-based approach” (p. 180) that can be used to both guide and analyze planning practice. Sork’s framework can be used in a wide variety of settings (“it is ‘generic’”), yet “assumes that each planning situation is unique and therefore requires a unique approach” (“it is ‘generative’”), and is built upon previous adult education planning theories and models (“it is ‘derivative’”) (p. 179). The questions Sork asks are clustered according to “the basic elements of program planning...analyze context and learner community, justify and focus planning, clarify intentions, prepare instructional plan, prepare administrative plan, and develop summative evaluation plan” (p. 180).

Sork (2000) argues that “being a capable planner involves developing understandings and skills in three closely related domains: the technical, the social political, and the ethical” (p. 176).
The technical domain is concerned with the mechanics and methods of planning. Questions regarding methods for analyzing learner characteristics, techniques for clarifying intentions, instructional plan elements, and marketing strategies, are examples of technical questions the planner should ask him or herself. In comparison, the sociopolitical domain focuses on questioning who is (and is not) included in the planning process, whose interests are being represented at the planning table, and the power dynamics involved in planning.

The ethical domain is often overlooked in the planning process, although planners' beliefs, values and ethics underlie their decisions and actions. As Sork (2000) argues, “it is possible to plan programs without ever addressing questions in the ethical domain, but it is impossible to plan programs without making decisions and taking actions that have ethical implications” (emphasis in original, p. 186). Sork argues that planners need more than a “clearly articulated personal philosophy to guide practice” (p. 178). The purpose of this domain is to give ethical questions their turn in the forefront of the planning process.

The questions in one domain will often overlap with another domain (Sork, 2000). For instance, questions regarding which programs should be planned (e.g., sensory stimulation for clients with dementia) and conversely which will be cancelled (e.g., bridge club for the cognitively alert clients) will have technical, sociopolitical, and ethical consequences. Ethically, as a planner who believes that each client should receive a similar amount of my service, I would plan the sensory stimulation program for those clients with lower participation rates versus a bridge club for the higher cognitively functioning clients who are already active in many programs (but are nonetheless not receiving the amount of service they would like, and arguably need).
The sociopolitical ramifications of such a decision could include pressure from the head nurse or administrator, who, concerned with the number of complaints she or he is receiving from the cognitively alert clients about lack of programming, will press the recreation staff to provide more high-level programs. Meanwhile, staff and family members might advocate for more programs for the ‘silent’ non-verbal client with advanced dementia.

The above example portrays the interconnectedness of the elements and domains of Sork’s framework. However, besides developing a TR theory of practice that examines the impact of the context and of power and interests on the planning process, I would like to develop a more robust framework for TR planning. With this aim in mind, I will apply Sork’s framework to TR planning practice.

The TR models analyzed above included several of the elements Sork discusses in his framework. Although the TR models argued that clients could access the service components in any order or even consecutively, the planning elements were described in a step-wise fashion. For example, both the LAM and the HP/HP model indicated that programs should be planned in a systematic sequential manner. Contrastingly, Sork (2000) attempts to counter the traditional step-wise planning models by displaying his elements in a non-linear oval that indicates fluidity and interconnectedness between the elements. For example, formative evaluation is placed in the centre of the oval and is contained by a dotted line, indicating the permeability between the elements and formative planning. The oval is also ringed with a dotted border to indicate free movement between the planning elements. Furthermore, Sork attempts to distance his framework from the traditional technical rational models, which limit planning by suggesting specific techniques for all circumstances, by selecting more widely encompassing process-based
descriptors for his elements. Sork's question-based approach encourages planners to consider alternative approaches. In the following section I will further examine each element.

_Analyze context and learner community._ This element includes not only an assessment of the organizational setting, but also identification of the factors that constrain planners' actions and limit their options. Sork (1999; 2000) provides examples of elements of the context that planners' should consider and analyze before progressing with planning. Characteristics of the organizational context include “the sociopolitical environment, economic values and priorities, physical facilities, the policy framework, history and traditions, the role of education, cooperative and competitive relationships, and so on (Boone, 1985; Boyle, 1981; Beal, Blount, Powers, and Johnson, 1966).” (Sork, 2000, p. 181).

Furthermore, Sork (1999) proposes that planners ask questions regarding internal support and resistance, external support and resistance, organizational mission, and the stakeholders involved in the planning process. The learners who might have a vested interest in the program and the planning process make up the “learner community” (e.g., residents, family members, other staff members, volunteers) are also included in this analysis (Sork, p. 181). The traditional demographics, “age, gender, race, education and income level, occupation, and sexual orientation” (Sork, p. 181) are suggested for analysis, as are the potential barriers that might deter participation, the motivational orientations of the learners, and other characteristics of the learners.

_Justify and focus planning._ The purpose of this element is to focus the planning process and justify the resources being allocated to the program. Most models use some form of ‘needs assessment’ to achieve this, but Sork (2000) suggests that this traditional approach can be too reactive and intrusive when other approaches would serve the purpose better. In addition, Sork
notes that needs are socially constructed, and so the purpose of the needs assessment needs to be questioned, Sork’s intent goes beyond needs assessment and urges planners to critically examine “what we are doing and why” (p. 182).

This particular element of Sork’s framework resonates strongly with my experience planning programs in residential care. After learning about Sork’s and Cervero and Wilson’s theories of planning, I returned to my workplace and organized several meetings with my recreation team where we questioned what were doing and critically attempted to justify and focus our planning. For example, we recognized that clients with more advanced dementia were under-served when compared with clients with higher cognitive functioning. In addition, TR research demonstrated that this difference in participation was a common problem in residential care facilities (Voelkl, Galecki, & Fries, 1996). The inequity in our service delivery resulted in several intense meetings where we attempted to justify and focus our planning to provide more programs for these ‘silent’ clients with advanced dementia, and consequently fewer programs for the more verbal, higher cognitively functioning clients. While programs were focused on the clients’ needs, interests and abilities, the lack of resources required compromises and tradeoffs. However, by employing a question-based approach to analyze the learner and community context, the recreation team was able to focus programs, and by applying research, experience, and professional knowledge, was able to justify choices.

*Clarifying intentions.* Sork (2000) argues that adult education planning models favour “the use of objectives as the primary means to clarify intentions” (p. 182) at the expense of other, often more appropriate approaches. Although objectives certainly can be useful, the difficulty with them is that because they are difficult to write well, they frequently trivialize and understate
the complex learning that occurs. Additionally, objectives can require a lot of time to both write and to evaluate.

Nonetheless, regardless of the context, the LAM recommends that RTs develop treatment plans for all TR interventions. This approach is a reflection of a medical approach versus a holistic approach and limits the scope of the program while also implying socially constructed values and needs (e.g., “as judged appropriate by the therapeutic recreation specialist”). For example, a client may be more interested in the physical exercises of a relaxation program, and her awareness of identified sources of stress (a TR objective) might be a secondary concern. Furthermore, although RTs attempt to follow this standard (identifying specific outcomes) in their practice in residential care facilities, this type of objective writing is difficult to achieve due to the high resident to RT ratio (e.g., 50 or more clients to one RT). Consequently, RTs in residential care are continually trying to keep up with their charting and record keeping, when the actual treatment plan approach may only be relevant for a small part of their practice.

Sork (2000) suggests that other approaches can be used to clarify and justify actions depending upon the learner and the community context. Sork describes several general categories of approaches including the purpose approach, the process approach, the content approach, the benefits approach, and the combined approach (Sork, 1998, p. 295-298).

Prepare instructional plan. Sork (2000) describes the instructional plan as “the heart of the program” (, p. 183) and the actualization of the planners’ instructional vision. Sork does not provide details on what should be included in the instructional plan, but advises the reader that there are a variety of alternative models and frameworks available in the adult education program planning literature. In general, Sork notes that this element will require decisions about technology, content, activity sequence, instructional strategies, transfer of learning, learner
motivation, etc. In this regard, Peterson and Stumbo’s (2000) LAM provides excellent resources for developing program plans.

Prepare administrative plan. Sork’s (2000) fifth element is the administrative plan. This element recognizes all the important ‘other’ tasks that are necessary for successful programming such as budgeting, facilities and resource allocation, communication plans and other support services. As Sork notes, “every substantive instructional planning decision has administrative implications and many elements of administrative planning have instructional implications” (p. 183).

Similarly, in my experience in residential care, I have found that the administrative and instructional plans are closely interrelated. For example, a gardening program might require access to the greenhouse (facility allocation), gardening equipment and supplies (resource allocation), and a 2:1 staff or volunteer to client ratio (staff scheduling). In turn, the instructional plans for the gardening session depend upon the facilities and resources. The program could focus on planting baskets, maintaining and weeding garden beds, propagating plant cuttings, or flower arranging, each requiring different resources and lesson plans. This is an element that needs closer attention in the TR models described.

Develop summative evaluation plan. Summative evaluation is the sixth element. However, Sork does not intend for this element to be the last step in a sequence of steps. Contrarily, as is true for the other elements, planners will need to focus on this element early on in the planning process, as well as throughout. As noted in the above elements, Sork does not provide guidelines for preparing the evaluation plan, but refers the reader to the plethora of models available in the literature. Nonetheless, planners should select an evaluation method that meets the needs of the program and the organization. The evaluation purpose, intended use,
interested stakeholders, and the resources available to conduct the evaluation are a few of the factors that planners should consider when selecting an evaluation method.

Sork’s elements are useful starting points for analyzing and planning programs. Sork has attempted to include the core, vital elements of planning (technical, sociopolitical and ethical) into his approach, including a theoretical base for practice. The six elements are not prescriptive, in that they do not propose any one certain technique to be used in all planning situations, but encourage the planner to analyze each situation independently and to explore the best approaches for the context. I also find the question-based approach a refreshingly proactive method of planning.

However, Sork’s framework does not provide detailed information on the planning process to guide the novice planner. While it is useful for critiquing and examining practice and for suggesting an alternative view of practice, it does not explain the processes and practices of each element. For example, Sork includes the element of an instructional plan in his framework, but does not describe or discuss how to use various instructional strategies.

*Caffarella’s Interactive Model of Program Planning*

In this section, I will explore Caffarella’s (2002) interactive model of program planning, in particular her chapters on “discerning the context” and “building a base of support.” Similar to Sork’s non-linear framework, Caffarella has developed a flexible, non-sequential model that allows programmers to address a number of tasks simultaneously, or in any combination that best suits their planning situation. Caffarella acknowledges that planning is an ever-changing, dynamic process by portraying her model as a concentric circular figure with twelve spokes, representing twelve tasks involved in planning, directed towards the centre goal of flexible interactive planning (see Figure 1).
Caffarella’s (2002) model is based on seven major assumptions (p. 25-28) drawn from the adult education literature. Although Caffarella is referring to adult education program planning, her assumptions are also relevant to TR program planning and further exploration of the assumptions RTs make would inform the development of TR theory and models of practice for TR in residential care. Caffarella’s seven assumptions are:

1. Educational programs focus on what the participants actually learn and how this learning results in changes in participants, organizations, and/or societal issues and norms.

2. The development of educational programs is a complex interaction of institutional priorities, tasks, people, and events.

3. Program planning is contextual in nature; that is people plan programs within a social, economic, cultural, and political climate.

Figure 1. Caffarella’s Interactive Model of Program Planning (2002, p. 21)
4. Program planning involves both systematic, preplanned tasks and “on-your-feet”
(sometimes last minute) decisions.

5. People who plan programs for adults are sensitive to diversity and cultural differences
in their many forms.

6. Designing educational programs is anything but an exacting practice as there is no
single method of planning education and training programs that ensures success.

7. Individuals, using one or more planning models as guides, can learn to be more
effective program planners through practice.

(Caffarella, p. 25-28)

Caffarella (2002) argues that the first three assumptions are the most critical, and
likewise, I would argue that they should also be central assumptions for TR planning. For
example, RTs should similarly “possess a clear understanding of why they are doing what they
are doing” (Caffarella, p. 26) and be focused on what residents’ experience and learn and how
the recreation program results in changes in the residents and the organization. Second, planning
TR programs is also “usually a nonsequential process involving complex interactions among
institutional priorities, tasks, people, and events” (Caffarella, p. 35). Finally, Caffarella also
recognizes the importance of understanding the context and role of negotiation and other
strategies in planning practice.

Caffarella (2002) also discusses the adult education principles and practices, such as
beliefs about adult learning, that provide a foundation for her model. She recommends setting
parameters for each planning situation which consider five major factors: “current program
commitments, organizational context, current and potential learners, planning personnel, and
available resources” (p. 41). Caffarella provides many examples and checklists that highlight the key aspects of the planning process.

In *Discerning the Context* Caffarella (2002) argues that “program planners can no longer ignore the context in which they practice” (p. 59). As I mentioned in the introduction, Caffarella defines context “as the human, organizational, and environmental factors that affect decisions planners make about programs (Cervero and Wilson, 1994, 1996, 1998; Newman, 1995; Houle, 1996; Rothwell and Cookson, 1997; Guy, 1999b; Sork, 2000)” (p. 59). Questions about Caffarella’s three contextual factors provided direction for researching the context in my study.

**Human factors.** As mentioned earlier, there are many stakeholders who may have, or may wish to have, a say in how and what programs are planned. How RTs interact with the various stakeholders – who is invited to participate in the planning process, who is responded to first, who holds the power over what programs get planned, are examples of the “people” factors in planning. Similar to Cervero and Wilson and Sork’s (Cervero & Wilson, 1994a, 1994b; Sork, 2000) arguments above, Caffarella argues that because of the people work of planning, “planners must have finely tuned social and communication skills; and the ability, in most planning situations, to constantly negotiate among all involved parties (Forester, 1989; Cervero and Wilson, 1994, 1998; Ottoson, 1995a; Wilson and Cervero, 1996a, 1996b)” (2002, p. 60).

**Organizational factors.** Drawing upon the work of Forester (1989), Mills et al. (1995) and others, Caffarella categorizes organizational factors as being structural, political, and cultural (see Table 1). Caffarella’s conceptualization of organizational factors was usefully combined with Umble et al. (2001) work on frame factors discussed above to help provide my research with a framework for studying the organizational factors influencing RTs planning practice in extended care.
Table 1

Categories of Organizational Factors (Caffarella, 2002, p. 63)

<table>
<thead>
<tr>
<th>Structural</th>
<th>Political</th>
<th>Cultural</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Mission, goals and objectives of the organization</td>
<td>• Power relationships among groups and individuals</td>
<td>• History and traditions of the organization</td>
</tr>
<tr>
<td>• Administrative hierarchy</td>
<td>• Coalition building</td>
<td>• Organizational beliefs and values</td>
</tr>
<tr>
<td>• Policies and procedures</td>
<td>• Bargaining for position</td>
<td>• Organizational rituals, symbols, etc.</td>
</tr>
<tr>
<td>• Organization decision making patterns</td>
<td>• Politics of funding</td>
<td></td>
</tr>
<tr>
<td>• Financial and other resource</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Physical facilities</td>
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</tbody>
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Environmental factors. The third contextual factor, the wider environment, is “the more general economic, political, and social climate within which planners work [and it] is increasingly becoming more important, especially as program planners work across numerous types of borders, from geographic to cultural to ideological (Forester, 1989; Sork and Caffarella, 1989; Newman, 1995; Rothwell and Cookson, 1997; Sparks, 1998; Cervero and Wilson, 1999; Longworth, 1999, Sork 2000)” (Caffarella, 2002, p. 65). While it can seem daunting to try to consider all the contextual factors when planning a program, it is important that RTs be aware of the context and its influence. Caffarella argues that not every program will require an in-depth analysis of the context, but awareness of the context is necessary for completion of the other components of the program planning process.
Power, negotiation, and ethics. Caffarella (2002) explores in depth three primary issues that arise from using contextual knowledge: power, negotiation and ethics. As discussed above, power relations shape planning practice, and by understanding the dynamics of power, planners “have the opportunity to empower both themselves and those with whom they work” (p. 67). Power can be used both positively and negatively to influence the program planning process. Caffarella provides examples of the influences of power discussed earlier in this paper (Cervero & Wilson, 1996; Forester, 1989; Morgan, 1986) and depicts how power is used in “shaping ‘felt’ needs, setting program agendas, determining populations to be served, making decisions, allocating types and amount of resources, and choosing who benefits from the program (Forester, 1989; Mills, Cervero, Langone, and Wilson, 1995; Archie-Booker, Cervero, and Langone, 1999; Cervero, Wilson, and Associates, 2001)” (p. 69). Caffarella also discusses Yang and Cervero’s (2001; 1998) tool for measuring the tactics planners’ use in their practice, (discussed above) and suggests that planners can use the tool to reflect on their practice and the effectiveness of their planning strategies.

In residential care, RTs work with people who have diverse ideas about the value of therapeutic recreation for the residents. Many of the staff in residential care believe in the “medical model” of care, and also view TR programs as being “diversional” and “nice”, but not particularly necessary. Other people do not appreciate the value of a healthy leisure lifestyle for residents who are nearing the end of their life. In these circumstances, RTs can use power relations to not only provide high quality programs for residents, but to also “challenge the status quo” (Caffarella, 2002, p. 72) in terms of beliefs about the needs, interests and abilities of residents and the value of TR programs.
Caffarella argues the importance of negotiation to the planning process and the need for planners to have good communication skills, people skills, analytical skills, and group process skills. Caffarella refers to Cervero and Wilson’s negotiation theory which I described in detail in the previous section. Because of their experience and training in group skills and helping skills, RTs generally have excellent communication and negotiation skills. However, none of the theories of TR practice highlight the role of power and negotiations in the planning process and so this role has not been foregrounded in TR practice.

The third issue that arises from understanding the context of planning is the issue of ethical practice. Although RTs have a professional code of ethics which guides their practice (see Appendix E) “staying true to one’s own values and beliefs and those of the unit becomes much more problematic when these beliefs clash with those of the organization for which they work, other stakeholders involved in the planning process, and/or with the ethical stance of the wider community” (Caffarella, 2002, p. 75). Differences in ethical practices can arise when choices must be made regarding who will receive the scarce amount of the RTs’ time for programs. For example, the TR code of practice states that all people deserve opportunities to participate in leisure activities, but on a daily basis the RT must decide who will receive opportunities and who will not. Caffarella discusses the conflicts planners can encounter and the choices planners must make in their practices. Similarly, Sork’s question-based model discussed above can be used to help planners consider the ethical issues arising in each component of the planning practice.

*Building a solid base of support.* In the current health care climate, where services are being cut or contracted-out, Caffarella’s (2002) chapter on building a firm base of support is particularly pertinent to RTs. Caffarella discusses strategies for establishing the support of participants, supervisors, managers, the organization, and the wider community. Her chapter
includes suggestions for using advisory committees and for developing collaborative partnerships. Although Caffarella’s examples are from the field of adult education, they can be easily applied to TR practice in residential care. Building support and commitment from others is an ongoing task that is vital for successful implementation of the other planning activities.

The other components of Caffarella’s (2002) interactive model: identifying program ideas, sorting and prioritizing program ideas, developing program objectives, designing instructional plans, developing transfer-of-learning plans, formulating evaluation plans, making recommendations and communicating results, selecting formats, schedules, and staff needs, preparing budgets and marketing plans, and coordinating facilities and on-site events are equally as important as the two components I have discussed above in detail. However, because the focus of my research was on the people work of TR planning, and because the TR literature is a rich source of technical planning information, for the purposes of this study I focused on the insights provided in Caffarella’s two components: discerning the context, and building a solid base of support – components which are not adequately addressed in the TR literature.

Adult Education Planning Theory Summary

In this section I have explored in detail the key adult education literature which addresses the issues of power and interests in planning practice. Although there are many other theorists mentioned by the above authors, the theory, framework, and model presented respectively by Cervero and Wilson, Sork, and Caffarella resonate with my experience as an RT and usefully informed my research efforts.

Cervero and Wilson (1994a; 1996) and their associates contribute to the literature with their research into interests, power, influence strategies, and the factors which frame planning practice. While Cervero and Wilson’s negotiation theory provides RTs with guiding theories on
the social and negotiatory nature of program planning it does not provide a framework for planning. Conversely, Sork (2000) provides a framework for program planning that incorporates the sociopolitical and ethical dimensions as well as the technical dimensions of planning. In this respect Sork’s framework is more comprehensive than Cervero and Wilson’s theory, however, Sork’s framework does not include the same depth of analysis of the sociopolitical dimension of planning provided by Cervero and Wilson, nor does it provide the detail needed for practical application. Nonetheless, Sork’s question-based framework provides important direction on how to question the impact of sociopolitical and ethical factors. Caffarella’s (2002) interactive model of planning incorporates the work of Cervero and Wilson and Sork, but also provides detailed information for planning practice. However, Caffarella’s model is better understood with having first examined the writings of Sork, and Cervero and Wilson. Hence, I will argue that these three works are complementary and should be used to inform RT planning practice.

Summary

This chapter reviewed and critiqued the predominant TR models used in current practice, including the Leisure Ability Model (Gunn & Peterson, 1978; Peterson & Stumbo, 2000, 2004; Stumbo & Peterson, 1998), the Health Protection and Health Promotion Model (Austin, 1998), the Therapeutic Recreation Service Delivery and Outcome Models (Van Andel, 1998), and the Optimizing Lifelong Health Through Therapeutic Recreation Model (Wilhite et al., 1999). This review found that the theoretical foundation of these models overlooks the power relationships, conflicting interests and negotiations that shape TR practice. Furthermore, the treatment-oriented models conceptualize planning as a systematic, rational process and consequently do not help RTs understand the complex decision-making processes in planning.
Adult education theories, frameworks and models that address the contextual, sociopolitical and ethical dimensions of program planning were discussed and analyzed for their contribution to TR practice. Cervero and Wilson and their colleagues were the first to research and write extensively in adult education on the impact of power, interests and the context on planning, and on the tactics planners use to negotiate how programs will be planned. Sork’s question-based framework is examined in detail as it goes beyond the theories of Cervero and Wilson and provides planners with questions to guide and analyze their practice that foreground the sociopolitical and ethical elements of planning. Last, Caffarella’s Interactive Program Planning Model, and in particular the elements of discerning the context and building a solid base of support, were discussed because they provide a useful structure for analyzing the sociopolitical and contextual elements of therapeutic recreation program planning practice in residential care.

My personal experience as an RT and as a researcher are described in the next chapter followed by a description of the research site, the participants, and the research methodology used in this study.
CHAPTER THREE

RESEARCH METHODOLOGY

In this chapter I first describe my background as a researcher and a recreation therapist. Following, I discuss the research methodology employed, including a step-by-step account of how I proceeded, a discussion of how I established the trustworthiness of the data collected, the strengths and weaknesses of the methodology and how I addressed the acknowledged weaknesses.

My Background as a Researcher/Recreation Therapist

In this section I describe my education and experience as a recreation therapist and what I learned in a pilot study researching TR planning practice. As I noted in the introduction, I have over 20 years experience working in TR. I graduated from the UBC recreation program with a specialization in TR in 1985 and commenced working in residential care. I have been active in my professional association (BC Therapeutic Recreation Association, or BCTRA) since its inception in 1986, serving on the board, participating in conferences, workshops and professional meetings. While working full time in TR at a large urban extended care (EC) facility, I completed my Masters in Business Administration at UBC (1990), strengthening my knowledge and understanding of organizational and management theory.

Following completion of my MBA, I was hired as senior recreation therapist at another large urban EC facility. During this time I continued to plan, organize and implement TR programs as well as supervise a growing recreation department (in 1994 the EC expanded from 75 to 200 beds and the TR team correspondingly increased from 2 to 7 staff). While continuing to work in this position I returned to UBC to obtain a Masters in Adult Education (2001) and for
my graduating paper I wrote about an evaluation I conducted of the TR program at my workplace. I continued on with my studies in the PhD program, and in partial completion of a course in ethnography, in February 2002, I conducted a fieldwork pilot study of the planning practice of the therapeutic recreation staff working at the extended care facility where I was employed.

The process of conducting a mini-ethnography helped me to focus my research interests and to understand the commitment required to conduct research. I reviewed documents and literature to help me develop my sensitising concepts. I conducted an informal observation of the extended care setting, formally observed a therapeutic recreation staff weekly planning meeting, interviewed one of the recreation staff members, and kept a field diary throughout the process. The experiences I gained in this pilot project were usefully applied to this research project.

Themes emerged from the interviews that lead to further questions and areas of research. It also guided me in my search and review of the therapeutic recreation and adult education planning literature. The process of transcribing and coding the interviews increased my awareness of how I ask questions and probe for answers and suggested areas for improving my interviewing skills. Last, it highlighted the need for focused research questions. In the following section I will discuss the research methodology I used in my study, including selecting the research site and participants, and methods of data collection and analysis.

**Selecting the Research Site**

One of the redeeming features of the qualitative case study is that the data is collected in the natural setting of the phenomenon of interest versus in an unnatural laboratory setting. Random scientific sampling is not advocated for case studies, instead, sites should be chosen according to specific criteria (Merriam, 1998). Likewise, I was interested in researching a
specific case study. In particular, I was interested in researching the TR planning practice in residential care. Planning practice in residential care interested me because of my lengthy work experience, and also because of its unique planning environment. Residential care is unique in that it is funded at a higher level than Supportive or Assisted Living facilities and therefore there are usually more RTs, which provided a greater opportunity to study the planning practice of several people within one setting.

The Site

I obtained agreement to conduct my research at a large extended care facility which was part of a larger acute care hospital organization and located within the catchment area of the Fraser Health Authority. The site I studied exclusively served clients assessed at an extended or complex care level, and consisted of 6 units, each with 50 clients, for a total of 300 clients.

The site was chosen particularly because a survey of ECUs with 200 or more residents showed that it had more than average numbers of RTs per 50 residents (see Figure 2). In addition, as will be discussed below, all of the RTs had a minimum of a diploma in therapeutic recreation and all worked to their full scope of practice. That is, unlike some extended care facilities where the RTs’ scope of practice is limited (due to their job descriptions) to only organizing and implementing programs, the RTs at the research site were responsible for conducting client assessments, and independently planning, organizing and implementing recreation programs. The RTs at the two extended care facilities, F and G, which had greater numbers of RTs (see Figure 2), were not able to work to their full scope due to their job descriptions.  

6 The name of the research site has been changed to preserve the anonymity of the participants.
**Figure 2.** Recreation Therapy (RT) Staffing per 50 Residents in Extended Care Facilities with greater than 200 Residents

**Participant Selection**

While the participants in my study were not familiar with adult education planning theory, it was important that they had post-secondary education in therapeutic recreation and an understanding of the dominant therapeutic recreation theories of practice so that we had a common reference from which to discuss their practice. Additionally, to facilitate an in-depth collaborative examination of planning practice, it was helpful that the participants were interested in their own continuing professional development.

Not all residential care facilities employ RTs with post-secondary education in therapeutic recreation. Therefore, a reason for selecting a larger urban residential care facility for
my research site was that there were several recreation staff, all of whom had a minimum diploma in therapeutic recreation from Douglas College. In fact, the site employed 11 RTs reporting to a TR Manager, and the RT staff had regularly hosted the local BCTRA chapter meetings and had also participated in organizing the annual BCTRA conference, both indicators of active continuing professional development. Two of the RTs had previous work experience as resident care aides, one had her bachelor degree in kinesiology, and the TR Manager was nearing completion of her bachelor degree in TR. Of the twelve participants, two, or seventeen percent were male, which is a slightly higher ratio of males to females than exists in the current BCTRA membership, which has sixteen male members (eleven percent). The participants were not asked about their ethnic background because the impact of ethnicity and other personal characteristics was not a focus of the study. All of the participants spoke English fluently.

As Table 2 shows, on average the participants were mature, experienced RTs with many years of experience working at Pacific Memorial Hospital Extended Care. The average age of the participants was 42, with 5 in their 50’s and the remaining 7 aged between 31 and 40. The average years of experience as an RT and working at Pacific Memorial Hospital, was 10 years. The TR Manager had 17 years experience working in recreation therapy at PMH and was over 50 years of age. The demographic information in Table 2 is clustered into two age groups to help preserve the anonymity of the participants, while providing as much descriptive information about the RTs as possible. Further personal characteristics are not revealed to help protect the anonymity of the participants. Pseudonyms were used for all of the participants, including the TR Manager when her comments were not directly related to her management position.
Table 2

*Demographic Characteristics of Research Participants*

<table>
<thead>
<tr>
<th>Pseudonyms</th>
<th>Age (Years)</th>
<th>Years Working as an RT</th>
<th>Years Working at Pacific Memorial Hospital</th>
</tr>
</thead>
<tbody>
<tr>
<td>Barb</td>
<td>• 52 to 56</td>
<td>• 2 to 24</td>
<td>• 8 to 19</td>
</tr>
<tr>
<td>Joanne</td>
<td>• average 53</td>
<td>• average 12</td>
<td>• average 14</td>
</tr>
<tr>
<td>Kathleen</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lois</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Laura</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Debbie</td>
<td>• 31 to 40</td>
<td>• 5 to 12</td>
<td>• 5 to 16</td>
</tr>
<tr>
<td>Diane</td>
<td>• average 33</td>
<td>• average 9</td>
<td>• average 8</td>
</tr>
<tr>
<td>Gordon</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Irene</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Kate</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Kevin</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sheila</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Overall Min-Max**

<table>
<thead>
<tr>
<th>Age (Years)</th>
<th>31 to 56</th>
<th>2 to 24</th>
<th>5 to 19</th>
</tr>
</thead>
<tbody>
<tr>
<td>Years Working as an RT</td>
<td>10</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Years Working at Pacific Memorial Hospital</td>
<td>10</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Overall Average**

| Age (Years) | 42 | 10 | 10 |
Data Collection and Analysis

As noted above, decisions about what data to collect are determined by the research questions being asked (McCormick, 2000). Data collection is a holistic and interactive process in that the various methods used are usually interrelated and connected. For example, observations may lead to questions in interviews, which may in turn be substantiated by documents (Merriam, 1998). Consequently, interpretive ethnographic case studies invariably rely upon a variety of data collection methods including interviews, observations, and document or artifact analysis.

To help me determine what types of data collection were most relevant I reviewed other case studies researching planning practice. Comparable case studies of planning practice in the adult education field utilized interviews, observations, and document analysis (Cervero & Wilson, 1998b; Mabry & Wilson, 2001; Mills et al., 1995; Umble et al., 2001). Likewise, a 1998 case study of senior centre recreation planning incorporated several interviews of the planners, observations of planning meetings and senior centre activities, and document analysis (Hewson, 1998). Similarly, in a study of the RTs' clinical reasoning practice, semi-structured interviews, observations of meetings and activities, document analysis and debriefing conversations were the data collection techniques used (Hutchison, LeBlanc, & Booth, 2002).

In like manner, I used a combination of qualitative research methods including interviews and observations of planning meetings and document analysis. The data collection schedule for the research emerged as the project progressed and was slightly hampered by job action during the latter stages of the study. I was able to observe the monthly TR department planning meetings in February, March and April. The May meeting was cancelled due to job action. In addition, I observed one business meeting in March and received a recording of an April essential services planning meeting (a meeting planning programs in the event of a strike). I
conducted two interviews with each of the 12 participants. Additionally, I reviewed applicable documentation related to the TR program planning process and I did an in-depth analysis of a program review conducted by the TR department in November 2003. This review included an analysis of the programs offered and the client attendance records over a three week period. I also kept extensive field notes and a journal of my experience.

Whereas ethnographic methods (observations, interviews, document analysis, etc.) were appropriate to use in my research setting, a full-blown fieldwork study was not feasible due to time and staff constraints. Arguably, more focused, compressed research is sometimes possible when time, money, and/or staffing restraints prevent a full-fledged ethnography and when the ethnographer is already familiar with the research setting and when the focus of the study is on one aspect of the culture.

Interviews

As was noted above, I conducted two sets of semi-structured interviews with the TR Manager and each of her staff working in extended care (see Appendix C and D for detailed information on the research questions). The first set of interviews, each lasting approximately one hour, were completed during March 2004 and after conducting a preliminary analysis of the first interview transcripts a second interview protocol was developed. The second interviews lasted between 30 and 40 minutes and were conducted between late April and mid-May 2004. In both interviews, I asked questions that emerged from my observations of the RTs planning practice, meetings, and documents and I used questions derived from Yang and Cervero’s (2000; 1998) work, Sork’s (2000) question-based framework, and Caffarella’s (2002) interactive program planning model. As the research progressed several informal debriefing interviews were
conducted with the TR Manager. Short follow-up telephone interviews were also conducted with three of the RTs to clarify information from their transcripts.

Interviews are an integral component of the interpretive ethnographic case study data collection. They elicited rich details about opinions, thoughts, and practices that cannot be obtained through other methods of data collection. However, good interviewing takes skill and practice and bad interviewing can result in the collection of biased, sparse information. An inexperienced interviewer who is not sensitive to her or his verbal and non-verbal effect on the interviewee, nor experienced in phrasing questions that elicit rich detailed answers, and who does not anticipate the problems he or she may encounter during the interview, will be frustrated and disappointed with the data she or he collects (Britten, 1996).

To reduce the risk of unproductive interviews, researchers should consider their effect upon the process, their communication skills, and their awareness of external influences. Interviewers must also anticipate how interviewees will perceive them and how their characteristics, such as race, gender, class, and social class, may affect the interview (Britten, 1996). I experienced an effect I might have had in my research when the RT supervisor and one of her staff made a comment regarding my advanced education and hence supposed expert status and awareness of the issues surrounding therapeutic recreation practice. Consequently, I was aware of both my assumptions of interviewees' meanings, as well as the assumptions the interviewees made of my knowledge of their situation, and I checked and probed the interviewees' answers to achieve a clear understanding of their stories.

Qualitative interviewers also need to be sensitive to the concepts and language they use (Britten, 1996). While it was advantageous for me that, because of my 15 years experience working in residential care, I shared both the medical terminology and therapeutic recreation
language used in EC practice, it was very important for me to continuously check my assumptions. Asking good questions is also an acquired skill. Good questions are “open ended, neutral, sensitive, and clear” (Britten, p. 30). I learned from my interviewing experiences that I needed to be constantly alert to the cues interviewees give me, to probe appropriately, to give interviewees enough time to explain themselves, and to be aware of how directive I was being in shaping interviewees’ answers. However, there is always a need for learning and improvement. Reviewing audio-tapes of interviews shortly after the interviews was particularly useful for self-evaluation and assessment.

Debriefing interviews with the TR Manager consisting of questions relevant to the preceding event also occurred on several occasions and notes from these meetings were recorded in my journal. Follow-up interviews explored other issues and questions that had arisen during the research process.

Researchers should also be aware of any potential distractions, and the comfort of the interviewee and themselves. Other people, telephones, faulty tape recording equipment, and noisy environments are examples of factors that can disrupt interviews. Additionally, the comforts of the interview room – seating arrangements, heat, light, and space can affect the success of the interview. Interviews can also be disjointed and frustrating if there is a lack of flow in the questions, or either the interviewer or interviewee is uncomfortable with the process, or if there are misinterpretations due to translations or assumptions (Britten, 1996). My experience interviewing residents with various physical and mental challenges has heightened my awareness of the effects of interviewer and interviewee health, and of environmental conditions on the interview process. Nonetheless, I needed to be continuously diligent about my interviewing technique and arranged to conduct the interviews in private areas at the research
site. Ten of the interviews were conducted in private offices, one by telephone and the remaining thirteen in recreation rooms. On several occasions when the RTs were unable to obtain an office for our interview and we met in their recreation room, we were occasionally disrupted by a resident, volunteer or staff person knocking on the door or by the telephone ringing. Nonetheless, after each of the interruptions the RTs continued on with their comments where they had left off with minimal or no prompting. Anonymity was not entirely possible amongst participants because the participants are easily able to identify each other. As a result, each participant was provided with the opportunity to review their quotes that were used in this thesis and to clarify her or his comments.

**Documents**

Documents are useful for substantiating and augmenting evidence from other sources and can also provide new avenues of investigation (Yin, 2003). As in my pilot study of RT practice, in this research project, planning meeting minutes, TR standards of practice, organizational charts, mission statements and policies, program protocols and procedures, activity calendars and schedules, residents’ attendance records, and field notes were useful sources of information. In addition, theoretical literature, research reports, and other health care related documents were reviewed.

Documents can be analyzed to elicit themes or content in visual and written material. There are several dimensions by which documents are commonly classified (Brewer, 2000). Primary documents refer to original sets of data, such as a tape recording of a meeting, whereas secondary documents include data derived from a primary source, such as an edited transcript of a meeting. Tertiary documents are data, such as a book, based on secondary documents. Documents are also classified as formal versus informal, personal versus official, and
contemporary data compiled at the time of the event versus retrospective data, which is recorded after the fact. It was important to determine what classification a document is, and how its classification affects its validity and reliability. The advantages of documents are that they are

stable—can be reviewed repeatedly,
unobtrusive—not created as a result of the case study,
exact—contains exact names, references, and details of an event,
[and provide] broad coverage—long span of time, many events, and many settings.
(Yin, 2003, p. 86)

However, “documents should never be taken at face value” (Jarvis, 1999, p. 114). Each document is produced for a purpose and when analyzing a document it was important to considering whom the author(s) were and the context within which the documents were created. In addition, documents may not be retrievable or accessible, and those that are may reflect a hidden bias of the author. Researchers are also concerned with the authenticity, purpose, message, and audience of the documents, and with the consistency of the document content with the historical context of the document.

Participant Observation

Observations of planning meetings were an important means for me to learn about how RTs negotiate with each other in deciding which program to plan, when and for whom. Schwartzman (1993) conceptualizes meetings as communication events that are interesting to examine because they are constitutive of the organization’s socio-cultural structures. Meetings provide participants with an opportunity to interact, negotiate, transact, strategize with others, and interpret communications. Schwartzman examines the specific components of meetings, including the participants, communication channels and codes, meeting times, location, norms and interpretations, goals and outcomes, the nature of the meeting, and the cycle and pattern of meetings (p. 64-65). Similarly I was able to observe how the meetings were conducted, how the
agenda was set and followed, and how the RTs participated in the meeting. Both audio recordings and notes (using a computer notebook) were taken during the meetings. The audio recordings were later reviewed to increase the accuracy of the transcripts.

Observations provide firsthand, contextual information about the phenomenon being studied. Observations of the RTs’ work spaces and of the RTs as they conducted their daily work and interacted with other stakeholders on their units were also important as they provided insight into the practice of the RTs and of the operation of the organization. In addition, issues that I would otherwise have been unfamiliar with emerged that I was then able to follow up with in the interviews. On several occasions while I was in-between interviews I was able to assist the RTs with their work, such as unloading and loading the bus, preparing for a special party or luncheon, and gathering supplies for a program. During these times I was able to observe how the RTs interacted with the other staff, family members, volunteers and residents. I recorded my observations in rich detail, utilizing my journal or my notebook computer.

Analysis

Transcripts of interviews and observations, audio and videotapes, field notes, and other documents require a different kind of analysis from quantitative data. In this section I will describe the process and skills used to analyze the data using a constant comparative and a recursive analysis method.

Basically, researchers “need to figure out what patterns their data can reveal and what stories their data tell” (Schensul & LeCompte, 1999, p. 149). However, the process is more complex than the previous statement implies. Zucker (2001) recommends “mapping the data from multiple data sources” (p. 5) as a strategy for organizing data and identifying patterns and
clustering concepts. Likewise, Hutchison (2002) reviewed her data “developing primary codes, and then returning to the data for categorizing and conceptualizing themes” (p. 26).

Schensul and LeCompte (1999) explain the process of analysis clearly in the following example of data analysis. During an iterative or recursive analysis researchers attempt to analyze their data for patterns, elements, structure, or items that are related to the research question. Items, patterns, and structures only begin to emerge and coalesce after the researcher has read, re-read, organized, and re-organized the data. “Items become those events, behaviors, statements or activities that stand out because they occur often, because they are crucial to other items, because they are rare and influential, or because they are totally absent despite the researcher’s expectations” (Schensul & LeCompte, 1999, p. 150).

As the researcher compares, contrasts and sorts through the items, patterns of thought or behavior will emerge from the data (Fetterman, 1998). “Patterns consist of groups of items that fit together, express a particular theme, or constitute a predictable and consistent set of behaviors” (Schensul & LeCompte, p. 155). Structural analysis examines the overall picture emerging from the patterns. Related items are organized into categories and sub-categories while structured analysis searches for links or relations among patterns of items. Similarly, I coded phrases in documents and transcripts using phrases that emerged from the quotation. Sub-categories emerged from the above sensitizing concepts, and correspondingly, sub-sub-categories. I recoded the data several times and while coding the documents and transcripts, sub-themes began to emerge.

Analysis is arduous work that requires constant “sorting, sifting, matching, clumping together those that are alike, and separating those that are different” (Schensul & LeCompte, 1999, p. 151). I needed to be disciplined, persistent, organized and patient. I explored the most
effective procedures for data recording for my purposes. For example, I used computer software programs Microsoft Word and Excel to manage my data and Atlas.ti to facilitate my analysis. Furthermore, it is vital that the researcher operationalize, or clearly describe how he or she has defined, understood, or categorized an item, so that another researcher reviewing the data could similarly identify the items observed (Schensul & LeCompte). I kept a journal recording my coding and analysis decisions and also, using Atlas.ti’s comments feature, I defined and explained codes as they were linked to phrases.

After formulating and reformulating the data, I developed models depicting the relationships in the structures and patterns. These conceptual models were tested and revised repeatedly as the research progressed. This process is referred to as “iterative or recursive analysis” (Schensul & LeCompte, 1999, p. 158).

In summary, data analysis is a recursive process, requiring the researcher to repeatedly review and assess the data. Ethnographic case study researchers need to begin analyzing data as they collect it in order to make sense of what they are observing as they proceed. New, unanticipated questions may arise as the researcher becomes involved in the field. For example, I found that the process of transcribing and coding interviews increased my awareness of how I asked questions and probed for answers, suggested areas for improving my interview skills, and revealed themes and categories for analysis and future research.

Quality of the Data

Lincoln and Guba (1985) argue that qualitative research should be assessed according to its *credibility, transferability, dependability* and *confirmability*. To establish *credibility* the researcher needs to “demonstrate that the inquiry was conducted in such a manner as to ensure that the subject was accurately identified and described” (Marshall & Rossman, 1999, p. 192).
To enhance the credibility of the findings in this study, detailed descriptions are provided of my qualifications, experiences and perspectives as a researcher, the research setting, the participants, their interactions, the data collection and analysis. Additionally, numerous examples from the raw data are provided to show the connections between those data and my interpretations.

Another strategy used for enhancing credibility is triangulation. "Triangulation is the act bringing more than one source of data to bear on a single point" (Marshall & Rossman, p. 194). The use of multiple methods and sources enhances the believability and robustness of the results — more so than if a single method was used (Marshall & Rossman).

The transferability or usefulness of findings to others depends upon "readers of case study reports [who] must themselves determine whether the findings are applicable to other cases than those which the researcher studied" (Gomm, Hammersley, & Foster, 2000, p. 100).

Nonetheless, while the reader of the research judges whether these findings can be applied to, or inform her or his own situation, the researcher is responsible for providing a rich detailed description of the case studied and the assumptions that were central to the research so that users can assess whether the context or situation they are interested in is similar enough to the context studied.

The criterion of dependability refers to the need for an accurate and complete account of changes that occurred in the context as the study was being conducted and of the possible impacts of these changes on what was being observed (Trochim, 2002). Detailed documentation and descriptions of the changes that occur in the setting and how these changes affected the way the research approached the study are provided in this thesis. For example, the job action (union strike) that occurred during the research is documented and the impact it had on the research is explained.
Confirmability, "captures the traditional concept of objectivity" (Marshall & Rossman, p. 194) and refers to the whether the findings of the study could be confirmed by others. While qualitative studies, by their nature, cannot be replicated because change is constant, to enhance confirmability, I have carefully and thoroughly described the design and methods of the research, that is, how I carried out the research, so that others who might wish to can (to the extent that this is possible in a qualitative case study) confirm my analysis.

Limitations of the Study

There are a number of limitations of the study including studying only one residential care facility, which may limit the application of the practice-based insights regarding program planning to other facilities that are structured differently. This study is also limited to specifically unionized, non-profit, complex, or extended care residential care facilities attached to a larger acute care hospital located in the Lower Mainland of British Columbia. Facilities attached to acute care hospitals have higher than normal resources when compared with other smaller, unattached residential care facilities. The study is also limited to programs planned by professionally educated RTs, working to their full scope of practice under the supervision of another RT, versus by activity personnel with rehabilitation or other education, working to a more limited scope of practice and under the supervision of a nurse or occupational therapist or some other discipline. Additionally, the perspectives of the residents and other stakeholders were not included in this study.

Summary

My background as an RT and as a researcher was described in this chapter followed by information about the research site and participants. Pacific Memorial Extended Care was the
site selected because of the relatively large numbers of RTs – as potential research participants – and because the RTs were similarly professionally educated and worked to their full scope of practice. In this case study, twelve participants were interviewed two or more times each, several planning meetings were observed, and numerous documents were analyzed. A step-by-step discussion of the research methodology employed provides information on the strengths and weaknesses of the data and its analysis. In the next chapter the results of the study are presented.
CHAPTER FOUR

RESULTS

In this chapter I discuss the results of the research study, reviewing the data collected from interviews, meetings, observations and documents. The data are presented in relation to the following research questions:

5. How does the context of extended care influence planning practice? What organizational (e.g., structural, political and cultural), environmental, and human, factors influence planning practice?

6. How and why do RTs plan programs in extended care? That is, what do RTs believe about the purpose of TR in extended care and how are programs chosen to be offered?

7. How do organizational, professional, and personal power and interests influence RTs planning practice in extended care? That is, how are needs shaped, agendas set, populations determined, decisions made, resources allocated and residents chosen?

8. What do RTs know and do – what tactics do they use when planning programs (e.g., reasoning, consulting, appealing, networking, bargaining, pressuring, counteracting, negotiating) and why (i.e., what are they attempting to change)?

How Does the Context of Extended Care Influence TR Planning Practice?

Caffarella (2002) defines the program planning context as three interconnected facets, "the human, organizational, and environmental factors that affect decisions planners make about programs" (p. 59). Using Caffarella’s definition as a framework the following section will explore the program planning context of the research site.
The larger environmental factors that impacted planning decisions will be discussed first, followed by the organizational factors impacting planning, which are grouped into cultural, structural and political influences on program planning. Last, the human factors, which includes all of the people who have a stake in the programs being planned, such as the residents, family members, funders, nursing staff, doctors, volunteers, support staff and management staff will be described.

Environmental Influences on Planning

The larger environmental factors that impacted the RTs planning practice included the provincial government and its Ministry of Health and Ministry of Labour, the labour management relations between the Health Employers Association of BC (HEABC) and the unions representing the health care workers, and health risks in the local community. Specifically, during the research project, the factors that were most influential were changes made by the Ministry of Health to the residential care access policy and the increased demand for residential care, the government’s changes to the labour legislation, the breakdown of talks between HEABC and the Hospital Employees’ Union which resulted in a strike, and several influenza outbreaks that lead to quarantining of the residents.

Residential Care Access and Demand

As the population in the Health Authority has aged, the demand for residential care has increased. In 2001/02 there were 6,000 admissions to facilities in the health authority and of these 34% or 2,040 were extended care (Fraser Health Authority, 2003, p. 35-36). In 2001/02 the research site had approximately 38% of the extended care beds in the health authority (they have since closed 60 of their beds) and therefore their proportion of admissions during the 2001/02
year would have been 303 admissions or almost 100% turnover in a year. Indeed, Barb noted that "our discharge rate has doubled in the past year."

In addition, in 2002 the provincial government changed the residential care access policy resulting in only residents presenting with the most complex care needs being admitted to extended care (Ministry of Health Services, 2002). Consequently, the health challenges of the residents and the turnover in the resident population was increasing (that is, residents being admitted into the extended care were sicker and also were not living as long) resulting in increased workload for the existing staff (because the staffing component was not correspondingly increased). As Barb and Kathleen shared, the increasingly complex needs of the residents complicated the assessment process and combined with the rapid turnover increased the assessment workload for the RTs.

**Barb:** The population is becoming more and more frail, the admission process has changed so the people that we see coming into the hospital now are very much more ill than the people that were here even a year ago... The population needs far more support... you have people that are so frail that they can't wheel themselves down to a program.

**Kathleen:** I'm still behind [with my assessments]. We had a lot of people pass away over Christmas and that and then you're starting again and there's a lot of people that are not able to communicate and some of the information you have to get from them, it gets complicated.

**Changes in the Labour Legislation**

As was mentioned earlier in this paper, the provincial government introduced legislation in 2001 that enabled health authorities to contract out services that were previously protected by collective agreements. In addition, the government indirectly encouraged the health authorities to take advantage of this change in legislation by freezing their budgets and suggesting that they consider contracting out as a means to meet their budgetary demands. Consequently the security service had been contracted out and during the research project the housekeeping services and
the cafeteria and café services were contracted out. Both instances resulted in layoffs of staff members who had worked on average 15 years. Additionally, some smaller facilities within the health authority had also contracted out their care aides and recreation staff. While these changes impacted the ways in which the RTs planned and implemented some of their programs, for example they could no longer take groups of residents to the nearby café for coffee parties, these changes also resulted in increased instability and anxiety amongst the remaining workforce.

*Job Action*

With the threat of more contracting out and of substantial wage roll backs, when the collective agreement under which the RTs worked expired on March 31, 2004 the union members overwhelming voted in favour of a strike. After the Hospital Employees’ Union took the strike vote the TR Department began planning for programming in the event of job action during which their services would be reduced by over 50 percent. The occurrence of job action during the research period enabled me to question the RTs on which programs took priority and why. Program selection was limited because volunteers and students were not allowed to cross the picket lines nor were entertainers allowed to come into the facility. The RTs were also faced with a limited amount of time to prepare for groups and also the chance that they might be assigned to an unfamiliar unit where they would not know the residents. The RTs met several times to discuss their plans and agreed that they would provide a cross selection of programs that addressed the holistic domains: cognitive, physical, and social/emotional. Hence they planned to offer an exercise program or physical game in the mornings and a cognitive/social event in the afternoon. Their goal was also to try to reach as many residents as possible – which meant larger versus smaller groups.
Joanne: [During job action] we tried to get together programs that would include as many residents as we possibly could in the short amount of time.

Diane: [We tried to] target as many residents as you can with a short amount of time. So that residents don't feel the great impact on programming; so general programs like exercises and bingo.

The uncertainty of job action also added stress to the RTs workload as they attempted to prepare for the unknown.

Irene: As well as politics, the strike coming up – that's really going to influence our planning. We're still going forward with our planning, but it's really in the air because we don't know if we're going to be here.

The implications of the decisions made in preparation for job action will be examined in the following discussion chapter.

*Provincial Government Imposed Collective Agreement*

After five days of job action, the Provincial Government legislated the health care employees back to work and unilaterally imposed a collective agreement that included an 11% wage cut plus an additional 4% wage reduction in lieu of working a longer work week of 37.5 hours instead of 36 hours. Consequently, the morale of the Hospital Employees' Union members, including the RTs, was affected. As Kathleen discusses below, the RTs that were used to donating an hour or two of their time on a daily basis were not as willing to do that with the new cutbacks in their wages.

*Kathleen: The way we used to do it [plan programs] was to stay over time. Not to get paid – this is our own free time. Once the cutbacks, that's not going to happen, I'm not doing that.*

*Influenza Outbreaks*

Influenza outbreaks influenced the recreation programs in a similar way that the picket lines did. During an influenza outbreak the floor was quarantined and the volunteers and the
entertainers were not allowed on the unit. However, instead of planning large versus small group programs, to reduce the risk of further infections, the RT often had to cancel all large programs and only implement small groups or one-to-one activities. For example, the April 13, 2004 Douglas 2 Residents' Council minutes record that the “March 9, 2004 meeting was canceled due to multiple illnesses on D.2.” In addition, those residents who were infectious were kept in their rooms. During the four month period of the research project three units were quarantined due to influenza. The impact of the quarantines is illustrated by the comments below.

**Gordon:** You can't do anything, or very little, if there’s a flu quarantine. You can’t go between the two floors. A lot of times we have shared programs and you obviously can't do that, or they can’t go into the pool. It just shuts right down, there’s a very limited [number of] things you can do. When it gets really bad they even stop us from doing groups in the dining rooms. We can only do one-on-ones. So that can be a big impact. And family members aren’t allowed to come and volunteers can’t come, so it’s a real down time for a lot of the residents.

**Barb:** Lots of things have been rescheduled because Georgia 3 was closed (due to Norwalk flu outbreak) so lots of things from the 9th of February on got cancelled until yesterday [February 23].

Although picket lines and influenza outbreaks put severe restrictions on the programs the RTs could plan, the disruption in the activity schedule and the cancellation of the “set” programs also gave them the opportunity to try something different.

**Kevin:** It actually was a good experience because it opened me up to just talking to the residents and seeing what they felt like doing that afternoon...rather than having this set structure on the calendar that you have to go by.

The implications of Kevin’s comment will be explored in the discussion chapter.

**Organizational Influences on Planning**

As was noted above, the organizational factors that can impact planning can be categorized as structural, political or cultural. First, the structural factors that impacted the RTs planning practice, including the policies and procedures, finances, resources and physical
features of the organization, will be examined. Next, the beliefs, cultures and traditions that influenced program planning will be discussed. Last, the political influence of the union, the administration, the Hospital Auxiliary, and the Family and Residents' Councils will be examined.

Structural Influences

There were many standards and protocols that directed the planning practice of the RTs spanning from those for assessment and program development to those for program implementation and evaluation. In addition there were numerous structural factors of the organization, such as the physical environment, supplies, equipment, funding, human resources, and organizational routines. Many of the structural policies and procedures were initiated by the Ministry of Health and were then adopted by the Health Authority, and then in turn implemented by the organization and the TR Department.

Assessments. The Continuing Care Division Standards for Residential Care Services activity programs (Standard 4.3) states that “an identification of activity needs is incorporated into the care plan…[and that]…there is evidence of an assessment of individual activity needs, interests and capabilities” (Ministry of Health and Ministry Responsible for Seniors, 1992, p. 48 – 49). The TR Department adopted the Ministry guidelines for assessment in their standards of practice, that state “the Therapeutic Recreation Worker collects systematic, comprehensive and accurate data on each resident/patient and determines the resident/patient needs in terms of active involvement in programs, leisure education and maximizing his/her optimal health level” (PMH Therapeutic Recreation Department, 2003b). In addition, the standard for TR documentation includes direction on the implementation of the assessment process stating that “The Therapeutic
Recreation Worker on the unit completed a leisure assessment on all patients/residents within 6 weeks of admission” (PMH Therapeutic Recreation Department, 2003e).

Although the RTs believed that programs should be planned according to the residents’ assessed needs, several of them acknowledged that they were not able to because not all of the assessments were completed. The following two RTs describe how the planning process should have occurred in an ideal world:

Kevin: *So basically after you’ve done your assessment of the resident, after you’ve gathered all your information through a leisure interview, if you could do it – observation, background information, talking to family and staff. Talking to the resident themselves if you can – you would come up with a picture of that resident’s leisure history, leisure knowledge, awareness, and based on that their strengths, limitations and needs – this is by the book I’m going by here. And the needs translate into goals.*

Lois: *In an ideal world I [would] have done all my assessments and interviewing of everybody on the floor and from that I would develop programs. But it doesn’t always work that way.*

Kathleen explained that in reality, assessment completion was difficult because of time constraints.

*Kathleen: Usually we try to do it [leisure assessment] within the first 6 weeks – to have the whole assessment done. Now that in reality doesn’t always work -that’s what we’d like. Reality is we start it – sometimes right away – [but] there are some that aren’t completed yet that have been a long, long time – like we’re talking a year – or more.....: It’s very difficult finding the time – and I know you have to take the time – but to do that you have to give up something else and that’s the hard part.*

Even when assessment and treatment plans were completed, they were not always useful because the resident was not able to commit to attaining the goals identified due to her or his cognitive abilities, and the RT was unable to fulfill her or his commitment to seeing the residents’ goals were met due to workload and/or planning issues.

*Diane: Well I would say that it’s easy to be able to write a goal for somebody that’s very specific, but it’s harder to follow through on that goal [and] for the resident ... it’s harder to attain the goal. ... Sometimes we set a goal for them [the resident] and they aren’t even aware of it, so there’s no impact on their part on following through on the*
goal. It’s up to the RT to assist in them following the goals. If we don’t have the time, or if we don’t have our calendar planned specifically for the residents, then it’s not going to happen. I know a lot of residents are in late stages of Alzheimer’s and need a lot of hand over hand to be able to participate in programs.

Regardless of why assessments were difficult to complete, the interviews revealed that the standards and expectations for completing assessments overshadowed the RTs in their planning practice. The TR Manager also acknowledged that assessment completion was problematic and that the lack of assessments was undermining the program planning process.

*TR Manager: Assessments should be what drives our programs [but] I don’t think people keep up with their assessments as much as they should be. So as good as any programming intervention can be, if it’s not based on client assessment, it’s not necessarily going to meet the needs of the individuals who are in the program.*

*Program standards.* The next traditional stage of the program planning process, clarifying intentions, (Sork, 2000) or developing objectives (Caffarella, 2002), was also influenced by program standards. The TR Department’s goals and objectives state that “each floor will implement a weekly gentle fitness programme” and that they will “write a standard for minimum weekly contact” with each resident (PMH Therapeutic Recreation Department, 2000). Another goal set was that “each floor will offer at least one gender-specific programme per week.” The evidence that these programs guided planning was illustrated by Gordon’s comment:

*Gordon: She’ll [TR Manager] kind of go through all the floors’ programs and come up with ideas that we are kind of lacking in this area or that area. “There’s not very many, you know, men’s groups, or specific groups like that. So, I think each floor should plan at least one of those a month.” So, we’ll make sure we plan at least one men’s group a month.*

The Canadian Council on Health Service Accreditation (CCHSA) program standards, which are voluntarily adhered to by all of the publicly funded hospitals and extended care facilities in B.C., also directs what programs are planned. The accreditation process involves “a review by an external panel of experts using national standards for care and service delivery”
(Fraser Health Authority, 2004a) and was regularly mentioned in the Health Authority’s newsletter as well as by some of the RTs.

Sheila: How we program for the residents, what the requirement is, [is directed by] accreditation. Accreditation states that we need to have ... church services, resident council, outings, community involvement – there’s a few stipulations as part of accreditation – so we have to meet those needs too.

Barb: I guess if there’s anything from accreditation that influences how we deliver programming, it’s how we deliver our resident’s council and that is that it’s mandatory that it’s done every month and on every floor unless they’re quarantined or something.

Program protocols and procedures. The implementation stage of the program planning process was influenced by the TR Department’s policies and procedures, written for 18 types of programs, which stated the purpose, goals, objectives, standards and procedures for each individual program. The programs that were included in the TR Department manual were:

<table>
<thead>
<tr>
<th>Baking</th>
<th>Dinner parties</th>
<th>Pastoral care</th>
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</thead>
<tbody>
<tr>
<td>Birthday teas</td>
<td>Editor’s corner</td>
<td>Pool/hydrotherapy</td>
</tr>
<tr>
<td>Bingo</td>
<td>Gardening</td>
<td>Pub night</td>
</tr>
<tr>
<td>Community outings</td>
<td>Life review &amp; reminiscence</td>
<td>Residents’ council</td>
</tr>
<tr>
<td>Crafts</td>
<td>Mobile making</td>
<td>Rhythm pals</td>
</tr>
<tr>
<td>Current events</td>
<td>Music</td>
<td>Social events</td>
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In addition, there were program codes for the different types of programs which were used to record residents’ attendance (see Appendix F). As was evident from their comments and from a review of the activity calendars, the predominance of the above programs indicates that the use of these protocols and codes influenced the scope and spectrum of programs that the RTs chose to plan and how they were implemented.

Diane: Well, with policies and procedure, you know we’re expected to do a resident council once a month. We’re expected to do a birthday party once a month. Those are MUST things that we have to have on the calendar. Bus outings have to be once a week. What we choose to plan for those bus outings is up to us. But if it’s available to us – you know the pool is every Thursday.
The procedure for preparing the monthly activity calendars directed which programs were planned. According to the procedure, the RT must “include regularly scheduled daily events, regular events and programs, special events, and other pertinent information (holidays, birthdays)” (PMH Therapeutic Recreation Department, 2003e). Thus, this procedure encouraged the establishment of regularly scheduled programs as well as a focus on traditional holidays. For example, one calendar advertised 10:30 Fun and Fitness followed by 1:30 Brainstormers and then 3:30 Advanced Fitness on every Monday of the month. The same unit also had consistent programs every Thursday, including: Sewing Circle, Visits with Paige the Dog, Book Review, Golden Pacers Exercises, and Music with Norma. Note that three of these programs (the pet visits, book review and music) were based on services provided by volunteers. This pattern of set programs for each day of the week was found consistently on all the units with some slight variation – some units had two or three afternoons a week that had a different program each week. For example, on Friday afternoons, one unit varied from bocce ball one week, a party the next, horseshoes the following week and bingo on the last afternoon of the month. Additionally, each unit also had its set days for using the bus and the pool, which predetermined the programs to be offered on those two days as well. The comments below illustrate how the policies and procedures influenced the planning process and fostered a structured, less flexible program plan:

Kevin: Suddenly it’s the end of the of the month, and...we’ve got to get our calendar done. We...get our core programs in the calendar, and here’s our bus outing, here’s our pool, and here’s our singing group that comes every Wednesday, and then it’s the filling-in process and what came up at council, what did we hear. What luncheon are we going to do this month? And looking at the calendar and saying, okay we don’t have any physical stuff here, why don’t I do a physical. And then it just goes in.

Gordon: You kind of get into that mould of doing the same programs over and over and it’s hard to think of new things to do.
Program attendance. In response to Ministry guidelines, the TR Department was required to record residents’ attendance at programs. This practice also acted as an evaluation tool, as the RTs reviewed their attendance records to assess how well they were meeting the needs of residents.

Kathleen: Well, through our stats, you know we also see who we’re not quite reaching, and try to make a point of getting to them at some point.

However, discussions with the TR Manager (personal communication, September 15, 2004) about the November 2003 program review undertaken by the TR Department revealed that relying upon attendance records for evaluation of resident goal attainment was problematic because there was no measure of whether the resident was attending the right program (that is, the program they were assessed as needing to attend) or whether their participation in the program was active, passive, or could otherwise be measured as being meaningful.

Work schedules. As the quotes below illustrate, program plans were also structured by the RTs’ work schedules and the provisions of the collective agreement which specified the days, times and hours of the RTs work.

Sheila: The policies and procedures state how often we can work, what days of the week – so you’ve got to stay within that.

The planning and paperwork demands of the job also limited how much time the RTs had available to actually be with the residents.

Diane: There may be times when the resident is willing and able and wanting to participate and they self-initiate to do something – but we’re at a point in our day where we really need to get some paperwork done, or the end of our shift is coming up, or we need to go out to buy supplies for another program. It would be the ideal time to offer that program or to be of assistance to the resident and you just can’t be. You have to allot time for everything.

Each unit was staffed with one full-time RT and one half-time RT. Consequently, programs requiring two staff persons could only be scheduled on the days when both RTs were working.
Lois: The special events have to happen on a day when Kathleen and I are both here. So they’re never going to happen on a Thursday and a Friday because I’m not here. And they’re usually on a Wednesday. Every second Wednesday I’m in so we try to plan it that way as well. So those are all factors that aid in determining when you’re going to have what and sometimes it gets very tricky.

Diane: Two staff members have to be on the bus at all times. You couldn’t even say, okay, well I’ll do the bus outing because I’ve got two volunteers to come and help me.

A discussion during the March planning meeting also revealed that it was expected that the TR Department had at least one staff member in the building during the weekdays, thereby limiting what types of programs could be planned on days when there were fewer staff working.

Joanne: We were thinking if the renovations in fact do go ahead, we thought we’d maybe have an extra bus outing on the 30th.
Barb: But that doesn’t leave many staff in the building, that’s the only thing. That would leave no rec staff in the building at all.
Joanne: Okay.

In addition, the collective agreement required the facility to pay the RTs double time if they worked on a statutory holiday, which the facility did not have the budget to do, therefore the RTs did not work on statutory holidays and scheduled holiday events as near to the actual day as they could.

Lois: [To celebrate Easter] we’re going to have turkey soup that we made. We’re having it on the 7\textsuperscript{th} although Easter is officially on the 12\textsuperscript{th}, which is a statutory holiday. We’re having it on the 7\textsuperscript{th}, as close to [the holiday] as we can get – that’s a big program so we need two of us present – two staff – so we’re having it that day.

Supplies. Not unexpectedly, the resources available to the RTs, including supplies, equipment, money and people, greatly influenced what programs they would plan. The TR Department had regular supplies it would purchase, such as craft materials, baking supplies, garden plants and so on, and these supplies were obtained because of the program planned. Conversely, the RTs also received supplies from volunteers, family, and other staff members that would, if appropriate, influence the type of program planned.
Laura: I had a volunteer give me all the things to make these little dish cloth outfits—I had never seen anything like it in my life. So again that was by a personal companion who donated it to me, and so I said okay I'll see if this is something the ladies and gentlemen would like to do...and they really liked it—and it was very good again because there was folding - each step of it is very easy.

Debbie: We got all these candies donated the other day by Safeway so I got all the residents to package them up into little bags and I sold them. We made it into an afternoon program by having the ladies open the bags and put the candies in.

*Equipment.* The equipment available to the RTs also influenced their planning practice including how programs were implemented and how the residents were able to participate. As was discussed above, the availability of the pool and the buses determined that community outings and hydrotherapy programs were regularly scheduled.

Irene: We have to share a lot of our equipment—so being organized in that sense—of communication. Make sure we know who has the bocce this day, who's got the horseshoes, who's on the bus, who's in the pool—that kind of determines what we can do as well... Sometimes we have it for the same day, and we say, let's see what we can do that works for each floor, works for each group. Maybe the afternoon is a better for us and it is for another floor—well, maybe we'll switch it to another afternoon. It usually works out fine.

In addition, the RTs had to share access to the catering department.

Lois: [Our unit has] one great big huge Xmas potluck dinner. [The units] cannot have them on the same day and that is because of availability of equipment and the availability of the catering from the kitchen. So you're juggling that as well.

New adaptive listening devices were acquired during the research period that demonstrated how equipment could greatly impact the residents' ability to participate in programs.

Irene: Some residents are very high level cognitive, social, but can't hear. So we have a new audio system, it is amazing. It has made a huge impact—a couple of residents that can't hear very well—I was able to talk like this and they were able to answer, whereas in another group they wouldn't answer because they couldn't hear.

The hospital had also installed computers throughout the organization and all of the RTs had access to their files on the hospital network “h” drive, which was available on any hospital
computer. This technology gave the RTs greater flexibility during the renovations of their offices when they could not use their own computers.

Barb: The good thing about the computer... is that everyone's on h drive now, so you can access your computer files from any computer – you can use the nursing station computer.

Funding. The RTs each had their own petty cash budget for their unit that they used to purchase supplies and services for their residents’ programs. The budget, which was small to begin with, had not increased in 17 years and therefore the RTs’ energies were often consumed with funding raising projects and financial concerns.

Barb: We have a petty cash budget that has not changed since 1987. What it boils down to is that we have $2 per resident per month to provide leisure programming. So...we try and figure out ways that we can raise money to operate our recreation departments on each floor and it’s the families and staff on the floor that support the program...So some floors need to fundraise more than others because they don’t have that family support.

Kevin: We have to basically do these garbage sales – white elephant sales and bake sales...we need some kind of money – if you want to...improve some of the programs.

The need for fund raising programs not only influenced what programs were planned (for example, bake sales and craft sales) but also what types of projects the RTs would plan for their programs. For example, projects had to be saleable; they were not necessarily projects that the residents would have chosen if the purpose of the activity had been solely for their enjoyment.

Diane: We’ll do a craft program – but it’s to sell a craft so we can regenerate the money – so we can sell the craft to make another craft.

Sheila: I mean we fund raise constantly. If it’s our gardening club that we have once a week; now we just split a whole bunch of plants and we’ll put them all on a little cart and we’ll sell them for 50 cents each and that’ll help. You know what I mean. Everything we do has something – like right now someone donated a bunch of books. They’re not suitable books for the residents, but thank you for the donation and we set it up and decided to sell them you know. It’s just a little way to fund raise.

As Kevin and Joanne explain, the limited budget also influenced the type of entertainment the RTs could bring in for the residents’ programs.
Kevin: You’re stuck with the same entertainers that charge a small amount – we get the same one every month – we’d like to get someone different...but we can’t afford it.

Joanne: Another thing is, she’s affordable. She’s an excellent musician, and she’s affordable. I pay her $10 – that pays her cab fare – that’s all it does.

*Human resources.* People and their skills were a major resource that the TR Department depended upon for its programs. The RTs’ personal knowledge and skills in fitness, crafts, gardening, baking, sports, and alternative health techniques such as aromatherapy and therapeutic touch enabled them to provide a wide range of activities with little support. The TR Manager summed up the importance of the RTs’ skills in the following quote:

*TR Manager:* You know the biggest resource that we have in our department, it’s the human resources. If the RT is skilled and creative, you can run a program that doesn’t cost anything for the most part.

As was noted in the above discussion of the stakeholders involved in the planning process, many of the programs were only possible with the physical assistance of volunteers and were scheduled around the availability of the volunteers. Hence, if volunteers were not available a program would be cancelled, or a resident who needed assistance would not be able to participate.

*Barb:* Our adapted aquatics program is very labour intensive and each resident that comes to the pool has a volunteer – it’s a one-to-one situation. So, for example, if a volunteer cancels, and we can’t replace that volunteer, then the resident doesn’t go into the pool.

*Gordon:* If we’re going on an outing and we need volunteers...if they can’t be there at a certain time, we’ll have to reschedule a planned outing ...or take somebody else who maybe has an electric chair so they don’t need a pusher.

*Kate:* For my Yoga program, if I didn’t have 1 volunteer and 2 candy stripers, yoga wouldn’t be able to happen...The yoga instructor, she is paid to come in and run the yoga program – she’s not going to gather everybody up.
Volunteers were also subject to organizational procedures which limited what they could do. Some of these limitations are discussed later with regards to the strictures of the collective agreement, but Sheila also describes a procedure implemented for safety reasons.

Sheila: Working with volunteer services itself there’s criteria that they have, [what] the volunteers are allowed to do [and] cannot do. Like they cannot take people off the hospital premises. If say a resident wants to go up town and shop and there’s no one to do that with them and they just need someone to push that wheelchair – can’t have a volunteer do that – there’s liability issues.

Community resources. The availability of resources in the community, including the facilities in the community that the RTs and residents accessed as well as the community groups that came in to entertain or to provide some other service were another major consideration in the RTs’ planning.

Lois: I think the community connection is important. When the men’s group started, I had three male residents who were appropriate and we made contact with the wood working group at [the high school] and so that’s what we did on men’s group days. So long as it wasn’t absolutely teaming with rain we would walk down with the wheelchairs. I’d have to have a volunteer assist for each resident and we’d go right into the high school wood working shop. And they put us with a troubled teen and he was so good.

Laura: Also...having people call us – like choirs that want to sing, dancers that want to come and perform. I just had that last month that someone called and said they had 25 dancers [aged] from 7 to 20 that want to come in and perform from the ballet school...and it was an incredible show. And it’s nothing that I went out there [to request], and the residents never discussed that they wanted that or anything, But the opportunity was great and it turned out to be a great show so it’s something that we would have again when they call.

Programs were planned around the availability and affordability of community resources and accommodations were made to fit them into the schedule as is illustrated in the conversation from the February 2004 planning meeting:

Barb: Lois, wasn’t part of the reason we changed the date because of the conflict getting the animals to come to the show?
Lois: Yes... that [was] a problem; because a lot of the shows go on the road and June 26th might be better for that reason.
Barb: Okay
Sheila: Do we want to start planning for that day then?
Barb: Will that work for most people then?

Similarly, a request by the Douglas 2 Resident Council to have a performer entertain had to be delayed, “Hula Dancers – they are not performing at the present time and we will try to get them in the spring when they will be performing again.” (November 4, 2003, D2 Resident Council Minutes).

Physical plant. The physical plant was another major structural influence on the RTs’ program planning. The types of rooms available for programs had a profound impact on the implementation of programs, the numbers of residents that could attend, and the potential quality of the residents’ participation. The RTs regularly had to use the dining room for programs as it was the only large room on the floor. However, as the quotes below describe, noises and interruptions were very disruptive and impacted the quality of the residents’ participation.

Barb: The environment isn’t conducive to a lot of types of programs that you need to offer for a frail older adult. You know the large dining room, and now starting next month...they’re going to be doing their food preparation in the dining room. So if we’re doing a group in the dining room and the food service worker is preparing lunch, it’ll be, the noise level will be just that much higher and that much more difficult for the seniors to hear what’s happening.

Kevin: Because our area is a wide open dining room area...some of the care aides [will see us in an activity and say to a resident] “Oh look, they’re baking over there, why don’t we go over?” And that can change the dynamic of the group because first of all the group is being disturbed – you might have someone that’s coming in and she’s going aye-aye-aye-aye [Kevin demonstrates perseverating behaviors by banging his hand repeatedly on the table]. So you’ve got to stop your group and try to refocus that resident.

Only one of the six units did not have a patio, which meant that the 50 residents on that unit could not have their own easily accessible outdoor garden or barbeque programs which were regularly enjoyed by the other 250 residents.

Debbie: One of the things that really affects my floor that I’m not really happy about but I can’t change...is a patio – I don’t have a patio on this floor.
Despite the health authority’s and the organization’s belief in promoting a homelike environment, the facility continued to have many institutional features that impacted programs, such as big tables and long hallways that were filled with medical equipment.

*Kevin:* It’s very institutional...with the big tables, there’s no storage so there’s lifts all over the place, equipment and everything’s jammed at the end of the hallway because there’s no storage. There’s no real recreation area for the residents – just a multi-purpose area [where they] eat.

*Barb:* You have people that are so frail that they can’t wheel themselves down to a program. Those are long hallways that one person has to run to bring people.

*Organization routines and schedules.* Another organizational structure influencing planning was the established schedules and routines of the various departments and services such as food services and nursing.

*Kathleen:* We try and work around routines the best that we can – baths, meals, family coming in. Some have personal care workers – or companions, some can only go [out] in the morning.

*Sheila:* There are things that are scheduled, when they are getting up, when they have their meals, if they like to rest. So you’re not always able to plan for everyone at the time that’s best for them...You have a window of opportunity from say 9:30 in the morning until noon. And then you have 50 people. And you have another window of opportunity, maybe about 1:30 till about 4:00.

*Political Influences*

Caffarella discusses the political influences on planning as being the coalition building and power relations and the politics of funding and resources. Although there were many individuals and groups that wielded some political influence, the RTs predominantly discussed the political influence of the union, and the power relations of the administration, Auxiliary, Family Council and Residents’ Councils on their planning practice.

*Union.* The unionization of the RTs work involved several political considerations. The RTs had to be careful about what the volunteers did so that they were not doing work that should
be done by a member of the union bargaining unit. However, volunteers were used to assist with many tasks that blurred with the RTs roles, such as assisting with special meal preparations, portering residents to programs, and entertaining the residents. With the pending changes to food services, the RTs brainstormed having volunteers assist them with food preparation, but then reconsidered the idea because it could have been construed as union work. Similarly, as Kate describes below, the RTs discussed having volunteers come in to run diversional programs while they were on the bus, but then decided not to because it might have given management the idea that they could be replaced by volunteers.

Kate: And sometimes we think to maybe have a volunteer in – maybe to put in a movie or do a tea or something ... but then you’d get into, well is that good to maybe get volunteers to come in here when we’re not in here and what are the implications of it... then are they going to say, hey we don’t need any recreation staff, we can get a volunteer to come in and put on a movie; get a volunteer to come in and put on 5 card bingo. So when we think about planning, there are certain things we’d like to try and enhance our programs and our schedules with and you get stuck with – what are going to be the long term ... cause and effects if we do this.

The RTs also viewed the unionization of their work and the collective agreement governing their working conditions as fixed, unchangeable frame factors. They did not perceive that as a small department they could negotiate any changes to the terms of their collective agreement. However, following the example of another extended care facility, in my practice as an RT I engaged in negotiations to alter the terms of the collective agreement for a special camping program. The program could not have proceeded with the overtime pay rates defined in the collective agreement, but I was able to negotiate a one-time variance in the agreement including no overtime pay. This example illustrates how even the most daunting frame factors have the potential to be altered.

Administration and organizational hierarchy. The RTs also felt the influence of administration’s decisions about resources and funding. The feeling that emerged was one of loss
of control as administration unilaterally imposed changes that impacted the RTs programs.

Sheila and Lois express the opinions of the other RTs in their comments about the kitchen renovations:

*Sheila:* I think we're always dealing with politics...I'm thinking of the kitchen renovation. Here comes in a group of people who are going to change the kitchen...[and] we use the kitchen as part of our program. We weren't happy at all. We put a proposal through; we did what we could to say no, this isn't going to work. We're working with these residents in an area that works right now, if you're asking us to now take it to a different area it's going to affect - and we named off all the things it's going to affect and we wrote it in writing what we thought, the way it should look, and in the end, they had already made their plan. Although administration looked at it, the plan was already underway; they already had someone coming in to do this. So, it was moot that we even put a proposal together on how we thought we could have adapted the kitchen changes.

*Lois:* We were asked for feedback on the kitchen renovation. We spent hours planning...and we came up with what I think were some really good ideas. But no, it's going exactly back to the way it was in the first place. So you almost felt that you were wasting your time.

As was discussed earlier, the TR Manager also noted the impact of administration’s reorganization of the organizational reporting structure, which included a new reporting layer for her, and a matrix reporting relationship for the RTs on the units. The RTs reported to both the Unit Manager on their unit as well as to their clinical supervisor, the TR Manager, although the TR Manager retained primary control over the RTs hiring, training, performance, and scheduling.

*TR Manager:* If we were to come together as a group, say every morning, do a check in before we start out, little things ... could be shared as a department. [But] we don't have a central meeting spot, and we are set up as a matrix reporting system, so the recreation staff are based on the floor and they report to me as their professional practice chief, and they also report to the unit managers.

In addition, the TR Manager no longer had access to the same amount of organizational information.

*TR Manager:* I see it as somewhat of a loss of control that recreation has had up until recently – with this new layer put in. Where again, I think you are going to see that
throughout the organization and our health authority – that used to be sort of a pretty flat organization where there was lots of information given out to all of the staff. Everybody knew where we were at, but now the reporting structure is more like a stove pipe kind of thing. So you talk to this person and you get a little bit of information and whatever trickles down is the information that you get and I think that that has taken away from some of the decision making that we’ve had in the past...Certainly from a manager’s position that’s the way I see things happening. And when I speak to other people who are in similar roles to me it’s the same thing – we’re just not getting that information any longer.

Similarly, one of the RTs noted the impact of the organizational hierarchy change on her efforts to gain support for her programs.

Joanne: It’s the constant struggle, and I think that education is the way to go to get them [nursing staff] on board. But you know what...in order for that happen, it’s like the pyramid thing, you’ve got to have the people at the top that respect what you’re doing and encourage and back you up and say, yes, you know you need to get these people up and yes you need to work with recreation. And if they don’t, if the people at the top don’t value what you’re doing it’s very hard.

As she describes below, the TR Manager’s involvement in the organization’s administration was additionally limited by the devolvement of the geriatric team of which she had been a member.

TR Manager: For example we had a geriatric service team that all the disciplines sat on, so when the geriatrician was talking about something that he wanted to see happen in the acute unit, and then we could hear what social work’s response to it was, and physio’s and you could sort of see the flow and the changes in the currents that were happening within that service. And you could respond to those changes. Now you don’t see, you don’t hear. You don’t know what’s happening in any of the other disciplines, you’re just kind of going along doing the best that you can. So it’s a change in the communication and dissemination of information...The geriatric service team, that was also an opportunity for me to educate other disciplines on what we were doing and get them to engage and support it and it was wonderful.

Hospital Auxiliary. The Auxiliary as an organization had substantial political influence in the organization because of its generous donation of funding and volunteer services they contributed to the hospital and extended care.

Barb: Well, the Auxiliary, for example, is a very powerful organization within the hospital. They’re funders, they’re fund raisers and they like to do things for the residents. They have their own ideas on what they think is going to work. And we can make
suggestions, but more often than not it works out that they are going to do what they would like to do.

Family Council. Similarly, the Family Council advocated for the residents by lobbying for structural and staffing changes. Barb described how the Family Council’s efforts resulted in improvements to the sidewalks.

Barb: The Family Council has an interesting dynamic in our organization. They’re highly respected and speak for residents who can’t speak for themselves. Family Council took on widening the sidewalk – the sidewalk was not wide enough for two wheelchairs to get by. And the administration responds.

Also, as the minutes below record, the Family Council lobbied the hospital administration for an increase in recreation services.

Joe Marshall reported a small committee (Joe Marshall, Bob Black and the TR Manager) met with Fred Jones and Jane Smith. The Committee was requesting an increase in Recreation staff from 1.5 to 2 positions. Jane Smith has advised the committee that no resources are available at this time.

Bob Black drafted a very well written letter to Jennifer Clark, Health Services Administrator, outlines the need for increased resources. Copies of the draft letter were circulated at the meeting. Discussion followed as to how best to make the needs known to the Fraser Health Authority. Suggestion: have residents/families write letters, sign a form letter or sign a petition.

( November 19th, 2003, PMH Extended Care Family Council Meeting Draft Minutes, p. 2)

However, the Family Council’s actions reverberated throughout the TR Department as the administration turned the blame for the Family Council’s complaints onto the RTs.

Gordon: Just recently we went through a thing where there’s all these cuts at the hospital right, so Family Council got wind that they thought we needed more rec therapists. So they had a big meeting and the minutes were printed out. They were basically saying how we need more rec therapists, and they went to the unit manager and said there should be more, and things like this. And so, not that it did anything. They try different ways of advocating for us and improving things. That was kind of a touchy subject because the unit manager didn’t like that very much and thought that we were actually going to Family Council and saying, “We need this and that.” Which wasn’t the case, they just kind of interpreted it themselves.

Barb: They are very supportive of our department, but they also tried to get more staff for us and it backfired. They took it upon themselves to ask for more TR Staff and
administration came back to me and asked if we could “work harder” and reduce our “soft times.” Soft time are times spent standing in the hallway talking to nursing, building rapport with the care aides, building relationships with the staff – they are important.

Residents’ Councils. The Residents’ Councils were other players in the political scene of Extended Care. Each unit of 50 residents had a Residents’ Council. As was noted in the discussion of how programs were planned, the RTs seriously considered the suggestions of the Resident Council when it made planning decisions. The Resident Council not only made suggestions about types of programs, but also negotiated about substantive details such as how they were formatted. For example, as the minutes explain, the Georgia Three Residents’ Council negotiated to have one large council meeting for all three units in the pavilion.

The council had brought up the idea of having one large council meeting for all of Georgia. Residents could have an opportunity to raise concerns on their floor and talk about issues that concern the whole pavilion. [The RT] attended the December recreation business meeting on Dec. 2nd and discussed this issue with … [the] Manager Therapeutic Recreation and the recreation staff. The staff agreed that the idea of meeting once or twice a year as one council for Georgia with all the residents would be possible. If a council requests to meet with other floors to discuss a global issue or concern in Georgia, a meeting can be arranged for all floors to be represented. Otherwise, regular monthly resident council meetings will continue to be held independently on each floor as usual. (December 29th, 2003, Georgia Three Resident Council Minutes, p. 1)

This meeting was held in the spring of 2004.

Additionally, as Gordon shares below, the Resident Council attempted (unsuccessfully) to influence administration in its allocation of resources.

Gordon: You know we don’t have a patio on [the third] floor and Residents’ Council is always writing letters to have a patio on this floor because there’s a patio on every other floor.

Cultural Influences

Cultural traditions and beliefs of the organization were another influence on the RTs’ program planning practice. Seasonal events traditionally celebrated in Anglo-Saxon cultures
dominated the activity calendars and were mentioned in the interviews. A more subtle but strong influence was the traditional belief about the activity-based role of TR in long-term care. Similarly, the traditional medical norms pervaded the organization despite the stated beliefs in holistic care.

Seasonal events. A review of the activity calendars found that the statutory holidays (e.g., Remembrance Day, Christmas, Good Friday, etc.) were featured and celebrated. For example, Remembrance Day services were planned both before the actual holiday as well as on November 11th. Christmas events were highlighted throughout the month of December starting with Christmas decorating on December 1st, and then proceeding with Christmas Baking, a special breakfast with Santa Claus, Christmas Light Tours and special choir performances from the schools and community groups.

Other special events traditionally celebrated in Anglo-Saxon Canadian culture were celebrated. Valentines’ Day was noted with pink calendars, special teas, lunches, trivia, cookies and sing-alongs. St. Patrick’s Day was celebrated with pubs, travel videos of Ireland, and green decorations. Interestingly, although the May calendars noted the Victoria Day Holiday, the theme surrounding the holiday was not about Queen Victoria and Britain, but was a western theme in conjunction with the local community’s annual holiday weekend rodeo and featured horseshoes and a western barbeque. Similarly, if they were able to, the RTs would try to include the traditional cultural activities residents from other countries celebrated. Irene and Lois discussed the importance of continuing the celebration of seasonal events in the extended care:

*Irene: Seasons also determine [and] effect our programming as well. For the residents it’s a really good orientation to time and place and date and also can bring back a lot of reminiscing; especially if you really celebrate Christmas or Easter, if you’re Scottish, Robbie Burns, if you’re Irish, St. Paddy’s.*
Lois: Culture would be another program consideration. We do consider cultures just as we do consider special events. We consider cultures of the people. Like we've had a couple of residents who were Ukrainian and were really into baking and so we've had somebody help us with pierogies and we try to focus around whatever information we can gather about people that we think is going to be meaningful to them and we can build around that.

Traditional beliefs about the activity-based role of TR. The role of the RT in extended care has evolved over the years from an activity-based service to a more formalized clinical service based on assessments, goals and objectives. This is reflected in the post-secondary education of all of the RTs (diploma in recreation therapy) and as was discussed above, the Ministry’s and Health Authority’s expectations that all residents would receive leisure services based on their assessed needs. However, this transition in the role of TR only started approximately 20 years ago, marked by the start of the Douglas College diploma program in therapeutic recreation in 1980 and the formation of the BC Therapeutic Recreation Association in 1990.

Consequently, being unaware of the tasks involved in program planning, many of the nursing staff expected a full schedule of activities for the residents each day.

Sheila: I know that there is a requirement that it LOOKS LIKE THINGS ARE HAPPENING... I know everything is PR, what are they doing, what looks good, how often do you do it. It's like the "party girl." To me that's what the organization is expecting of us.

The nursing staff liked to see the residents kept busy, but the increasing complexity of the residents meant that the RTs needed to plan smaller groups or one-to-one activities, but they were pressured to plan the traditional large group programs that kept more residents occupied.

Kevin: And the staff are going, “Like what’s going on?” “What’s on this afternoon? There doesn’t seem to be anything going on.” And you’re down in the room trying to do a quality one-to-one program. And a lot of us succumb to the pressure and say, “Okay we’re going to do this ...so it looks like something’s going on!”
However, the RTs made attempts to alter the nursing staffs’ expectations for traditional programs.

_Irene: And another thing too facing staff members [is that] they’re not going to see as much ...social events and big programming in the dining room, [because] we used to do the majority of our stuff in there that everybody could see and everybody could be involved in. However, there are residents that aren’t being targeted as much and can’t sit in large groups [because it’s too] overwhelming. So we’re going to have to take it, like into this room [the recreation office], or into a private area. [The problem is] ... to gain that understanding that we’re still here._

In like manner, most of the RTs felt that their time was better spent directly interacting with the residents versus sitting at a desk doing the required paperwork. The conflict the RTs faced over the dilemma of paperwork versus programs was evident in their comments:

_Barb: I think it happens because balancing programming and paper work has always been; it’s an ongoing problem in recreation. It’s hard to see 50 residents sitting out in the dining room and you’re sitting in the recreation room working on your assessment._

_Kathleen: Both Lois and I feel guilty when we’re in here doing some paper work and there’s a bunch of people out there that are needing attention or something._

_Therapeutic recreation norms._ The TR Manager, who was nearing completion of her Bachelor’s degree in Recreation Therapy and also had her 2-year diploma in Recreation Therapy, as was noted above, hired, supervised, directed and evaluated the RTs’ clinical work. All of the RTs similarly had a diploma in TR from Douglas College. Hence all members of the TR Department had been taught the same skills, knowledge, and philosophies of TR which resulted in a relatively homogenous working group that held many common beliefs about the role and purpose of therapeutic recreation.

_Medical norms._ Medical norms were also evident in the extended care setting despite the organizational belief statements that promoted a holistic, home-like environment. Although the complexities and implications of the medical norms will be discussed in the following chapter, the following quotes illustrate the RTs perceptions of the medical norms.
Barb: Although the rest of the medical team espouses to a residential care, quality care setting, it’s still very strongly rooted in the medical model. And we can say that it’s holistic but it isn’t.

Kevin: I believe that, it’s like, you read their philosophy, mission, vision of the place – and basically it’s like we want to provide the residents with a caring home. It seems to be like there’s this “holistic” view of the place and its mission and vision of the place. But I don’t see it – it’s the old medical model still here...[During resident care conferences medical] is the main thing – let’s get to the pharmacist, the drugs, right. Let’s get to seating and swallowing assessment – that’s the main thing. There’s a DOCTOR there. They don’t want to know about how Margaret did in the sewing group. Which is exciting for us, that we see her how she sang along to a song and she doesn’t even talk, ever. It’s like “Isn’t that nice...now let’s get back – what is her blood pressure?”

While the RTs strived to promote a holistic approach in their practice, because medical norms dominated the environment they felt that they needed to try to “talk the talk” to gain recognition for their service. For example, although Barb argued that “therapeutic recreation is an art – health care is more of a science” she also acknowledged that to gain credibility with the rest of the health care team that the RTs needed to use clinically based assessment tools.

Barb: The reason its clinical [assessment] is because we put it on the medical chart and we have to see ourselves as fitting in with the rest of the team. And if we just put a few words in...it didn’t look like a medical type assessment, it probably wouldn’t be seen as anything that was valuable to the rest of the team. Especially if you include numbers in your assessment [or] some kind of a scale. I think it just... validates what we do. If you look at numbers on lab reports and percentage of fluid intake, and all the rest of it, if you have a scale that talks about their... score on their leisure competency measure on admission and where they score 6 months later – it’s a number that you can show them. And numbers, it’s maybe a science.

Similarly, Laura argued that completing assessments was important “because if it’s not on paper, it’s not done.”

Laura: I think in the whole big scheme of things, I think it [assessments] would make our profession more valid and reliable...I think it’s very important because I think we’re just as important as nurses and care aides, but they see us doing and doing and doing and they’re not looking at the documentation. If they saw what we had to do to assess people to put them in certain groups, they would maybe think twice about, “Oh here, take this person” and just wheel[ing] them in and put them down.
Human Influences on Planning

As was mentioned above, the “human” factors influencing the context of this study included the residents of the EC facility, family members, hospital administrators and managers, community members, volunteers, and the “multidisciplinary” team members who worked with the RTs (e.g., nurses, doctors, care aides, occupational therapists, chaplains, music therapists, housekeepers, maintenance workers, food service workers, social workers, etc.). The RTs who planned and organized the programs obviously played a central role in the planning process but their influence on planning will be explored in detail in a later section discussing the tactics used by the RTs. In this section, the influence of the other stakeholders on the RTs’ planning process will be discussed.

The Residents

The impact of the changing resident population and their increasingly complex care needs on planning programs was evident in the comments made by the RTs. The impact felt was manifested in all areas of planning practice – the assessment process, determining residents needs and interests, developing programs that were meaningful for the residents, implementing programs and evaluating the effectiveness of the programs – were all increasingly difficult with the growing number of residents who had severe cognitive and physical limitations.

The RT staff at the research setting commonly used the terms high, medium, or low to describe the different residents by their cognitive functional abilities. When asked to explain to what she meant by “high, medium and low” Lois described the differences:

Basically we're talking cognitive when we're speaking high, medium and low... High functioning we're looking for people who have high cognitive abilities. To me low are the people who are participating in aromatherapy – so the difference between a medium and a low would be that the medium is able to communicate somehow with you. It's unfair to say verbally, but quite often you'll judge it on their verbal response. They may not
necessarily make sense to you, what they’re saying, but they will respond in some way that says this is pleasurable and we’re visiting. Whereas the low functioning people would be ... very difficult to assess that they’re communicating to you. And sometimes even eye contact is difficult.

The TR Department at the research site had compiled data on the composition of its resident population in November 2003. Similarly, three levels of cognitive ability were used to identify residents:

1. cognitively well (high)
2. cognitively impaired (medium)
3. cognitively impaired and frail (low)

Another of the RTs expanded on the difference between residents’ functioning level:

*Sheila: If they’re physically and cognitively able to participate, they are more well – a higher person. If there’s a lot of cognitive deficit, I would say that they’re lower, even though they might be physically [able] – unless it’s a physical program. But yes, I would call them lower. When someone is really frail, I consider them lower. ... Usually they know who they are, but [not] where they are, and what day it is, time, [and] I would call that lower.*

I studied the data collected using Excel and discovered that half of the residents were identified as being relatively well cognitively (50%), while the remaining 50% had some cognitive and/or physical impairment that affected their ability to participate in programs (see Table 3).
Table 3

*Functional Cognition Level of Research Site Residents (as of November 2003)*

<table>
<thead>
<tr>
<th>Resident Type</th>
<th>% of Residents</th>
</tr>
</thead>
<tbody>
<tr>
<td>Well cognitively</td>
<td>50%</td>
</tr>
<tr>
<td>Impaired cognitively</td>
<td>26%</td>
</tr>
<tr>
<td>Frail &amp; impaired cognitively</td>
<td>24%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>100%</strong></td>
</tr>
</tbody>
</table>

The comments below illustrate the struggles the RTs had with planning meaningful activities for residents with increasingly complex needs:

*Kevin:* Working in extended care is so hard. Am I making a difference? Are my residents really improving in these areas – it’s hard to see. You have to believe in yourself and know...there’s quality and benefits to programs, but are we meeting the needs of the residents in our programs how we’re currently doing it?... Planning programs for residents who are at late stages of dementia, Alzheimer’s, is very challenging – so that definitely effects the planning.

*Gordon:* It’s just hard to find things that really reach them [lower functioning]. I find it very difficult to find a program that you really see them benefiting from.

Aside from their functioning ability, the fragile health of the residents also influenced the planning process. The RTs would plan in advance to offer a program of interest to a specific resident or group of residents and then the resident(s) would be unable to attend on the day of the event because of poor health, or because they had passed away.

*Gordon:* The health of the residents is a big influence [on planning]. There’s one resident that we just started in pool therapy and then he got quite sick and so we had to cancel him for a little while and replace him with somebody else until he’s better and then he’ll continue on.

*Laura:* As soon as spring would come we would start talking about fishing. We were redoing a fishing pole in the winter time – re-corking, rebuilding the whole thing. Well then one fellow transferred out, and another couple died, so there wasn’t anybody and so that’s stuffs all in storage now – some of it’s half done.

*Sheila:* We program looking ahead for the month, looking at the individual need, looking at a group, and then when that time comes up; those few individuals...if they’re not feeling well that day...your group that you originally programmed... a month or so in advance, you may have only two out of the six people.
The higher functioning residents who were cognitively aware and able to speak out also influenced the planning because they were able to express their opinions. For example, when planning for limited services in the event of job action, Kate explained that they chose large group activities versus small one-to-one interactions because the higher functioning residents would be demanding more active programs:

Kate: They'd be the most vocal if we didn't have anything going on. They'd be the ones running to the nurses and complaining.

Family Members

As Debbie describes, some of the family members who were very active in the day-to-day life of their family member/resident influenced what programs were planned.

Debbie: All the ladies that I have on the floor that are family members of the high functioning men residents on the floor right now...actually have quite a bit of involvement on what goes on, on the floor. They're always coming to me with ideas [for activities or outing destinations, donating food for teas etc].

Other family members influenced how the program was implemented. For example, Kevin described how programs would be disrupted by interruptions from family members.

Kevin: There's family coming in, "Oh look at the baking group." And [they] break the whole flow of the group, which is very distracting [and] frustrating.

Other family members directly controlled their family member/resident's attendance in programs.

Lois: Yes, there's a really nice fellow here; his wife has got severe dementia and he curtails everything because he wants his wife in a very quiet environment. I took her on one bus trip and he said, "No more." And it's so unfortunate -- and he's lovely -- I really get along with him, but he has this idea of the way he wants his wife looked after. But whether that's meeting her needs, I don't know, [but] you have to go with that. There's obstacles to your programming.

In other circumstances, the residents would not participate in a program without the attendance of their family member.
Kate: Shirley won't come out without her Mom and so we need to arrange for her Mom to come with us. It’s true for quite a few of the residents – most of the men; they won’t go out unless their wives are coming with them.

**Funders**

The funders impacting planning in the Extended Care included the Hospital Auxiliary, and the Hospital Foundation. As Barb noted in her interview, “the funder is all powerful,” particularly the Auxiliary which provided support in both money and volunteer services. For example, the Family Council meeting minutes recorded that:

The Auxiliary is very active in providing quality of care and increased well-being with our residents in Extended Care. The Auxiliary raised $514,000 last year which they donated to Pacific Memorial Hospital...The Auxiliary provides many services to the Residents of Extended Care, examples: Monthly Birthday parties for residents (the Auxiliary supplies all the food); Christmas gifts to every Resident in Extended Care...[they] funded hydrotherapy pool...[and] purchased two wheelchair buses for Extended Care Outings at a cost of $95,000 each.
(Pacific Memorial Hospital Family Council Meeting, Wednesday, November 19th, 2003, p. 2).

As is illustrated in the following quote, the RTs were very aware of and appreciative of the support provided by the Auxiliary for their programs, such as birthday parties, bus outings, and the hydrotherapy program.

Diane: The auxiliary [is] a really great asset to our department – to the whole hospital. ...they help provide us with some of the supplies and the equipment so that we can offer better programming...If the hospital auxiliary didn’t fund raise to help get us our bus, we wouldn’t be able to get as many residents out into the community as we have...They’ve got all of our large tents that they purchased for our department so it provides shade for the residents. So no matter what the weather is, it could be rainy or it could be sunny and we can still offer the program. So the auxiliary has bought a lot of the large scale equipment and supplies [and] I think that if they [the Auxiliary] provide us with something, they obviously want to see us use it. So, if we can, [we] make the best use out of what they get us.

While the Auxiliary’s gifts of equipment and supplies unquestionably benefited many of the residents, they came along with a cost. The planning process was consequently structured by the auxiliary’s gifts in that the Auxiliary funded programs, including the pool times, bus drives...
and birthday parties were scheduled into the activity calendar first, and the other activities were “fit” in around these programs. Although there were occasions when the RTs would reschedule or change the time of an Auxiliary funded program, they were rare and exceptional.

The TR Manager noted that “the foundation is another one of our big funders. They fund some of the equipment [and] that’s how they would influence our programming.” However, while the equipment they funded certainly impacted what programs the TR department could plan, the political impact they had on the planning process was the pressure they put on the RT staff to not compete with them in soliciting donations.

*Debbie: With the Foundation we have to be sensitive how we raise money otherwise we could be compromising the Foundation’s attempts to fund raise in the community. For example, when we put together the Big Country Fair and the Show & Shine the money we raise can only be used to fund those programs again next year.*

*Management Staff*

The management staff who had daily impact on the program planning process were the TR Manager and the Unit Managers. The staff reporting structure was re-organized within the past two years, which resulted in a new reporting layer for the TR Manager and a matrix reporting relationship for the RTs on the units. Whereas the TR Manager originally reported directly to the Director of Health Services, she now reported to her through one of the three residential care managers (also referred to in the interviews as the “unit managers”). Each of the three unit managers had responsibility for the nursing staff and general operations on two of the six units. In addition, one unit manager supervised the clinical nurse educators and the unit clerks, while the second oversaw rehabilitation, volunteer services and dental services within extended care, and the third oversaw recreation therapy, social work and pastoral care.
Although the RTs still reported to the TR Manager, they also had a matrix reporting relationship with their specific unit-manager, and in the absence of the TR Manager, to the unit manager who was responsible for recreation therapy. However, on a day-to-day basis, the RTs did not have much interaction with the unit-managers.

*Sheila:* The unit managers probably once a month have a meeting with the staff. But direct recreation involvement, you seldom see them. But I’m just saying what I see, they probably have meetings all the time with our manager, but we don’t hear a lot about it.

*Kevin:* In terms of managers... I don’t really see them.

As will be evident in many of the quotes throughout this chapter, the TR Manager had the greatest impact on the RTs’ planning practice.

*Gordon:* She’ll evaluate what we aren’t doing and come up with ideas in the areas we’re lacking. She’ll go through our calendars, talk to all of us.

Overall, the RTs felt well supported by their TR Manager as their comments below illustrate.

*Joanne:* I’ll bounce ideas off her, she’s very clever and she’s an extremely good manager.

*Kate:* She is very open minded and very trusting in our abilities.

*Kevin:* It’s nice to have the person at the top [who] knows exactly what we do and where we’re going, and [has] the [same] philosophy and beliefs of what we do.

**Nursing Staff**

The nursing staff, which included Registered Nurses (RNs), Licensed Practical Nurses (LPNs) and Resident Care Aides (RCAs), influenced how and what programs were planned in many different ways. First, their assistance with communicating the RTs’ program plans amongst each other and with the residents played a large role in ensuring that the residents attended the appropriate programs. Second, the nursing staff influenced the residents’ interest and participation in a program. Although most staff were very encouraging of residents to get involved and supportive of the programs offered, when it conflicted with their workload or
beliefs they could undermine the aims of the RT. Third, the work assignments of the nursing staff and nursing students impacted who the RT would chose to attend a program. Last, the nursing staffs' expectations of the RTs role influenced their program planning practice.

Kevin explains how the RN played a critical role in communicating the goals of the RT with the rest of the care team:

Kevin: For me, the critical person on the floor is the RN and the communication from the RN to the care aides is the most important thing. Because we go to the RNs and we let them know what's happening. And if the RN doesn't tell the care aides at report what's happening [then they may not get the right residents ready]. See they'll say, “Margaret has to get up, she has a bath today, [and at] two o'clock she has to go over for an x-ray” — that's it. Then you have the RN who'll say, “Oh there's garden club at 2 o'clock, Margaret's got to go to that. She has music therapy at 11. Or Harold's going out on the bus today on an outing.” RNs tell the care aides, the care aides know...that sort of RN who's on the ball; she knows what's going on for recreation too. And then there's the [RNs] that come in and don't know and they'll go, “Oh, there's an outing today? I never knew.”

The nursing staff also played a role in motivating and facilitating residents to participate in programs.

Diane: The care staff play a huge role because they're our biggest supporters. I know that on our floor that we are really, really, lucky because we've got such a good rapport with each other.

However, sometimes the nursing staff would discourage a resident from participating in a program because it would perhaps increase their workload. For example, Joanne’s attempts to get a resident to try the hydrotherapy program were stymied by the staffs’ discouragement of the endeavor because it would mean extra work for them.

Joanne: It wasn't so much about convincing her (the resident) as it was about convincing the staff. Because I would get her almost convinced and they would tell her, “No way, you can't do that, why would you want to do it, this is ridiculous, you can't do that, it's too much work”; “We can't do this, it's too much work”; “Her skin's not intact enough to go into the pool.” They threw every road block up that was possible to throw up.
At other times, the nursing staff disrupted residents in the midst of a program to administer medication or to perform some other medical treatment.

Kevin: You have an LPN coming in to change a dressing in the middle of a group [or] someone is taking their blood pressure during the group.

The third factor the RTs considered was the nursing staffs' schedules and workload. During the day shift, each of the 50 bed units was staffed with two RNs from 7:00 a.m. to 3:00 p.m., two LPNs from 8:00 a.m. to 1:30 p.m., four care aides (RCAs) from 7:00 a.m. to 3:00 p.m. and four RCAs from 7:30 a.m. to 1:30 p.m. In the evening there were only two RNs from 3:00 p.m. to 11:00 pm, two RCAs from 3:00 p.m. to 9:00 p.m. and two RCAs from 3:00 p.m. to 11:00 p.m. (personal communication with Sheila, October 5, 2004). Consequently, the RTs considered the workload of the staff when they planned programs and selected participants. For example, the RTs ended their pub nights early enough to enable the care aides to get the residents in bed before their shift ended. During the day shift, the RTs considered the individual workload of each care aide, who had approximately 6 residents to get up in the morning, when they selected which residents they wanted to attend an early outing.

Gordon: Sometimes there's times where maybe we'll choose too many residents from one wing to go on an outing, or something like that. And the care aide, who works on that wing will get a little upset and say "Maybe you should choose someone different from the other side – the other wings, you've chosen 5 people from this wing and it's a lot of extra work for me" and they'll get kind of bent out of shape that way. Which, you know, you can understand. So we usually try to get people interspersed from all the wings so it's not such a big work load on one care aide getting them up and getting them dressed and getting them all ready.

Another factor impacting workload was the presence of nursing students who were unfamiliar with the routines of the organization and therefore required extra communication to ensure residents were prepared for programs.
Sheila: Having [nursing] students on the floor changes the routine ... So right now part of my planning this morning for my bus outing I had to ensure who had which residents so they would be up for the 10:15 bus outing.

Last, the RTs mentioned that nursing staff did not appear to understand the amount of documentation work required to plan programs because they often felt pressured by nursing to “keep the residents busy” at all times.

Lois: You have that pressure...some days it’s more pressure than others, but you have the pressure, are you also meeting the needs of the staff? For instance... during the strike we were providing two programs a day. When we’re back to work, [because of paperwork] I can’t provide two programs a day [every] day. I can’t. I know Kathleen had a few comments because she was first one back, saying, “That was really nice, we really enjoyed knowing that the residents were going to have that program every morning, and this one every afternoon”... and it was the same programs every day... But they’re not looking at individual needs. They’re looking at that they can depend on those programs and they can bring people out.

As a result of the pressure to provide more activities, the RTs often delayed completing their documentation.

Kevin: Because of the pressure to do programs from residents and from other staff, the thing that gets neglected is the assessments and the parts [required] to do really good planning and stuff.

Doctors

Although doctors were not mentioned often, their influence within the organization was apparent in the comments made. When the doctors arrived, their needs took precedence over the other disciplines; similarly, the doctors had the final say in whether residents could participate in certain programs, such as the hydrotherapy program.

Kathleen: We have to get a form for the doctor – the doctor has to give permission [for the resident to participate in hydrotherapy].

When the doctors wanted something, they were accommodated regardless of the RTs plans. For example, Diane describes how a visit from the podiatrist took precedence over the program:
Diane: You know, all of a sudden on a whim the podiatrist is here. “Whoops, sorry we’ve got to pull you from gardening because the podiatrist is here – sorry you can’t engage in the program – it’s either now or wait till next month.”

On the other hand, they were a powerful ally if they supported the cause of the RT. Kate shares how she won the battle to get a cognitively competent resident the right to take risks (that is, eating out when he was at high risk for choking) by getting the support of the doctor.

Kate: So the doctor agreed thank goodness. He was there and he’s a really open doctor. And he said, “No, he should be able to eat what he wants.”

Support Staff

The housekeeping and food services staff also influenced the RTs programs because their support was instrumental to the implementation of many of their programs. For example, the following comments explain the roles of the support staff in the RTs program plans.

Sheila: Housekeeping, without them we wouldn’t have the space cleared, we may not have access to something. They help out.

Sheila: Dietary and kitchen is involved with a lot of our programming, either tray, meal cancellations or needing supplies from them.

Other Staff Members

The RTs practice is occasionally influenced by other members of the interdisciplinary team, such as the social worker, occupational therapist, physical therapist, music therapist, and dietician. Overall, the interdisciplinary team members all try to work together for the benefit of the residents. For example, Joanne recruited the support of the unit Occupational Therapist (OT) to help convince the nursing staff to get a resident up for a program. However, friction sometimes arises due to conflicting schedules or workload, such as when Kevin experienced that “you have rehab coming in taking residents out of your group because it’s their time for a walk.”
Volunteers

Many of the programs, including hydrotherapy, community outings, gardening, special events, and parties were only able to run with the assistance of volunteers. In addition, volunteers also contributed ideas and resources, as well as their time and skills, all of which influenced what was planned and when activities were offered.

Sheila: And then we had a volunteer who said, “I used to make teddy bears.” And it just started to take off from there.

Kevin: I had a volunteer come in the other day and she said, “You know what, I’ve really got a good idea for a Christmas craft.” And she brought in some Christmas cards and she wanted to do a craft with them.

Lois: There are certain set ones [programs] – every Friday there’s a music program at 10:30 and at 3:30 and that’s because we have music volunteers who can come in at that time; that’s the best day for them.

However, sometimes volunteers literally became residents of the TR Department and were included in programs because of their past contribution to the organization.

Barb: Sometimes the volunteers are here for the therapeutic recreation services as well. So sometimes, bless their hearts, they’re as much work as the patients that we’re working with. [For example] there’s a spouse of somebody in the hospital and they want to give back ...to the hospital. So they go through volunteer services and they come and help us out [but] they’re frail, and we need somebody that can push a wheelchair up a little bit of an incline and physically they just can’t do that... But they enjoy the party!

How and Why Do RTs Plan Programs in Extended Care?

The beliefs RTs hold about the purpose of TR in extended care should precede why and how programs are chosen. As will be revealed in the following sections, the overarching purpose of TR was to improve or enhance the residents’ quality of life. This belief is echoed throughout the organization. What quality of life means is explored in the RTs explanations and several related purposes of TR emerged from the interviews.
"To meet residents' needs and interests" was the most frequently mentioned reason given for why programs were offered and it appears to be in accordance with the purpose of enhancing residents' quality of life. However, other reasons why programs were offered emerged that do not appear to be directly supporting this overall purpose of improving quality of life. These reasons will be explored after the discussion of the RTs' beliefs.

**What Do RTs Believe About the Purpose of TR in Extended Care?**

The RTs were asked what they believed the purpose of TR was in extended care and while 12 related but distinct belief statements emerged (see Figure 1 below), the overwhelming theme was *improving residents' quality of life*, which was specifically mentioned by 11 of the 12 RTs interviewed and referred to by its characteristics by all of the RTs. A catch-all phrase for good care, reference to improving quality of life is prevalent throughout the health care field and was found in documents of the Ministry of Health, the Health Authority, the facility, the Family Council, and the TR department.

The Quality of Life Research Unit at The Centre for Health Promotion, University of Toronto, has developed a Quality of Life Model and defines quality of life as, "the degree to which a person enjoys the important possibilities of his or her life" (2004). The Quality of Life Model, which assumes that quality of life is holistic in nature, has three life domains, *being*, *belonging*, and *becoming*, each of which has three sub-domains: *being* – physical, psychological and spiritual being; *belonging* – physical, social, and community belonging; and *becoming* – practical, leisure and growth becoming (see Appendix G for more information). Furthermore, the Quality of Life Model argues that “quality of life needs to include the quality of the environment in which the person lives” and that a quality environment is considered one which:

1. provides for basic needs to be met (food, shelter, safety, social contact)
2. provides for a range of **opportunities** within the individual’s potential
3. provides for **control** and choice within that environment
   (emphasis in the original, Quality of Life Research Unit, 2004).

Applying the above definition, the interviews and documents included reference to many factors which could be attributed as contributing to or as being part of the definition of quality of life. These themes are displayed in Figure 3 in oval shapes connected in a circle, which represents the interconnectedness of the themes. The themes in the larger shapes are those that were referenced more frequently than those in the smaller shapes at the bottom of the figure. In the following discussion chapter, the ramifications of the quality of life discourse will be examined further.

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**Figure 3.** Beliefs About the Purpose of TR
In the following pages I will discuss and provide examples of the themes that were uncovered in the interviews as well from the meetings and from the organization’s documents.

*Improving Residents’ Quality of Life*

The phrase “quality of life” is mentioned repeatedly by the participants and throughout several of the documents examined. The health authority web page states that its purpose is “to improve the health of the population and the *quality of life* of the people we serve” (Fraser Health Authority, 2004b). In their document, *Model Standards for Continuing Care and Extended Care Service*, the Ministry of Health (1999) defines quality of life as “the degree to which the resident is satisfied that they have opportunities to achieve happiness and fulfilment (Green and Kreuter)” (Ministry of Health and Ministry Responsible for Seniors, 1999, p. GLO 6-7).

Within the organization, the Family Council minutes record that “we have no doubt [recreation therapy] adds to our loved ones *quality of life*, promotes social interaction, well-being and self esteem” (emphasis added, PMH Extended Care Family Council, 2003, p. 6). The TR department’s Therapeutic Recreation Pamphlet also advocates for resident quality of life, quoting the BCTRA philosophy statement “We believe that recreation, leisure and play are inherent and significant aspects of the human experience as they promote *quality of life* and wellness at every stage of development…” (emphasis added, PMH Therapeutic Recreation Department, n.d.).

Several characteristics of *quality of life* became apparent during the RTs discussions of the purpose of TR in extended care. Treating residents with respect, enabling them to participate in activities they enjoy, maintaining or improving their functioning are a few of the characteristics that are illustrated in the quotes below.
For example, Debbie discussed the importance of treating the residents the same way she would like to be treated. Debbie’s comment reveals a more democratic counter discourse to the predominant paternalistic medical philosophy in which the health care practitioner “knows best.”

Debbie: Quality of life is learning about the resident and treating them the way I’d want to be treated – and that’s my motto in life. Do unto others as you would like others to do unto you...Making sure they enjoy their life.

Similarly, Irene and Lois argued that improving quality of life meant enabling residents to be themselves and do the things they enjoyed.

Irene: Ensuring that people are happy and have a good quality of life in their final stages, learning new things, meeting new people, just being normal – being able to be themselves to the extent that they can.

Lois: It’s my job to facilitate whatever I can do to make that happen for them...For instance, John was talking of his interest in the casino and I noticed that John hasn’t been getting involved. For me I’m developing his quality of life, because I’m thinking, okay he’s got an interest in casino, he hasn’t been that actively involved. This is my opportunity to go with something in this direction.

Kate provided a detailed example of how the RTs worked to improve a resident’s quality of life by enabling them to participate in leisure activities. Although it appears to be a straightforward example of using encouragement to engage a resident in programs, it was a complicated political process and it will be referred to later in the discussion of strategies used by the RTs to achieve their residents’ goals.

Kate: I think therapeutic recreation in extended care it’s to provide a certain quality of life....There’s the one lady; she never got out of bed. She has MS...she’s got bad swelling in her joints and ankles and legs – really, really bad and she’s also young – she’s 43 or 44. Through a lot of encouragement she started going to the pool. And so that opened up for her at least getting up once a week. Once she started getting up, then her parents talked her into coming home once a week on a Monday. And also, we finally have gotten her to go on outings, which is a really big thing because cognitively she’s aware [and] she feels very uncomfortable in her body and being in a wheelchair and being around the older people. But we’ve planned outings [by] talking to her, “Like what would you really love to do?” She loves movies so I said, “If I plan an outing will you come?” And she said she would. And so now she’s come out to like 3 movie outings. She’s come to the shopping mall twice. So it’s opening doors for her – doors that probably never would
have been opened had we not taken the time to sit down and talk with her and almost plan certain outings for her needs. And now she's easily agreed to come out for a movie matinee on a Wednesday afternoon. You know, other than that Sharon just sits in her room unless she gets some visitors, but she was never really involved in any recreation programs at all. So that's a really big example [of enhancing quality of life] on our floor.

A last example of the RTs' belief in quality of life is provided as it illustrates the RTs' belief that all residents deserved to enjoy a quality life regardless of their health status. While quality of life for some residents might mean getting out to the casino or a movie, for other residents with advanced Alzheimer's it might mean moments that bring a smile to the resident's face.

Kevin: I think our role is to improve or maintain their quality of life through leisure, recreation... While [with] some of the lower functioning residents, it could be just moments of leisure or enjoyment that they get.

Enhancing or improving residents' quality of life encompassed many other beliefs about the purpose of TR (see Figure 2 above). Quality of life emerged as a central core purpose that was either supported by or was associated with the other beliefs. In the next section I will describe these beliefs about the various purposes of TR in greater detail, and in the following discussion chapter I will analyze the relationships between the RTs' beliefs and their planning practice.

Helping Residents Overcome Challenges to Participation

Enabling residents to participate in leisure activities emerged as a large component of improving residents' quality of life. The following belief statements capture this purpose of TR:

Lois: You're helping people with their abilities and whatever aides you can use in that-like aides to facilitate hearing

Barb: I think where we look at is, the most they're doing now, and how can we support them to keep them going for as long as possible. Because the reality is they're not going to get better, they're going to need more and more support as time passes.
Kate: A lot of what we do is guided by our residents. They will come in to our office and say, “I want to do this, can you help me?” And if it’s something we can realistically help them with, we’ll try to help them.

In addition, “Respect, Support, and Enable...Guiding Principles for Residential Care” is the title of the Health Authority’s framework for residential care. Principle IV of the guide states that “residential care facilities will enable and optimize the abilities of the residents. Their role is to compensate for disabilities and to promote independence” (Fraser Health Authority, 2002, p. 3). However, as will be discussed in the following chapter, the implementation of this guiding principle of enabling was compromised by the limitations of the physical and human resources as well as by attitudinal barriers.

**Providing Opportunities for Choice and Self-determination**

Ten of the participants specifically mentioned the role of TR in providing residents with opportunities for making choices and for controlling decision making. The TR department philosophy statement also noted that “Therapeutic Recreation believes that individuals...have the right to make decisions in their own leisure planning to include control, competency, decision making and dignity of risk” (PMH Therapeutic Recreation Department, 2003a). The Ministry of Health reinforced the importance of choice stating that “client autonomy and self-determination are supported and respected. Residents enhance their ability to direct their own care by defining their unique needs, identifying their preferences and making independent choices about their lives.” (Ministry of Health and Ministry Responsible for Seniors, 1999, p. v). However, similar to the fate of the guiding principle of enabling the abilities of the residents mentioned above, residents in extended care appeared to lose most of their autonomy and self-determination upon
admission as was evidenced by their loss of control over their meal times, bath days, and often toileting times.

Kevin’s comment, while describing how he tries to give the residents’ choices, illuminated the contradictions with the MOH guidelines as he described the loss of autonomy residents encountered when they entered residential care.

Kevin: I find in extended care some of the residents have given up so much of their independence – their choices are taken away so much – that they’re just used to just – here’s a meal you get at lunch, here’s a meal you get at supper, here’s when you’re going to bed, here’s when you’re getting up, here’s when your bath day is. So for some of these folks, it’s hard for them to actually choose something. “I have a choice on what I’m going to have for lunch next week? I have a choice on where we’re going out on the bus? I have a choice on what we’re going to bake?”

However, even the alternatives Kevin provided to the residents were restricted. For example, the choice he offered is “what to bake,” not whether to bake or to do some other activity.

Nonetheless, the RTs’ belief in the importance of providing the residents’ with opportunities to make choices was echoed throughout their interviews.

Sheila: You know it just runs through my mind. Are they individually choosing this? It’s always there when you plan things. An example is yesterday I had a cognitive group. There’s about 6 residents who’d really like to maintain, a couple have cognitive deficits but they like to be challenged, and we play scrabble. So its decision making, looking at the letters, trying to come up with the words...I can ask if they would like assistance, and we help each other. But I leave them to make the choice, even if it’s a simple word as “is.”

Similarly, respecting the residents’ right to refuse was mentioned by more than half of the interviewees. Even so, the RTs would use their professional judgment to determine whether the resident really meant no because they often found that residents did not understand the choice being offered.

Gordon: It’s their choice, and [if] they just refuse, flat out refuse everything, you’ve got to respect that as well – it’s their choice.
Laura: I will go around and ask, and if they say no, some of them I get to know that 'no' doesn't really mean 'no' and if I bring them, and just say, "Why don't you come and sit with us, you don't have to do anything", and then they end up doing it the best. But, when I get to know a person and they say 'no' they mean 'no' and they really don't want to. And then I respect that.

The TR Manager's comment below illustrates how she reinforced the importance of the RTs providing the residents with choices.

I've challenged the recreation staff in our department...to have a day that's called "at your leisure" where the residents decide what they want to do. Because it isn't normal to have every day planned on what you're going to do for your leisure that day; so the residents can take some control.

As has been alluded to above, contextual and political factors impeded the full implementation of this belief in promoting residents' choices and control and the TR manager's challenge to the recreation staff to fulfill this aim of providing choice will be examined further in the following discussion chapter.

Resident Centred Care

The theme resident-centred care was repeated throughout the documentation and the interviews. The TR Department's philosophy statement read "We believe that quality care is comprised of continuous resident-centred care based on a process of assessment, planning, implementation and evaluation of leisure needs" (PMH Therapeutic Recreation Department, 2003a). There were 24 quotes related to the theme resident-centred, such as:

Gordon: They come from such different backgrounds and such different histories, so much different likes and dislikes and idiosyncrasies that they are so different they require different intervention techniques, or programs that you can plan for them, everybody is different and responds differently to different programs

Sheila: Recognizing that individual person and what they specifically enjoy and then trying to follow through with that.
In addition, as will be discussed below, when asked about how they chose what programs to offer, all of the participants said that their programs were based on the needs of the residents, which implies a belief in resident-centred care. The Health Authority and the Ministry of Health also promoted a resident-centred approach as the Ministry explained that “A client-centred organization understands and responds to the needs of its residents by measuring resident satisfaction, identifying their priorities and applying what is learned to the design and delivery of care and services” (Ministry of Health and Ministry Responsible for Seniors, 1999, p. 5).

However, as was mentioned earlier and will be examined in the discussion chapter, completion of residents’ assessments was problematic and despite their intentions the ability of the RTs to meet residents’ individual needs was limited by several factors including the organizational structure and the available resources.

Providing Opportunities to Participate in Past Leisure Interests

Another frequently mentioned purpose of TR linked to enhancing residents’ quality of life was to provide residents with opportunities to participate in their past leisure interests.

Kevin: Opportunities to do things from the past that they haven’t done [lately]. Like for people who like to sew or bake, or swim, finding out if they want to continue that and being able to provide them with that opportunity.

The RTs were skilled at adapting activities in order to provide residents who had multiple health challenges with opportunities to participate in their activities of interests. Sheila described engaging a cognitively alert yet physically challenged resident in gardening while Irene relates a story of involving a cognitively challenged resident.

Sheila: I try to focus on what the individual or interest of a group of people are, and bring that to them. For instance, someone might have a past interest like gardening, and they love to garden but they say they’re no longer able to garden because they’re here. Well, hey, how else can we do this, lets look into this, and I get them involved in planning
- if its even just ideas - even if they're not physically able to do it, if they're mentally able to do it, or if the reverse.

Irene: There is a resident who really enjoyed gardening all through his life although he can't really communicate that clearly. But I still ask him questions, or tell him what's happening, throughout the program. And I feel that it is benefiting him, in the way he looks. Watching and observing. He might not be able to physically manipulate or do any of the actual work that he used to, but I really think that he's still enjoying, and maybe reminiscing and still thinking about what he used to do. That's what I believe.

Promoting Residents' Right to Recreation

Promoting residents' right to receive recreation was an integral component of helping residents' improve their quality of life. The TR department information brochure quotes the BCTRA philosophy statement that "we believe that individuals of all abilities have the right to benefit from leisure and recreation" (PMH Therapeutic Recreation Department, n.d.). However, as will be discussed later, residents' access to recreation was not equal due to many factors. Nonetheless, the recreation staffs' feelings about the importance of all residents having a right to some recreation were demonstrated in the following quotes:

Lois: I believe everybody has a right to recreation regardless of their abilities.

Kathleen: Well everyone has the right to be involved in any programs of interest to them. Or something maybe that they used to do before. And if they're not able to because of, for example, a stroke or something, you just find another way. You adapt it.

Joanne: I take pictures of the residents and show them to [the nursing staff]...And just showing them how important it is [for the resident to participate in TR programs]. Like how important it is that these people be treated with respect and with dignity. And be allowed to make their own choices.

The TR Manager quantified the residents’ right to participation in recreation programs by stating that, "I believe that everyone should have contact with the RT at least once a week."

Participation rates was another complicated factor that will be examined further later on.

In like manner, Debbie discussed the importance of equal opportunities for residents to go on bus outings. Indeed, all of the RTs kept attendance records of who went out on the bus and when and
attempted to take all of the residents who were physically able out on the bus at least once a month. Only residents who became physically ill or agitated were removed from the bus list.

Debbie: I do think it's very important too, that everybody gets an opportunity to go out on bus trips.

Promoting a Holistic Approach

The Ministry of Health defined holistic as “a system of comprehensive resident care that considers the physical, emotional, social, economic and spiritual needs of the individual...” (Ministry of Health and Ministry Responsible for Seniors, 1999, p. GLO 4-7). Similarly the TR Department’s belief in a holistic approach was repeated in its brochure, standards of practice, program review forms, and in its philosophy statement, which asserted “therapeutic Recreation believes that individuals are unique and that their well-being comprises of physical, emotional, cognitive, social and spiritual domains” (PMH Therapeutic Recreation Department, 2003a). However, as was mentioned earlier and will be explored in detail in the discussion chapter, the implementation of a holistic approach was obstructed by the dominant medical norms of the organization.

Regardless, the participants’ echoed this belief in a holistic approach in their interviews.

Kevin: When you’re trying to plan programs – some for physical, some for social, try to hit every domain so the residents can benefit from all areas... Improving their physical, cognitive, the whole holistic view.

Lois: Look at all the domains, and meeting them all in programming and trying to balance it out.

Joanne’s description of a program demonstrates consideration of the holistic needs of residents:

Joanne: It’s like [when] we went to the nursery to get the flowers the other day. We took a busload of people out to get the flowers. Well so, well we went on a bus outing and that was one thing. We had lunch out so a lot of socializing. But then when we got to the nursery the ladies started, they reminisced about what they had done in their past, and then they determined what kind of flowers we needed to buy for the deck. They had to
think through what kind of sun our deck gets, what would be the best thing. And then the next day we went out and planted it all with their help.

Similarly, the RTs debated what programs to offer in the event of job action, during which their services would be severely reduced, and as Kate described below, a belief in a holistic approach was evident from their decisions:

*Kate:* We tried to do a balance of having social programs, having a cognitive program, having an exercise program, a physical fitness program, and one-to-one visits.

*Promoting a Homelike Environment*

Creating a homelike environment is believed to strongly influence the quality of life residents enjoy. Although extended care was very institutional with its large dining room and tables, and long hallways lined with medical supplies, transfer lifts, and linen carts, it was still “home” for the residents. Consequently, the RTs were frequently engaged in projects that attempted to give the institution a homelike feel.

Barb described the application of some of the concepts of a prevalent philosophy of care, the “Eden Alternative” which prescribes several physical features as well as alternative staffing models.

*Barb:* It’s normalization, what we try and do – the Eden alternative...more plants, more pets, more kids – those are all programs that we offer.

The following quotes illustrate the RTs attempts to create a casual home-like atmosphere with the smells of baking and flowers, as well as with home-like activities such as preparing for meals and dropping in to visit with friends in their kitchen.

*Laura:* I think it feels normal to walk into a place or into a home and have home baking and then being able to taste [the baking] warm off of the tray and have them later that [with] their coffee.

*Kathleen:* [We try] to make it as home-like as possible, to get them involved in something they did at home, such as folding napkins, arranging flowers.
Lois: A homelike environment, because this is their home, is so, so important. So I think when I’m looking at that particular program [baking], it’s somebody’s kitchen, it’s the homelike part of it all, it’s not the formal dining room – it’s let’s drop in [to the kitchen].

At the March planning meeting Barb described how the TR department could be involved in making the facility more homelike:

Barb: So I talked to Marjorie yesterday and we’ve gotten the funds from the Foundation to start proceeding with the environmental enhancements in the dining room. So that could be exciting for us to be involved in and helping ... present some ideas, and help them with planning with what would make it homelike.

Barb also described how the TR staff assumed the role of “keeping the house running”, which could be argued, promotes a homelike environment:

Barb: Our role, although no one ever stands up and says this, is almost as though we keep the house running, in a lot of ways. So if someone is working on the floor, she sort of comes in in the morning and she checks to see what’s happening in the dining room, checks in with people to see what they’re doing, how they’re feeling. Checks in with nursing, starts to bring people together. Gets them ready to eat, tell them what’s happening a little bit later in the morning. Sees that the dishwasher isn’t working and calls to get that sorted out. She makes plans for the afternoon’s leisure programs. Somebody’s hearing aide isn’t working – she’s so accessible to all of the residents. The residents all know her so well they’ll come to her for help. So yah, overseeing the general operations of the unit in a lot of ways – the day-to-day activities that happen on the floor.

Moreover, the Health Authority theoretically promoted a homelike environment, stating in their guide that “Residential Care Environments will be welcoming and home-like” (Fraser Health Authority, 2002, p. 4). The support for creating a homelike environment also emerged during a planning meeting, when the TR Manager described a joint Family Council and Food Service project called the Joy of Dining and emphasized the role that the TR department could play in this project. The TR Manager read from the Family Council minutes:

“The Joy of Dining is a quality initiative that will aim to enhance our meal time environments...”

TR Manager: They’re talking about more like a wooden style dining table like you’d see at home – table cloths – we could play a really key role in what would work for the dining room.
Interestingly, a lengthy discussion followed this announcement about the need for tables that could be folded up and wheeled away to make room in the dining room for large group activities. As will be examined in the discussion chapter, despite the desire to have homey tables with cloths and flowers, the physical environment required that the dining room be available for multiple uses, which complicated and influenced how the RTs and other staff created a homelike atmosphere.

*Creating Opportunities for Family Involvement*

Another purpose of TR that was mentioned was to create opportunities for family involvement. While the family members' involvement in programs was desirable because it often enhanced the experience for the resident, involved family members were also more likely to be strong advocates for recreation therapy as well as a source of financial and material support.

The importance of family involvement was also reinforced by the Health Authority's guiding principles for residential care, which stated that "residents of care facilities will be supported to maintain their relationships with family and friends and to develop new relationships with staff and other residents" (Fraser Health Authority, 2002, p. 3). However, the organization did not provide any designated rooms that were private for families to be with the resident and the only tangible support evident was secretarial and facilitation support for the Family Council.

The TR Department policies and procedures support for family involvement was illustrated by the first goal of Dinner Party Programs: "To provide an activity which promotes social interaction between the residents and their families" (PMH Therapeutic Recreation Department, 2003d). The RTs particularly supported family involvement in social events, outings and parties as is illustrated in the following quotes.
Laura: I like to get families involved, like I said with that one group I have a husband that participates. And some of our large socials and our music groups and our special luncheons, I like the family involved so they can be a part of it. And not just them waiting on their family members but to actually participate and sit down with them and enjoy the meal with them.

Irene: Family involvement [and] family being able to attend programs with their loved ones – [we] definitely want them to come and [we] consider family and invite and encourage family to attend. We do phone calls; usually for events or outings. To be able to have the family involved is wonderful...we just really promote that in our program.

However, as was discussed above, family involvement in programs could sometimes be very disruptive if the family member attempted to control the resident’s participation.

Promoting a Sense of Self Worth

Providing opportunities for residents to have a sense of self worth was another purpose that arose. For example, the TR purpose statement for its craft programs was “provide the residents with a feeling of self-worth and accomplishment” (PMH Therapeutic Recreation Department, 2003c). Laura’s description of residents building a remote controlled airplane also illustrated promotion of a sense of purpose and accomplishment:

Laura: A lot of fellows could do a lot of hand work and...we got it all together, we took it out, and we flew it; our maiden flight. We have it on video, everybody got a video tape of that day and we were so excited! It actually does loop-d-loops and it’s an incredibly balanced plane. It’s just something to be really proud of.

The following quotes illustrate the RTs beliefs about TRs role in providing meaningful activities that give residents a sense of purpose:

Debbie: Making them feel like they have a purpose in life for living. Making them feel like they’re important, that they’re needed...This is a different generation, a generation that the Mom’s took care of kids, and house, and were always needed. You retire, you don’t have a job anymore, you don’t have kids anymore, and all of a sudden you feel like you’re not needed. And if you can make them feel like they’re needed, and they’re important and they have a purpose in their life [then] they have enjoyment.

Kate: Jack is another resident that we have. He’s 50, 51, he has MS and...he says he doesn’t have a meaningful role or purpose and he feels, you know he says he feels himself
declining...So we started up a men's group and we kind of have a young man coming in and doing a men's program. You know we talked to Jack about that being a purpose. You know, here's a young guy, he's 20 years old and he needs guidance. He doesn't have a Dad at home. And so [Jack's] kind of taken on a mentoring role. And it's nice, you know he feels, you can see his self esteem it's gone up a little bit.

Easing Transition into the Facility

The participants in the study strongly felt that another one of their purposes was to help residents adjust to their move into the facility. Although many of the purposes discussed above could help ease the transition, such as facilitating socialization and providing residents with choices and meaningful activities, as is illustrated below, the interviewees specifically referred to their role in helping residents adjust to the transition of moving into residential care.

Gordon: (Our purpose is to) make the transition from the community to here easier.

Laura: They're lost, they're put in a communal situation and they don't quite understand if this is their home; what they're doing. And I think our role in TR is to integrate them into the community...to sort of take that person under our wing, learn about them so we can find out their likes and dislikes and find people who are compatible...

How and Why Were Programs Chosen to be Offered?

As was mentioned above, the resounding reason RTs gave for offering programs was to meet the individual assessed needs and interests of the residents. In like manner, the TR Department philosophy statement noted that “planning is carried out in accordance with identified leisure interests and needs” (PMH Therapeutic Recreation Department, 2003a). However, other reasons were discussed for planning programs, such as the fact that they were traditional, fixed or on-going programs. While these latter reasons for planning programs may have addressed the individual needs of some of the residents, it appeared that because the program resource was available (such as the swimming pool), it was prescribed as a need of the residents versus emerging as a felt need from the resident. This did not mean that the residents
did not enjoy or benefit from these prescribed programs but that it was not necessarily the
program that best met the residents’ needs and interests. In the following pages the factors that
influenced how and why programs were chosen will be discussed.

Meeting the Needs and Interests of Residents

All of the participants stated that programs were or should be chosen based on the
assessed needs of the residents. The assessment process focused on identifying what would be
best for the resident, or in other words, meeting the “ideal” needs and interests of the residents
(Isaac, 1987, p. 107). Those who argued that programs should be based on assessments noted
that the assessment process was problematic for many reasons, which will be discussed later in
the section examining the influences of the context on planning.

The assessment process involved reading the resident’s chart, interviewing the resident
and/or family if possible, and observing the resident. As a result of their cognitive disabilities,
such as confusion due to Alzheimer’s disease or aphasia (impaired ability to understand or
produce speech) due to a stroke, many residents could not answer questions about their interests,
or their answers were nonsensical. In addition some residents did not have family members or
friends who could be interviewed for information about the resident. Regardless of the
challenges, the RTs’ quotes below illustrate how they assessed residents’ needs and/or interests.

Diane: [Programs are chosen] first of all by reading as much information about the
resident’s past as possible, doing our assessments, interviewing the resident if that’s
possible [and] either basing it on what we see as the primary need, or what they’re able
to communicate where their interests lie.

Laura: So getting back to how I decide to put certain programs in...I guess its part of the
interview process. Where I’m talking to family and they’re giving me feedback on this
person, that they used to have an incredible garden, or they make statements that they
really liked flowers. Or even if they’re even very non-verbal, I’ll find them going around
to the plants and feeling them and picking at them. And [I’ll] say, okay this person [may
like gardening].
As Sheila explains below, if residents expressed an interest in a particular activity the TRs would try to meet that need.

Sheila: I plan specifically if I know of past interests. This lady was very into arts and crafts. This gentleman used to do woodworking. So I will incorporate a program that they can somehow still be a part of their past leisure interest.

Kate’s quote also illustrates how the RTs had to consider other factors, such as available resources and time, before they could try to meet a resident’s individual needs.

Kate: I try and do an assessment, try to do a formal assessment but most times I find it’s an informal as I’m walking through I’m talking to people and all of a sudden they say something, “oh, I used to do that” and then I kind of get them to tell me more about it. And if it’s something I think they’d be interested in then I’ll think about starting another program, and I’ll kind of talk to a bunch of other people and say, “Oh you know we’re thinking about doing this, what do you think?” And if there’s an interest we’ll go with it.

The RTs also planned programs based on residents’ suggestions or requests, or in other words, the “expressed” needs of the residents (Cervero & Wilson, 1994a, p. 124).

Kate: We were doing crafts one time and I said what can we do for new programs? And they said yoga. And so that was something that I picked up on was an interest within the group. And so we started a successful yoga program.

Barb discussed how she started investigating how to meet the residents’ needs for some kind of memorial service after several residents expressed a need to have a service for a fellow resident who had died.

Barb: A resident had died and the residents wanted to say good-bye to this individual on the floor and [so] we had a minister come in to do a bit of a memorial service. [After] we talked to a couple of people and thought...about how we can better facilitate for the residents to say good-bye to somebody in our community here at the hospital.

As Joanne describes below, occasionally circumstances arose when no one was interested in participating in the program that had been planned and so the RT would solicit suggestions from the residents.
Joanne: Sometimes we change programs because this is a very high functioning floor overall and so, we’re given a lot of change and that’s not driven by me, that’s driven by the residents. If I say we’re going to do baking this morning, you know that’s what I’ve got on the calendar, and I don’t see any response to that – I’m not seeing people wanting to do that – or they’re reluctant, they’re not coming to the table – then, I’m going to say, “Okay, what would you like to do?” “What have you got in mind?” And we’ll switch it.

Other Reasons Why Programs Were Planned

Other reasons why programs were planned were because the program was fixed or had always been offered because of cultural traditions, or because a program had been requested by another stakeholder. Several programs were considered “fixed” or “ongoing” because of organizational traditions or available resources. For example, the TR department had 3 buses in which to take residents on drives and outings and they had access to an in-house hydrotherapy pool. Both the buses and the pool had been provided by the Hospital Auxiliary and the programs were planned in part because these resources were available. Consequently, as was discussed above, the RTs had many “set” programs, which because of their limited time, constrained the number of other programs they could plan.

Lois: And we have some set programs, and why are they set? Part of it is facility equipment. Monday’s our bus day because we have the bus. Tuesday’s we have access to the pool so that’s when the pool program happens.

Barb: And there are things that are standard. Like the Auxiliary graciously offers to host a monthly birthday party and that happens – it’s ongoing.

Programs also became “ongoing” because volunteers provided services that became established and routine:

Lois: Every Friday there’s a music program at 10:30 and at 3:30 and that’s because we have music volunteers who can come in at that time. That’s the best day for them.
In one instance the RT felt committed to letting a volunteer continue entertaining because of her long service to the organization even though the quality of her service was declining due to dementia.

Joanne: She's more confused that most of my residents. But you know what, she's a great piano player, and nobody else will have her play piano anymore. And you know, she comes here, she plays the piano, she's happy, the residents who like her are happy; it's not hurting anybody.... It's kind of about the residents, it's kind of about her, it's kind of about the fact that she's been here forever and the staff know her and love her and we all -- she's just like part of our family. Because she's getting to the point where she suffers from some dementia, what are you going to do? Cut her loose and then she wouldn't have anything to do? I personally can't do that. So Sally will continue to come as long as we can pay her fare and I can keep her directed and I just kind of lump her in with everybody else and move along.

Traditional holidays and celebrations also influenced what programs were planned. Although these programs were planned because they were thought to be of interest to the residents, they were not based on their individual assessed needs.

Kate: When the rodeo's on we try to do something around that. In August when the sea festival days are on we try to plan something out in the community that relates to that.

Some of the seasonal events celebrated were traditional Anglo-Saxon or Christian events such as St. Patrick’s Day, Easter, Christmas, and so on.

Kevin: Sometimes we try to take a theme for the month -- so like St Patrick's Day -- we'll have a “travel to Ireland”...an Irish stew lunch...Irish crafts -- the seasonal holidays do influence.

Lois: So we've got Easter, so we're going to be planning Easter, it's a religious holiday, so we're going to be addressing the fun of Easter as well as addressing spirituality.

Many of the programs, such as fitness, baking, and pub socials appeared at regularly scheduled times on the calendars and similar to the bus outings and hydrotherapy sessions, these programs were seen to be meeting the general needs of most of the residents. However, one participant questioned whether these programs were meeting the needs of the residents, or were just simpler for the RTs to plan:
Barb: It's simpler to just say, "Let's do baking now, and then we're going to do bingo." And you know that certain clusters of residents have certain needs and interests and [in] a broad picture that these programs work, but in a lot of cases I don't think it's based on assessment.

In addition, the number of fixed programs limited the amount of time available for other, perhaps more individualized programs. This limitation on planning will be examined further in the discussion chapter.

Sometimes programs were planned because of family members', community members' or nursing staffs' requests or offers. For example, at the February 25th Residents' Council meeting, the residents decided that they would like to have a coffee social for a staff member who was leaving. The minutes recorded that the recreation staff would therefore facilitate this event. As is illustrated in the comments below, although the ideas for the programs may have come from other people, the RTs also mentioned that they were programs that they thought the residents would also enjoy. Nonetheless, as will be discussed later, in some circumstances the needs and interests of family, volunteers and staff appeared to take precedence over the needs of the residents.

Lois: Sometimes [we'll offer programs because of] staff suggestions. Like nursing staff, they might come up with an idea like "So-and-so is getting married, and the residents are really close to this particular person; how about we have a bridal shower, or have some type of wedding tea?" And we'll try to fit that in.

Gordon: Well, a lot of times these groups call us, and they say, "Can we perform on your floor for the residents?" And knowing the residents – they love music; I mean most of them love music; so that's always a good thing. [Music] brings back a lot of memories for them [so] you can never go wrong...and they really enjoy it.

**How do Power and Interests Influence the Planning Process?**

How do organizational, professional, and personal power and interests influence RTs planning practice in extended care? While there are many ways that power and interests are used
to influence the planning process, Caffarella (2002) argues that the most common are: “shaping ‘felt’ needs, setting program agendas, determining populations to be served, making decisions, allocating types and amounts of resources, and choosing who benefits from the program (Forester, 1989; Mills, Cervero, Langone, and Wilson, 1995; Archie-Booker, Cervero, and Langone, 2000; Cervero, Wilson, and Associates, 2001)” (p. 69).

Elgström and Riis (1992), who argue that planners engage in substantive and/or meta-negotiations regarding planning, provide another lens for examining how power and interests influence the planning process. Substantive negotiations are engaged in negotiating changes in the details of the program, that is, what the content of the program should be, while meta-negotiations refer to “attempts to change power relations and to reach a more favourable negotiatory position in re-opened substantive negotiations” (Elgström & Riis, p. 105). As was discussed above in the literature review, Umble et al. (2001) demonstrated an important distinction between meta-negotiations about power relationships (i.e., influence over the planning process) versus meta-negotiations about conceptual frame factors (i.e., organizational ideology, norms, values, standards) and material frame factors (i.e., resources, funding, personnel, equipment). While the application of the above theories to the results will be explored in the following discussion chapter, they will be also used as a framework for discussing the following results.

**Shaping Needs**

As is evident from the results discussed so far, the ability of the residents to express their needs varied widely due to their cognitive functioning. Kevin’s and Irene’s comments below illustrate the RTs awareness of the cognitively low functioning residents’ inability to tell them
what their needs are and the RTs efforts to ensure that “all voices that need to be heard are included” (Caffarella, 2002, p. 69).

Kevin: It’s hard when you want to plan a calendar and you don’t want to plan it just for these 10 people at the residents’ council meeting or these people who all eat, have regular diets, and plan programs for all the people who can speak out. What about the residents who are just sitting in their chair and they’re moving around – they don’t know where they are – they’re not oriented to time or place.

Irene: We have a lot of residents that stay in bed— and those residents, a lot of them can’t voice what they want.

Consequently, the RTs categorized the residents by functioning ability and then tried to ensure that there was the appropriate type of programming for each level of cognitive functioning. In this respect, the RTs shaped the needs of the residents by their ability to participate in programs.

Lois: We also look at our populations. I like to break it down into high, medium and low functioning residents and make sure that we’re offering programming according to the needs of those people.

Setting Agendas

The agenda for the planning process also influenced whose needs were being served by the RTs. The TR Manager regularly reviewed the residents’ attendance records and the unit calendars and discussed alternative ideas for program planning with the RTs, thereby setting the agenda regarding whose needs should be met. In particular, she advocated for those residents who she considered were being underserved.

TR Manager: I did a program review and assessed their calendars by the 5 domains (social, emotional, physical, spiritual and cognitive) and from a leisure perspective had the RTs rank the clients on their floor, for example we got information on how many residents participated in social programs. It shows the big picture and higher functioning residents get the majority of the programs.

The TR Manager also implemented an extensive review of the types of functioning level of all of the residents and their participation rates in the various programs. In this respect the TR
Manager set the agenda by encouraging the RTs to plan smaller groups and one-to-one activities that would better meet the needs of the lower functioning residents.

Gordon: [Our TR Manager] will evaluate what we aren’t doing and come up with ideas in the areas we’re lacking. She’ll go through our calendars, talk to all of us. Lot of times she’ll ask us to count how many low functioning programs you have for the month…. she’ll say, “I think we need to plan more groups for lower functioning residents.”

Irene: The toughest part for me is trying to balance low, medium, high programming. [I'm] having a real struggle right now with low [level programming]. We have a lot more low level residents. We used to always be a really high level floor until the past, I'd say 6 months… So trying to target a lot of our residents that stay in bed, or are just very low level and can’t communicate ...and trying to find quality programming for these residents...and how to measure that as well.

The following quote illustrates the TR Manager’s efforts to engage in meta-negotiations about power relationships, by changing the agenda of the group and by shifting the decision making power regarding memorial services for residents from the interdisciplinary team to the residents.

TR Manager: And they were going to pull people from the ID [interdisciplinary] team together [to decide what to do to remember residents who have passed away]. So I said, how about if we put it to the residents and get a focus group of them to come together and let them tell us what they’d like to do. So rather than the ID team determining how we would best honor the residents’ passing. We went first to ask the residents first and asked them how. Now we’re going to the ID team to say, “How can we implement what the residents’ would like?”

Determining Populations Served

Planning programs that provided opportunities for all of the residents to engage in recreation activities regardless of their functioning ability and their ability to pay was also very important to the RTs. To address the needs of residents whom the RTs determined were being underserved they established “closed” programs that were for specific residents targeted because of their lack of participation in other “open” programs. For example, specific music programs for cognitively challenged residents were established as well as groups for men.
Debbie: The music maker program that I have going on right now is definitely for lower functioning residents...and it’s a closed program... I could put higher functioning people in that, but because the lower functioning people don’t get a whole lot, as much as the higher functioning residents do, I try to save that program for the lower functioning residents.

Irene: We have some lower level programming, some smaller groups, some sensory stimulation, one-to-one visits – really important.

Joanne: Some of the residents don’t really care for Sally at all because they think that she’s too confused. But for the lower functioning residents – they really enjoy Sally and they enjoy her music. So there [are] a lot of things driving me to keep Sally coming here. She’s very good for the low functioning residents.

Similarly, the RTs introduced men’s groups because of an increasing number of male residents.

Lois: We developed the men’s program because what we saw was more and more men being admitted onto our floor and in order to offer them – you know there’s lots of crafts and baking for women – but for gentlemen we didn’t find that we had that to offer them so therefore we developed this men’s club.

When residents were not able to pay for a program that had a fee attached, such as a dinner outing, or music therapy, then the RTs found other funding sources, such as bake sales or their petty cash, so that residents could attend regardless of their income level.

Diane: And if the resident doesn’t have…money, that’s where we…use our discretionary funds – our slush funds from our sales. Then…we’ll pay for that resident to do it.

Alternatively, as Irene describes, the RTs would plan lower cost activities for lower income residents, or as Kate explains, they would negotiate lower costs.

Irene: But we have had family in the past that have said, “No, I don’t want my Mom doing this because we don’t have the money.” So we’ll incorporate something a little bit different for that resident, like an ice cream drive where we can pick it up from our slush if it’s something small.

Kate: And we [the yoga instructor and the RT] talked about cost, and I think she wanted to charge $60 an hour, and I said that there’s no way we can pay you $60 an hour. These guys have to be billed and $2.50 or 3 dollars is the most that they can pay, or that family is willing to pay. So she did it.
Interestingly, the RTs efforts to provide a variety of smaller groups to meet the diverse needs of the residents were not continued during the union strike. During the strike, the programming focus shifted to the needs of the high and medium level residents because the RTs purpose shifted to meeting the needs of as many residents as possible in a short time period. Also, the cognitively higher functioning residents were the ones applying pressure on the nursing staff and RTs if they did not have any activities and because they were, by nature of their abilities, more easily served in the short time allotted for recreation services during the strike. The RTs chose to primarily offer “open” large group programs in order to reach the most residents possible in their limited time. However, this plan excluded the lowest functioning residents who were only able to participate successfully in a small closed group.

Laura: I guess it comes down to the squeaky wheel gets the grease [comment made regarding who programs were planned for during job action].

Irene: I would say medium to high were mostly targeted during [job action]. However, I had a mix of all 3 in the programs... they were all open programs, I didn’t do any small closed programming at that time

Making Decisions

A goal set by the TR Department that indicated a belief in a democratic planning process was that they had a “mandate [for] total resident representation on all resident councils, particularly for those groups of individuals who cannot represent themselves” (PMH Therapeutic Recreation Department, 2000, p. 3).

Sheila: My big thing is first resident council...during residents’ council I asked the residents... “What else is an interest, what else would you like to see happening?” And we get ideas from there as well.

The RTs also attempted to foster a substantively democratic planning process (Cervero & Wilson, 1994a), by using strategies that included the interests of the lower functioning residents
who could not represent themselves. For example, the RTs used their attendance records as a tool to ensure that residents had fair and equitable access to community outings.

*Kathleen:* For the bus list, we have a book where we keep track of everybody who’s been out and when they were out last — so everybody gets a fair time out.

*Irene:* It really helped us go through [our attendance sheets] and seeing some of the blank spots in front of some of [the names of] these residents that are in bed. Right, we need to do something here. It was a real eye opener. We need to shift our programming.

Another strategy the RTs used occasionally was to count the number of different types of programs on their calendars and compare the ratio of programs by functioning and/or holistic domain type to the ratio of resident groups by functioning and/or holistic domain needs.

*Allocating Resources*

The experience and skills of the RTs were resources that greatly influenced whose needs were served. While the RTs themselves were certainly one of the TR program’s greatest resources, in their interviews, the RTs discussed how they struggled with providing enough programs for the lower functioning residents because of difficulties determining and planning appropriate, meaningful programs.

*Lois:* I think lower functioning residents, get, sometimes the lower end of the stick ... Because you get involved in...focus[ing] on the majority of interests and trying to group them together to make programs to fulfill needs of the people who live here. And the people who don’t fit into those slots well are the lower functioning people. The other people are able to verbalize somewhat of their needs, or you’re able to discover it... Whereas if somebody isn’t able to communicate with you... it’s much more difficult... I would like to be able to do more... [but] they’re really not getting the same amount [of programming].

How resources, such as supplies and adaptive equipment were allocated also influenced whose needs were served. In their efforts to obtain an extra bus, the RTs engaged in meta-negotiations about material frame factors, or in other words, about adequate resources to meet the needs of all of the residents.
Sheila: For instance, we have two buses now; ...we only had one [and] it wasn’t working [with] ...9 units sharing one bus [because] there’s only 5 days a week that people are working. So it was, what are we going to do, we need to do something else. We had to get creative on how we did our bus outings. It was a high need. People want to get out in the community. Eventually, it all ended up being fund raising and getting a second bus.

Choosing Who Benefits from the Program

Although the RTs’ goal was to meet the needs of all of the residents, several factors influenced who benefited from the programs planned. These factors included the functional abilities of the residents, the ability of the RTs to adapt the program to the residents’ individual needs and/or the RTs awareness of the residents’ interests and abilities, and the residents’ availability to attend the program at its scheduled time. Although the RTs had intentions to meet the needs of all the residents, this was not always achieved. For example, if a resident came to a program and was disruptive, the RT would take the person out of the group.

Gordon: Well, there’s some things, like small groups, if there’s a resident who’s very boisterous, speaks out and kind of interrupts the group: I know we try to include everybody as much as we can, but if one person is going to ruin it for the other eight that are there, then I think it’s best to try that one person in something else.

In another example, the RTs had specific criteria regarding the cognitive and physical abilities the residents needed to attend the yoga program.

Kate: [To choose people for the yoga program], I went around to the people who would be appropriate for the program. People who are not disruptive, people who are able to follow along. People who have the attention span of 30 to 60 minutes.

As Gordon describes below, because many of the residents were not able to verbally express their needs and interests, sometimes the RTs had difficulties determining what the resident enjoyed and how to adapt the activity to their needs.

Gordon: [When] we don’t know them very well yet a lot of things are just trial and error. And then it doesn’t work out, so you do something different next time. Try not to give up on the person though – you try something different. There’s always something that the person can enjoy, you can help them with. You need to think outside the box a little bit.
In an attempt to designate programs for specific residents, the RTs established closed programs and gave the nursing staff lists of names of residents whom they felt needed to attend those programs. However, whether the residents would actually be ready and available for the program then depended on the resident’s health and whether the nursing staff got them ready.

*Kathleen:* *We make lists for the nursing of who we want up and... if they don’t get them up it makes it very difficult for us because it affects who can go to a program or not... It’s not always their fault – a lot of time there could be something like bowel care, or the resident’s not feeling well. There are any number of reasons why that person isn’t up.*

Sometimes residents proximity to the activity appeared to determine who would attend as residents who were sitting in the area of the program would be invited.

*Lois:* *In the dining room there might be some people that you don’t know quite as well and you don’t know that their interest is baking, but you will invite them because they’re female, and actually we’ve come across a couple of men who really like it by accident for this very reason.*

Whereas as Irene describes other times the nursing staff or family members would bring a resident to a program unasked, “some [residents] it’s not a choice, some staff will bring residents in – just wheel people right on in there.”

**What Tactics do RTs use to Plan Programs?**

The RTs used many different tactics to resolve conflicting interests and priorities arising from the organizational context, the stakeholders, and the larger environment they worked in. Cervero and Wilson (1994a; 1996) propose that the primary strategy used in planning is negotiation. Subsequently, Yang and Cervero (2000; 1998) identified seven different behaviours that planners used in situations involving power issues, including: reasoning, consulting, appealing, networking, bargaining, pressuring, and counteracting. Yang and Cervero also examined the use of influence tactics in relation to the symmetry of the power relations between the planner and the particular stakeholder.
In the initial coding of the planning tactics found in the RTs' interviews 34 different, but in many respects similar, tactics emerged from the examples used by the RTs to describe how they behaved in situations involving conflicting interests and power. Further analysis of the transcripts found that the predominant planning behaviours in situations where power was an issue could be similarly classified using Yang and Cervero’s seven identified behaviours. There were five definable types of tactics used regularly by the RTs and two tactics that were definable but used less frequently. The five tactics found to be most prevalent were: reasoning, consulting, appealing, networking, and bargaining. The two other less frequently mentioned, but definable tactics found, were pressuring and counteracting. In the following section I will define these tactics and illustrate them with examples from the RTs meetings and interviews. As will be discussed and explained in the next chapter, how these tactics were used and with whom varied depending on the RT and the stakeholder.

Reasoning

Yang describes reasoning as when “planners use persuasion, logic or actual evidence with co-planners” (Caffarella, 2002, p. 71). Yang and Cervero (1998) contend that reasoning is used in situations where interests are consensual and power relations are relatively symmetrical. Reasoning was evident in attempts by RTs to convince other staff that their program plans were both feasible and logically congruent with their common interests in the residents’ quality of life. Reasoning was used at times by all of the RTs. For example, Kate used evidence of the residents’ enjoyment to reason with the nursing staff that an entertainer was appropriate.

Kate: For instance we had a singer and [the nursing staff] made fun of the singer the whole time. And they said, “Oh you shouldn’t have that person again.” But our response to that was, “Well yes we should because the residents really enjoyed it. For 45 minutes they were singing, they were laughing, they were clapping – so to us that’s successful. Maybe we didn’t enjoy listening to it, but they did.”
Similarly, Joanne and Gordon, who both had over 10 years experience working at PMH, illustrate the ongoing efforts of the RTs use of reasoning to increase the nursing staffs’ support for their programs with their comments.

Joanne: Every time you get the opportunity you throw a little [TR] education their way. You’re always talking about how important it is, and look at this person and look where they’ve come, where they were, and look where they are now. ... I take the pictures of the residents and show them to them [nursing staff]. “Oh, this is what we did today” and just showing them how important it is.

Gordon: But ...[when] the dining room is full of residents, and you’re in one of the rooms, really making contact, really connecting with a lower functioning resident – [the nurses] don’t see, they don’t really see that. [The nurses say] “Ah, there’s nothing going on today, it’s kind of a waste.” “What’s happening?”...They’ll come and say, “Is there anything going on?” And I’ll say “I was just in so and so’s room having a great conversation, and whatever, doing this and that.” And once you explain it to them they’re usually pretty good.

The quote below also illustrates the RT’s successful use of reasoning in substantive negotiations about the details of the program, that is, the location where the program would be held.

Irene: I said, “I’m not going to be in the dining room because there’s too many distractions.” We have a couple of residents that are very loud and distracting. And so, they [nursing] said, “Well maybe you could go at the end of the hall.” And...for them to say that and realize that this is something that has to be done is good.

Sheila, who had over 15 years working experience at PMH, illustrates two situations where she successfully engaged in reasoning with members from the interdisciplinary team regarding a conflict in the timing of their programs in relationship to the timing of her recreation programs. Sheila used the argument of what was best for the residents in the first circumstance and the restrictions of her resources in the second instance. The following quotations are also examples of an RT engaging in substantive negotiations about program details.

Sheila: Music therapy, first program was first thing in the morning at 10:15 or 10:00, and then she did a second one at like 2:00 in the afternoon. Now it affected the residents who enjoyed other programming that afternoon, only had a choice to go to music therapy
or not to go to music therapy. So we negotiated with the music therapist, listen this isn’t a good time of day, can we change the program so it suits.

Sheila: Physio has their programs[and] we had to talk with them, “How is this going to be most effective for the client group that we’re working with, because they like to go to your exercise, but they also like to do another established program that we cannot change because of access to that or volunteers?” So we’ve had to alter things.

Evidence was also used by the RTs to reason with their co-workers about their planning decisions.

Joanne: I just say [to my RT partner], in all fairness to all of our residents...I think there’s a whole group there that we would be missing. And when I look at my stats and I look at the residents and what I’m doing with them – there’s going to be a big hole over here and I don’t want to see that.

Consulting

Yang describes consulting as seeking “input and ideas from co-planners” (Caffarella, 2002, p. 71). Consulting is particularly useful when planners “are constrained by individual limits in identifying planning objectives and solutions” (Yang et al., 1998, p. 3). Consulting was a tactic frequently used by RTs to gain the support of other staff members for their programs by including them in the decision making process before they took any action. For example, if the RTs did not consult with the nursing staff before implementing a new program they would likely encounter resistance to their plans. Debbie, who was relatively junior in RT experience, found that consultation was critical.

Debbie: I find as long as I involve the nurses and the care team in some of my programming and planning as to who is going to go to the program, I find that I get a lot more turnout of residents ...And basically now, anytime I’m going to plan a program I’ll take it up to the nurses and say this is what I think will work, and I’ll get the care staff involved as well. I’ll say, “What do you think?” and that’s my way of involving them in the process and making them sort of part of a group team decision... I just think that number one, make it a team decision and when you involve all the other players it benefits the residents more.
Similarly, Diane, who was also relatively junior in RT experience, describes below how consulting is used to reduce friction over power issues, and consequent resistance to program ideas, that can arise with the nursing staff if they feel like they are being told what to do by an RT, who does not have greater power than them according to their position within the organizational hierarchy.

Diane: I find that if you miss that first communication step and if you just say, “Okay, this is what we’re going to do”; then they [nursing staff] don’t feel like they’ve been involved or been a part of it. It’s almost like – because we’re in an institutional setting it’s almost like a ranking thing – that we’re not trying to pull rank over them and tell them what they have to do. So I find [it helps] if you involve them in part of the planning and have them on your side to do it.

Consulting was a strategy used to influence the substantive details of a specific program, such as which residents would be up to attend a program.

Irene: Communication is key...there are certain strategies that we use: lists, the white board, the calendar; then we’ll go talk directly to...the head nurse. But I also talk to the care staff as well – if there’s any concerns for getting people up for our programs, considering if they have a heavy load for that day or if they’re understaffed or bath day or whatnot.

The above examples illustrate how consulting was used in situations involving power issues. Consulting was also frequently used for technical aspects of planning. For example, the RTs consulted with each other to identify solutions to planning challenges.

Irene: There’s a few challenges [to introducing programs for lower functioning residents]. One of them is finding programs – creating programs to meet the needs of these residents. And a lot of it, it really helps to communicate with other RTs. So we’re working on that right now.

The RTs also consulted amongst themselves about details of program planning.

Diane: The most important thing about planning that I haven’t said yet is just sharing ideas in-between staff members. [For example], in a planning meeting I’ll say, “Oh last month we tried to go to Vandussen Gardens and it was a successful trips, but there’s lots of hills.” So you can get tips from other staff members on what worked, what didn’t work, what they would do again, what types of residents would be interested, how long is their
seating tolerance, activity level, interest level [and] who'd be appropriate for different program ideas.

At the March 23rd, 2004 TR planning meeting, the TR Manager suggested that the department establish a formal consulting process to help each other with their assessment challenges. Although the TR Manager was suggesting a consultation process to improve a technical aspect of planning, she was also using consultation to foreground assessments as a planning issue to get the RTs’ buy-in to completing their assessments.

TR Manager: One of the things I’ve been asked about, and I’d like to put it out to you all to see what you think about it, is if you’re working on an assessment for someone, and you’re struggling with it, or you’re just kind of “What am I going to say about this person?” Is to maybe take one of our Tuesday in-service mornings [and] ... take 20 minutes and... present the case – “This is the person I’m working with, this is their blah, blah, blah,” and we all throw our 2-cents in to solve or to complete the assessment. Is that something that would be beneficial?

Appealing

Yang describes appealing as persuading a co-planner to assist with your plans by calling on their “emotions, predispositions, or values” (Caffarella, 2002, p. 71). Appealing was a tactic used by both the senior and junior RTs when they needed to appeal to the emotions of a staff member in order to gain their cooperation when they were dependent upon the staff member for his or her help, either for getting a resident ready or for obtaining supplies for a program. The two quotes below illustrate the use of appealing as a tactic to convince nursing staff to get residents ready for a program.

Gordon: Sometimes you’re maybe choosing 3 or 4 from one wing and you just go to the care aide the day before and say, “I’m really sorry, but I hope this is okay, and try to smooth it out that way.” Most times they’re very supportive.

Joanne: Some days [I will] go down and beg and plead [with the care staff] to get them [the residents] up.
Debbie appealed to the maintenance worker’s emotions and values when she successfully convinced them to build a planter for her gardening program.

*Debbie: So, I went down to maintenance and I said, for sure I know I can’t get a patio, so at least you guys can do is make me some planter boxes to make this sort of environment less sterile and more homelike.*

Kate similarly appealed to the emotions and values of the interdisciplinary team in her attempt to get support for “Bob”, a cognitively aware resident with a high risk for choking, to go on meal outings.

*Kate: And then we had a care conference for him and we kept talking about how important it is for Bob to be able to go out and eat what he wants to and choose what he wants to. His life is limited in here and he really doesn’t have many opportunities for pleasure, but this is one thing that provides him with pleasure.*

In another example, appealing was a tactic applied by the TR Manager to leverage substantive increases to the TR Department’s finances.

*TR Manager: I’m marketing as much as I can to people who are potential financial supporters. Maybe not soliciting funds, but telling them where we’re at with stuff. So where we need hospital money, with the petty cash not increasing, now we have to fund raise more, so we’re not doing as much programming as we could be doing because we have to fund raise.*

The RTs appealed to the emotions of the volunteers and staff by making an effort to show appreciation for the person’s good qualities, such as being helpful, so that the person would be encouraged to continue exhibiting their good qualities. This strategy appeared to be used as an investment in future assistance.

*Debbie: I probably have so many volunteers because I go the extra mile to make sure that this is a good experience for them and I just love them all to death.*

*Diane: Sometimes, they [nurses’ aides] don’t like to [get a resident up], then they end up just getting them up anyways for a program and I think thanking them for doing it [is important] – just a little bit of appreciation and telling them how much is was a benefit to the resident or “they really enjoyed it, thank you so much for getting them up” – letting them know that it was worth it.*
Networking

Networking is a strategy used when “planners seek to obtain the support of other people who are important to the co-planners” (Caffarella, 2002, p. 71). In other words, networking refers to including stakeholders who have authority or hold relevant knowledge, such as the doctor, OT, or dietician, to gain the support of the resistant stakeholder (i.e., the nurse). Networking was used widely by all of the RTs to secure both immediate and future support. In one situation where the nursing staff were not getting a resident up in time for an exercise program, the RT sought and received the support of the OT, who reinforced with the nursing staff the importance of the exercises for the resident’s health.

Laura: Nursing was leaving Jane (in bed) to do wound care later in the morning – so she wasn’t getting up until 11 o’clock so she was missing part of [exercises]... I actually worked with OT with this – because it’s better for her to be up doing these types of exercises – she (the OT) looks at it from that point. So I guess working together with another staff, [showing] there’s a real need, [that] she really enjoys this.

Similarly, when the RT was trying to get approval for “Bob” to go on meal outings, she obtained the support of the OT and the dietitian.

Kate: The OT came on board...I went straight to the OT and asked her what her take was...So the OT agreed with me too. [That] if [Bob] knows what can happen and he agrees that he understands the ramifications of his eating [he has the right to take the risk]. So OT and dietary had to go and talk to Bob and say this is the consequences of what could happen – worst case scenario – you know “Are you still comfortable with this – do you still want to eat outside?” And he agreed. They don’t have a form, but OT signed off in the progress notes, and dietary signed off that they discussed the implications and consequences of eating solid food with Bob and he accepted the risk.

The RTs would also obtain the support of the TR Manager when they felt they needed support for their plans. For example, Joanne received the support of the TR manager, who was also responsible for the hydrotherapy program, to convince nursing staff to let a very physically disabled resident try the hydrotherapy program.
Joanne: I got [the TR Manager] on board with it and she backed me on it. She was very supportive that yes, we should move ahead on this and that yes, I was on the right track... I had to have somebody on board with me because I was standing alone basically and I had to have somebody on board with me. And who better to be on board than my boss. I mean she can make it happen for me.... And the fact that we had it all worked out and what our plan was. Not things that I hadn’t already talked to them about, but reiterated it to them. And of course she has a lot more clout than I have. I’m sure, without her backing, it wouldn’t have happened.

Joanne also described how she networked with the nursing staff, by spending time with them and learning their names, their background, their interests, their work, all to build a relationship with them so that they were more supportive of the TR programs.

Joanne: It’s all about building relationships with them [nursing]. You do it lots of different ways... I quite often look at them and say, what do I need to find out about this person in order to determine ... how to best approach them to get them on board with me, what is it that I need to do to achieve that? You know I need to spend some time chatting with them, find out their background, I need to know their name, I need to be able to call them by name, I need to know what kind of things they like and they don’t like. I need to value the work that they do, and not only just value it but tell them that I value it and show that I value it.... I need to involve them in my programs somehow to whatever degree I can.... I have baking programs – I feed the staff. I try to invite the staff in to join the open programs. I’ll invite them to come in.

The RTs would additionally network with the family members so that they would become more involved and supportive of the TR programs.

Debbie: If I don’t take the time to get to know the family, it makes a big difference in the amount of resources that I have. But if I take the time, get to know the family, the family is offering to crochet a blanket for me for the sale, the family is offering to bring in baked goods, or the family is offering to bring in cakes for this birthday party... So it’s about networking and letting your presence be known too. That fact that I’m always on the floor and everybody sees me, really knows who I am.

Evidence of networking was also found in the Family Council minutes. The TR Manager was frequently invited to the Family Council meetings to share information and address questions. For example, at the April 16, 2003 meeting the TR Manager attended as a guest speaker and provided an overview of recreation services. Her presentation included an explanation of “the Leisure Assessment Program and how each resident is evaluated as to their
needs and how programs offered are of value.” The TR Manager used these opportunities to gain the political support of the Family Council for the TR Department, its staff, and programs. Similarly, the TR Manager networked with community members to develop professional contacts that would perhaps support them financially.

*TR Manager: Just recently I was at the Rotary breakfast, doing a big thank you for them for funding our bus. Then putting the bug in the Foundation’s ear, “I have another idea.”*

The RTs networked with upper management in an attempt to gain their support for their department.

*Kate: I find that Pacific Memorial Hospital, Jane Smith, she’s the big wig of extended care and she’s always been very supportive of the recreation programs. So I feel at this hospital, we have worked really hard to build a name for ourselves. A professional name [that] we know what we’re doing so they have a lot of trust in our abilities. Likewise, the TR Manager would network with the other nursing units by sending out to all of the units in the hospital an activity calendar listing programs that were open to acute care patients.

*TR Manager: The calendar I gave you “Recreation Therapy February Activities” is really more for promotion. We send it to all the nursing stations with the intent that if they have a patient on their floor that really needs something to do; they can send them to the program. They never do, maybe 2 or 3 times, but it lets people know we’re out there.*

**Bargaining**

Yang argues that *bargaining*, that is offering to exchange or do something for a co-planner, is sometimes used when planners “face situations of conflicting interests while organizational power bases are symmetrically distributed” (Yang et al., 1998, p. 231).

Bargaining was not as apparent as the previous four tactics, but was evident in the following description of the RT working with the OT.

*Laura: So, we’re trying to really work together – like I will help her to get the people up that she wants for her program and in turn she has been helping me, saying, “this is really important, this person shouldn’t be staying in bed because they have a wound on*
their backside, because actually it's making it worse." So with us together, we're able to get that person into things.

Sometimes Joanne, who had previous care giving experience, would attempt to bargain with the nursing staff to get them to get residents ready for a program.

Joanne: [When trying to convince nursing to get someone up] the thing that I try to bring back to them is, yes I'm asking you to get that person up, but for the next two hours, they're going to be involved...first in a program for maybe an hour or 45 minutes and then they're going to be involved in a kind of social activity which I always provide after my program, which is tea, coffee, juice and a snack. I do all of that, which takes the onus off them to bring that - I do all of that stuff. So really, I'm doing part of their job by providing those things for the residents. And when they're involved in a program with me ... the nursing [staff] can basically forget about them because I'm keeping my eye on them.

When the nursing staff did not agree with the RT's program ideas, they used bargaining to convince the nursing staff to agree to a trial program.

Debbie: If they [nursing staff] don't agree with [my program idea] I still suggest that we just at least give it a try. They're always at least willing to give it a try.

Bargaining was also observed between the RTs during their planning meetings. Within the context of the formal meeting and also in quiet conversations between themselves during the meeting, RTs with conflicting interests in equipment, supplies, or even work schedules, would bargain shift exchanges, equipment sharing and/or leadership of specific programs.

Sheila: About bingo palace on the 26th – I'm not here.
Joanne: You know what, I'll do [bingo palace] if you're not going to be here – how about if I take it up, because you did one for me, so how about if I return it and do that?
Sheila: Perfect.
(March 23rd, 2004 Planning Meeting)

Debbie bargained with a fellow RT about changes to a program, with the attempt to achieve both her interests for the residents to enjoy a game, and a family members' interests to celebrate a residents' birthday. The following quotation is also an example of an RT engaging in substantive negotiations about program details.
Debbie: For example, on Friday we’re playing Bocce, we always play [unit a] against [unit b], and Laura says to me “I had a family member come up to me and it’s Rose’s 100th birthday and I’m not going to be here how are we going to make this work?” I said well, why we don’t play bocce for the first half an hour and then because all of my residents are going to be down there there’ll be lots of people there. I’ll talk to Veronica, see if she can come down and sing a couple songs, and then we’ll make a birthday party of the last part of it and serve coffee and tea and we’ll have the program still done within the hour. So we’re sort of killing two birds with one stone. The family member is getting what they want, to celebrate the resident’s [birthday, and] I’m incorporating the other residents into it and we’re still getting the opportunity to play bocce.

Pressuring

The use of pressure to make someone do something was not a prevalent tactic used by the RTs and appeared to be used only when all of the other tactics had been proven ineffective. However, Debbie provided an example of an occasion when, after exhausting her efforts at reasoning and appealing, she had to use pressure to fight for the interests of the residents.

Debbie: I was called the little pit-bull for a while.
Janice: Why were you called “a little pit-bull”? 
Debbie: Well, because I was very upset because I went down [to maintenance] and I said, “So you’re going to tell me that not only we don’t get a patio, but we don’t get planter boxes as well”? They said they didn’t do that anymore. Well, [I said] “You know what maintenance, there’s six other extended cares here, they all have planter boxes and they all have patios, so hook me up some planter boxes.” And I wasn’t going to take no for an answer, I wouldn’t leave him alone, and then he phoned my boss, and my boss basically agreed with me and said you know, she’s right, they don’t have any planter boxes. And it’s been an amazing program ever since.

Counteracting

Yang found that in circumstances when they wished to block a co-planner’s efforts that planners would counteract, or “take wilful actions (or wilfully refuse to take action), which nullifies efforts of the co-planners.” While not a predominant tactic, the RTs would use counteractions in situations where they could not otherwise meet the interests of the residents. For example, in order to circumnavigate procedures that would result in the Foundation redistributing funds to other departments or services that family members donated specifically
for TR programs, the RTs established a method that ensured that their department would benefit from family members’ donations.

Debbie: For example, when we get donations from family, we have to tell family specifically to put “to Douglas 3” [on the cheque], or else the Foundation will use the money for other projects. For example, I’ve got a donation—I’ve got to go and meet with the TR Manager after this [interview] and I have to put it into the Foundation, then I have to go and spend the money—put my money up front—then bring them a receipt—give them the receipt—and then they’ll give me the money back in a cheque form. I’ve got to go to the bank and cash the cheque—and that’s in order for [family] to get a tax receipt. This is quite a rigmarole for the family that want to donate to the recreation department on the unit.

In another circumstance, when the care aides did not get a resident out of bed for a program as requested, the RT would bring the person to the program in their bed.

Joanne: Now I’ve gotten to the point where I just... bring them out in their bed. They’ve never on this floor ever brought people out in beds on this floor before. But I’m to the point now, where I say, “Okay fine”, you know you can’t get them up in a chair, whatever; I’m bringing the bed out. And so that’s highly frowned upon, but you know what, I just don’t care anymore if that’s what I have to do.

Similarly, when the RTs knew that a resident would not attend a program if their family member was visiting, or that a family member interfered with the residents’ participation in a program, they would plan the program when the family members were not in.

Kate: Family has an influence on who comes [to programs, so] with certain people we’ll try to do programs that we know they like on the days their family doesn’t come in. Because family can either be really helpful and encourage the residents, or they can kind of take over for the residents, or not let the residents go to the programs.

Summary

In this chapter I presented the data obtained from interviews, meetings, observations and documents. The results represented a network of beliefs about the purpose of TR in extended care, all centred on the umbrella theme of improving the residents’ quality of life. The beliefs in turn provided direction for why some of the programs were planned, but other factors emerged
from the data that suggest that the organizational frame factors and power and interests also
influenced program planning practice.

The context of extended care was examined in three ways: by the stakeholders involved;
by the organization’s structural, political and cultural factors; and by the larger environmental
factors that influenced the context. Next examined was the influence of power and interests on
the RTs’ planning practice, that is, how needs were shaped, agendas set, populations determined,
decisions made, resources allocated and residents chosen. Using the work of Yang and Cervero
(2000; 2001; 1998), the tactics and strategies RTs use when they plan programs were illustrated.
Finally, Elgström and Riis’ (1992) theories about substantive and meta-negotiations were used as
another lens for examining the RTs planning strategies.

In the next chapter I discuss and interpret the data starting with an examination of the
influence of the context. Next I analyze the beliefs that shaped the RTs planning practice. The
sociopolitical nature of the planning and the tactics RTs used are then examined. Last, I suggest a
sociopolitical framework for TR program planning.
CHAPTER FIVE

DISCUSSION

The overall purpose of this study was to understand how and why programs are planned in an extended care facility and to demonstrate how power and interests and the organizational and environmental context of an extended care facility impact the planning practice of RTs. Previous studies have established that the organizational and environmental context is an important influence on education planning. Similarly, this study demonstrates that the context influences TR planning and that more specifically, power and interests affect which programs are planned and for whom. The research results show how traditional medical interests are embedded in the context and the ways in which the medical focus impacts the programs planned and organized by the RTs. This study has moved beyond previous studies by showing how the organizational structure and culture in a residential care setting directly alters the technical-rational therapeutic recreation program planning process. Most importantly, this study shows that experienced RTs use a variety of tactics to influence the sociopolitical context in their attempts to implement their philosophy of TR in the face of many conflicting organization, cultural, and political interests.

In analyzing the results, the factors that need to be considered are the unique and common features of the research site and the research participants. The research site is similar to other large extended care facilities in the Greater Vancouver Regional District in that it is attached to an acute care hospital. Although it is a relatively large facility, having 300 residents, it is not the largest. The TR Department is unique in that every RT, including the TR Manager, has the same professional education – a TR diploma from Douglas College. In addition, unlike several other facilities where the RTs are under the direct supervision of an Occupational
Therapist and are mandated to only organize and implement activities, the RTs are supervised by a fellow RT and their job descriptions at Pacific Memorial enable all of the RTs to work to their full scope of practice, including conducting formal resident leisure assessments.

Moving from the global to the specific factors of the planning context I first examine the environmental and organizational factors influencing planning. Second, the relationships between the RTs’ beliefs and their planning practice and the ethical elements of planning are analyzed. Third, the social activity of planning, that is, the organizational, professional, and personal power and interests influencing RTs planning practice in extended care are examined, including the tactics the RTs engaged in to achieve their planning goals. Last, the application of adult education and TR theory to practice in this setting is discussed and a more robust planning framework for TR is outlined.

**The Influence of the Environment and the Organization**

A conflict many planners face in their practices is that of reconciling the reality of their planning practice in a sociopolitical organization with the prescribed program planning theories and models. Indeed, Wilson and Cervero (1996b) argue that “the reason planners do not – indeed, often cannot follow the steps prescribed by program planning theory is that the organizational power relationships within which they must act always profoundly structure their planning actions” (p. 7). Similarly, the RTs were frustrated in their planning practice by the structural limitations of the environment and the organization. However, the RTs’ political awareness of these structures and the options available to them to negotiate these structures varied.

Umble et al. (2001) demonstrated important distinctions between meta-negotiations about power relationships versus meta-negotiations about conceptual frame factors, such as
organizational norms and values, and meta-negotiations about material frame factors, such as funding and personnel. Umble et al. found in their study of continuing education program planning, that “stakeholders whose interests were not being fully met engaged in meta-negotiations to change the power relationships at the planning table” (p. 128). Similarly, the RTs used various tactics, with varying success, to challenge the norms and values of the organization and to negotiate the material factors, such as the equipment and supplies, which framed their practice.

The organizational dimensions that were most crucial to either enhancing or creating obstacles to the RTs work were the organization’s medical norms, the organizational structure, and the funding bodies. Pacific Memorial ECU’s culture (values and beliefs) and organizational structure (administrative hierarchy) reinforced a context that guided the actions of the RTs in their daily practice. The first section examines how medical interests are embedded in the organizational structure and culture and how they affected the actual process used in assessing and evaluating needs of the residents. The next section shows how administration and the physical nature of the facility impacted planning practice. The last section shows how organizational and funders’ interests promoted “traditional activities” and affected the programs constructed.

Holistic or Medical?

The RTs espoused a belief in a holistic approach to resident care which encompassed the physical, social, emotional, cognitive and spiritual needs of the residents. Indeed, they attempted to achieve a holistic balance in their monthly schedule of activities by ensuring that on a weekly basis they had programs addressing each holistic domain. However, the location of the ECU
within the Pacific Memorial Hospital organization, which directly represents medical versus holistic interests because of its emphasis on acute care, created and reinforced medical norms.

The RTs efforts to implement a holistic approach were contradicted and undermined by their attempts to gain greater credibility and respect within the organization by adopting a medical approach to outcomes and measurements versus attempting to establish appropriate holistic measures. Unlike the medical model, which promotes concrete physiological outcomes and measures, a holistic approach is more qualitative in nature and requires alternative outcomes and measures. However, attempts to use a more holistic approach were countered by pressures from the organization to follow standardized procedures for charting residents' "treatment plans" and "progress notes."

The Organizational Structure and Hierarchy

The medical model is reinforced by the facility's attachment to an acute care hospital and by many of the doctors and nurses who work in the facility. As was noted in the results discussion, the doctors and the unit managers (who were nurses) held the power, thus the medical model prevailed despite the organization's rhetoric about promoting a holistic approach to care. Organizational protocols and standards, the physical structure of the facility, and the terms of the collective agreement governing their work all reinforced the medical norms and reduced the flexibility of the planning process and the RTs ability to respond to the holistic needs of the residents. The RTs were frustrated by the influence of the medical norms as was illustrated in the examples of the struggles the RTs had obtaining respect and appreciation for their programs on par with the medical appointments and routines in the facility.

The TR Department lost much of its opportunity for influence within the organization with the introduction of a new reporting level which distanced the TR Manager from the facility
manager. The new organizational layer reduced the flow of information to the TR Department and also curtailed the TR Manager's opportunities to influence organizational decisions regarding recreation therapy. Although it was not acknowledged, the new reporting structure further weakened the power of the TR Manager because it created a matrix reporting relationship to the Unit Managers (who were RNs) for the RTs, thereby removing the sole responsibility for the RTs staff from the TR Manager. The introduction of RNs into the matrix further reinforced the medical norms. The dissolution of the Geriatric Committee was an additional blow to the power relationships the TR Manager strived to establish and maintain with administration because the TR Manager lost an important avenue for promoting the TR Department and for learning about organizational plans and changes.

Meta-Negotiations about the Physical Structure of the Facility

Closely linked to the 'holistic versus medical' conflict was the debate about institutionalization versus hominess. Just as the organization promoted a holistic approach it also promoted the creation of a homelike atmosphere. The RTs similarly argued for the need to create a homey atmosphere and they decorated the units, planned gardening, baking, flower arranging, and home cooked breakfasts to foster a more homelike environment. However, the lack of space required that the dining rooms be available for multiple uses, that the end of the hallways be used to store lifts and equipment, and that 50 people must live together without benefit of privacy or locked doors, all of which complicated and influenced how the RTs promoted a homelike atmosphere. Although the RTs negotiated with the nurses to have the ends of the hallways cleared so that they could hold small groups there, so that the residents benefited from more individual attention, traditions (which will be discussed below), time constraints and the pressure to see as many residents as possible influenced the RTs to plan large group activities.
Another structural factor that revealed conflicting interests was the planned renovations of the kitchens and recreation offices. The RTs were consulted by administration for their ideas and they earnestly invested hours into writing up their suggestions for the renovations, only to have administration thank them for their input and then proceed with their original plan. The organization's plans included moving the kitchen facilities into the current recreation offices, thereby reducing an already small space that was used for closed programs to a space that was unusable for small programs. Consequently, the RTs are now left without any closed rooms on their units of a substantial enough size to accommodate a group of residents. Furthermore, the removal of the baking facilities from the main dining room arguably gave the dining room a more institutional feel. Administration's rationale for the renovations was not revealed during the research project, but the outcomes of their decisions appear to contradict their vision for a homelike setting.

*Traditional Activities versus Therapeutic Recreation Programs*

The TR programs were funded by the Pacific Memorial Hospital, its Foundation, the Hospital Auxiliary, and by donations from families and volunteers. This funding arrangement created a complex environment in terms of power relationships. The TR Manager and the RTs must be sensitive and accountable to the nurse Unit Managers, the Auxiliary and to family members in order to continue receiving funding and support.

The RTs successfully nurtured their relationship with the Auxiliary and with family members as was illustrated by the additional funding they received for supplies and equipment. However, this study found that RTs planning practices were strongly influenced by these power relationships, which largely supported the planning of "traditional activities" versus new and different therapeutic recreation programs that were perhaps more appropriate for an increasingly
medically complex resident population. Although the Auxiliary undoubtedly had good intentions and provided these resources because the organization had identified a need, or because the TR department had requested it, traditional activity interests, reinforced by organizational interests, influenced the resources available for program planning. For example, the birthday parties, bus outings and hydrotherapy programs were all funded by the Hospital Auxiliary with the understanding that these programs would be offered. The Auxiliary’s good will was maintained and fostered by offering the traditional programs.

Problematically, the needs of the resident population are changing and the traditional programs are no longer meeting the needs of many. For example, the large birthday party program is not appropriate for the increasing number of cognitively impaired residents who become agitated and upset in noisy crowds. Similarly, many of these same residents are not able to tolerate community outings and bus rides. Nonetheless, the RTs program calendars were first filled with the ‘set’ programs: bus trips, hydrotherapy, and birthday parties.

In addition, other “traditional activities” such as sing-alongs were continued because volunteers or community groups had been providing that service (i.e., musical entertainment) for years, and the RTs felt that they could not cancel these programs because of their feeling of commitment to these long-serving volunteers. Interestingly, although picket lines and influenza outbreaks put severe restrictions on the programs that the RTs could plan, the disruption in the activity schedule and the cancellation of the “set” programs also gave them the opportunity to try something different. One of the RTs discussed how he was able to plan different programs he would not otherwise have been able to due to the set schedule.

In an attempt to alter the material frame factors, that is the funding available for their programs, the RTs did engage in alternative funding activities, such as bake and craft sales,
which enabled them to purchase supplies without any obligations to a funding body. However, the amount of money raised in these sales was small, usually only a few hundred dollars, which was not enough to substantially impact the programs the RTs could plan.

The TR department did not examine these underlying traditions although it acknowledged that many of the programs they were planning were not meeting the current needs of the residents. However, closer examination of the power relationships within the context reveals that dominant interests have influenced which programs get constructed and the TR department has lacked a model or framework of planning that analyzes the contextual frame factors.

Beliefs and Ethics

The beliefs and values of the RTs are embodied in their actions and can be examined by the prevalent types of interests represented (ideal, expressed and real, which were discussed earlier in the literature review), and by whose interests are being served. Although the RTs may have tried to keep the residents' best interests "as the paramount criterion to guide decision making, [RTs were] also influenced by the expectations, norms, and sanctions of the organization [in] which they work and by their own value systems" (Sork, 1988, p. 34). The quality of life beliefs espoused by the RTs are examples of ideal interests, or those interests that are best for the residents, and these beliefs were challenged by competing professional and organizational interests.

Quality of Life – Rhetoric or Reality?

The quality of life discourse contains several sub-discourses and dimensions and the RTs addressed most of the elements included in the Quality of Life Model (see Appendix G). The
RTs explanations of what quality of life meant similarly included elements of physical, psychological and spiritual *being* as they discussed helping clients overcome challenges, treating the residents with respect, providing residents with choices, providing client-centered care and a holistic approach. Likewise they included the elements of *belonging* by facilitating family involvement in programs and the residents' adjustment to facility life. Last, the RTs addressed the residents' *becoming* needs by promoting meaningful activities, a right to recreation and to participation in past and current leisure interests.

MacLean's (1996) case study of medical continuing education programs highlighted the political and ethical challenges planners' face when they must balance the demands of multiple competing interests. Likewise, attainment of the above mentioned dimensions of a quality life was complicated by conflicting interests. Certainly on a one-to-one level and within the planned programs the RTs demonstrated that they did give residents choices and did treat them with respect and dignity. Nonetheless, because of the rigidity of the planning structure and the predominance of set programs, the choices the RTs provided were generally limited to the substantive details of a specific program such as the choice of what to bake or where to go on a drive. Similarly, although the RTs argued that if the residents did not want to do a planned activity that they would offer an alternative, the alternative would still be limited to the resources at hand and the time required for preparation. Thus the interests of the organization and its funders and their influence over resources emerge again as obstacles to providing meaningful leisure choices to the residents. Equally influential on the RTs ability to provide leisure choices was the organizational routines, such as medication, bath, toileting, and meal times.

The Ministry of Health's definition of quality of life as the provision of opportunities for happiness and fulfillment are similarly hollow because of the lack of adequate TR staffing and
resources, particularly with the increasingly complex needs of the residents, to implement this vision. Another conflicting interest was the expectation of creating a homelike environment (expressed interest) and the demand for equipment and wheelchair lifts in each hallway to increase the efficiency of the nursing care of the residents (real interests).

*Holistic Care or Professional Recognition?*

As was mentioned above, the RTs believed in a holistic approach to resident care (ideal interest) but they also wanted to gain recognition and respect for their profession (expressed interest or interests revealed by the actions of the planner). Consequently their ideal interests were sometimes compromised by their expressed interests for recognition and with generating measurable medical reports for the residents’ care conferences that were recognized by their peers (real interests). These real interests are not necessarily reflections of the RTs’ beliefs, but they are reflective of the norms within the institutional setting. Assessing residents needs, clarifying objectives and evaluating outcomes was problematic for the RTs and the TR theory and models available did not help them resolve their problems because they did not include the sociopolitical elements of planning, nor provide a question based framework, such as Sork’s (1999), for examining their issues.

Conflicting interests are also illustrated by the demand for recreation programs that improved the residents’ quality of life (ideal interests) and for programs that kept the residents’ busy (real interests). The strike that occurred during the research study provided an opportunity to examine what was considered “essential” services and what the RTs prioritized when faced with a 50% reduction in their work time. Need assessments, program evaluations, and long-term program planning tasks were left undone, although it must be acknowledged that essential service guidelines are historically based on the experience that a health care strike will not last
for more than a few weeks, and so the rationale for not completing these particular tasks was that they could be put off until the strike was over. Program implementation and keeping attendance was the only part of the RTs work that was considered “essential” by the organization during a strike. During the strike volunteers and entertainers were discouraged from crossing the picket line and could not be utilized by the RTs. Consequently, most of the traditional/set programs, such as bus trips, hydrotherapy, and birthday parties, were cancelled during the strike because they could not be implemented without volunteer assistance. During the strike, the RTs attempted to continue promoting a holistic approach by providing a variety of programs from the holistic domains, such as physical exercises, cognitive discussion groups, and social teas. However, individual and small group programming was foregone in place of large groups that could reach more residents. Hence, quantity prevailed over quality and the RTs’ belief in individualized “resident-centered” care yielded to the cultural pressure of “keeping the residents busy” in large group activities.

*Right to Recreation*

A further conflict with the RTs belief in the residents’ right to recreation was found in an examination of attendance records, which showed a large discrepancy in participation rates, with some residents participating in 10 to 15 activities per week while others (primarily the cognitively challenged and frail) participated in only 1 or 2 activities in the same time period. This trend of lower participation rates among the most cognitively impaired was also found in Voelkl’s study of participation rates (1996). As in this research study, Voelkl found that participation was greater amongst the cognitively impaired residents that were located in the lounges and recreation areas and were therefore physically available at the time of programs. The TR department was aware of the lack of equal access to recreation programs and it was discussed
regularly at their meetings. As will be discussed below, the RTs actively negotiated with the other stakeholders for more programs appropriate for these residents, but their progress in changing their planning practice was hindered by the traditional interests and organizational culture discussed above, by the available resources, and by their lack of awareness of the sociopolitical nature of planning.

Singarella and Sork (1983) argue that planners need to question and examine the values and ethical foundations of their decisions and conduct. RTs do not just plan programs for residents. There are other legitimate reasons for planning programs, such as providing opportunities for family involvement, or to raise funds for other programs and there are other more questionable reasons, such as providing activities for volunteers, or to keep the residents busy so the nurses can do their medical work uninterrupted. Therefore, it is important for RTs to ask whose interests count and whose interests are being served. The above examination of the RTs actions shows how their values and those of the organization influenced their decisions and conduct and suggests that a planning model or framework that illuminated these conflicts would better support responsible, ethical planning practices. As Wilson and Cervero argue, “without an ethical stance on what matters, the dominant interests and power relationships will determine which programs get constructed” (1996a, p. 95).

**Planning is a Social Activity Constituted of Power and Interests**

Organizational, professional, and personal power and interests influenced RTs’ planning practice in extended care and were an important factor in the RTs program planning decisions, who they involved in making those decisions and thus whose interests were served. Wilson and Cervero (2001) argue that planning practice must be viewed not as a technical activity, but relationally, as a social activity that is “embedded in and constitutive of wider social settings” (p.
2) wherein planners continuously negotiate interests via socially constituted interactions such as conversations, meetings, phone calls, letters, and so on (Cervero & Wilson, 1998a). The RTs were aware of many of the “social activities” of planning and their ability to navigate through the sociopolitical elements and negotiate with stakeholders was illustrated by their stories. To competently engage in the “social activities” of planning, the RTs were aware of who was involved in their planning practice (nurses, care aides, housekeepers, food service workers, volunteers, family members, other RTs) and who should be involved more (isolated and lower cognitive functioning residents).

The impact of other stakeholders on the RTs planning practice was evident in the study. Family members, who wielded power with administration, influenced the TR department. The RTs were constantly negotiating, consulting, appealing and bargaining with the nursing staff. Volunteers’ interests and needs were also considered in the planning process as many programs were dependent upon volunteer support. The RTs own interests and skills were central to the programs they were able to plan. Most importantly, the residents were central to the RTs planning decisions.

In the above section on beliefs and ethics the types of interests that prevailed in this study were analyzed. In the following section, I examine how interests were represented in the “social activities” of planning, that is, how the RTs represented the interests of the residents within the ECU context.

Planners Negotiate Interests

Many of the negotiations the RTs engaged in were on behalf of the cognitively impaired and frail residents as well as on behalf of the therapeutic recreation department as a legitimate and important service within the organization. The medical norms of the facility contributed to
the conceptualization of the resident as a patient, with primary interest in their medical versus holistic needs. Negotiation occurred when the RTs reasoned with and appealed to the nursing staff for the rights of the cognitively impaired and frail residents to be considered as “the same as anyone else” and therefore deserving to have the right to recreation. The TR Manager also influenced the planning practice of the RTs by setting the planning agenda so that the needs of the lower functioning residents were brought to the forefront of their planning discussions. In another circumstance, the TR Manager negotiated with the interdisciplinary team to bring the residents’ voices to the planning discussions about residents’ memorial services.

The RTs used photographs and stories of residents’ participation in programs to illustrate the capabilities of the residents and the value of therapeutic recreation within the organization. These efforts to engage in meta-negotiations about the value of TR and of the residents themselves were ongoing. Stories and pictures were shared with staff and family members and were displayed in the lobby of the facility and in scrap books on the units. The TR Manager attended the Family Council meeting to explain the purpose of the TR assessment process in an attempt to increase their understanding of the value and purpose of TR and to build their support for the programs. The RTs noted how they would repeatedly need to explain to nursing staff why it was important that they plan low-level programs, such as sensory stimulation, for residents who were non-communicative and bed ridden. The nurses’ support for the RTs plans for more low-level programs is evidence that progress was being made at changing the cultural values of the nurses. The need for the RTs to engage in these meta-negotiations suggests a corresponding need for planning models to include this element of planning.
The Influence of Power in Planning

The influence of power in planning can be examined by who knows what, by who exercises power and who obeys, by who defines which problems receive attention or are neglected and by who cooperates with whom. As was discussed above in the analysis of the organization’s structure, with the new reporting structure the TR Manager lost power as far as what she knew about changes in the organization. The RN Unit Managers were the ones in the know and the ones who exercised power over the TR Manager and the RTs. Consequently, the TR Manager and the RTs cooperated with Auxiliary, the OT, the social worker, the dietician, and occasionally with the doctors, to alter the power relationships and to define what problems received attention.

To shift some of the financial power from the administration and Unit Managers to the TR department, the RTs cooperated with the Auxiliary to get additional funding for recreation equipment and supplies and they engaged in fund raising activities to gain discretionary funds that they could spend as they saw fit. The TR Manager also built relationships with community service groups, such as the Rotary Club, to get further financial support for recreation programs.

The RTs also cooperated with their co-workers to alter power relationships within the organization. For example, the TR Manager cooperated with the social worker to shift the decision making regarding memorial services from the medical interdisciplinary team to the residents. In another example, an RT cooperated with an OT to get the nursing staff to change a resident’s medical routine so that she could get up for a program. In the case of the resident wanting the right to eat what he wanted on outings, an RT gained the support of a doctor, a dietician and an occupational therapist to convince the nursing staff to let the resident choose what risks he wanted to take.
Within the TR Department and with the nursing staff, the TR Manager yielded a great deal of power, not only because of her position as supervisor, but also because of her personal leadership abilities, her long length of service within the organization, and because of her advanced education in therapeutic recreation. When the RTs encountered difficulties with other stakeholders, such as the nursing staff, they gave examples of including the TR Manager in the planning process on the unit to help re-focus the problems with the nurses so that they (the RTs) could achieve their goals.

The Family Council’s use of power in the organization was illustrated by their engagement in negotiations with the organization’s administration in an attempt to alter a material frame factor – that is the staffing level of the RTs. Unfortunately, their campaign to increase staffing was unsuccessful and even resulted in negative repercussions for the TR staff, who were reprimanded by administration for the Family Council’s actions. Although the RTs did not instigate the Family Council’s campaign, neither did they consider the ramifications nor act politically to mitigate the outcomes.

The Residents’ Councils ultimately yielded little power within the organization. The organization’s standards state that Residents’ Councils are required by the organization and by the accreditation body. However, close examination of council’s terms of reference and minutes reveals, that because of the varying cognitive abilities of the residents and because the meetings are coordinated and facilitated by the social worker and the RTs, that the proceedings of the meetings can be easily manipulated by the staff members. Consequently, while the TR department takes seriously the suggestions and recommendations of the residents with regards to their program preferences, unlike the Family Councils, the credibility of the Residents’ Councils’ decision and motions do not carry much credibility or power within the wider organization.
Tactics Used by the RTs to Plan Programs

The RTs engaged in several definably different behaviours in planning situations involving power issues. Which behaviours they used appeared to depend on the power of the stakeholder within the medical setting and on what was effective in the circumstance (that is, the RTs would try a different tactic if their first effort was not effective). The key stakeholders that were the primary focus of the RTs efforts were the nursing staff, including the RNs, LPNs, and care aides. Consequently, most of the planning issues arose with the nursing staff. However, the RTs did regularly engage in negotiations with other allied health professionals, such as the OT, PT, and social worker, as well as with family members, volunteers, and Auxiliary members.

The nursing staff held powers of controlling the availability of the residents for programs. They also held considerable power within the facility as “experts” on the medical needs of the residents. The RTs gave many examples of using reasoning, consulting, appealing, and bargaining with the nursing staff. The results showed that RTs used several tactics in a specific situation depending upon the success of each tactic. For example, in their negotiations with the nursing staff to get residents ready for their programs, the RTs would attempt consulting, then reasoning, then appealing, next bargaining, and if none of those were successful, counteracting.

Reasoning was used to persuade nursing staff to increase their support for programs and to alter details of the program, such as the location. Consulting was used to solicit nurses’ ideas and to thereby reduce their resistance and increase their support for program ideas. Consulting was also used to influence program details that the RTs had little control over, such as which residents were out of bed and available for programs. The RTs used appealing, which in some circumstances became begging, to solicit nursing cooperation and assistance with getting residents ready for programs, and to convince nursing to change their medical decisions about a
residents' care, such as the residents' right to take the risk of eating out. Bargaining was used particularly with one RT who had previous work experience as a care aide and who would bargain with a care aide to get particular residents up in exchange for her looking after the care aide's assignment of residents by keeping them busy in her programs.

The specific circumstance of using counteracting, which was used occasionally by a few of the RTs, occurred when the nursing staff refused to get a resident out of bed for a program, and so the RTs would then bring the resident to the program in their bed. The use of this tactic could damage the networks and relationships the RTs have built with the nursing staff if the RTs' actions cause the nursing staff embarrassment or to lose face. However, only one of the RTs implied that she was showing the nursing staff that she could meet the interests of the residents (to attend a program) despite their lack of cooperation. Whereas, the other RTs who discussed bringing residents to programs in their beds implied that the resident was not up through no fault of the nursing staff, but that the resident was not well enough to sit up in a chair but would be fine if they could come to the program in their bed. The other examples of counteracting discussed were not confrontational, but were cases of achieving the interests of the residents by circumnavigating procedures or people who would block the RTs efforts.

In a setting such as residential care, where the RT is so dependent upon the goodwill of the nursing staff for the success of their programs, the use of these more subversive tactics, such as counteracting and pressuring, needs to be carefully evaluated for their future impact on the working relationship between the planner and the stakeholder. Although it might appear to be easier to counteract a decision, the long term effect might be more costly than imagined.

The other allied health professionals that the RTs used negotiation tactics with in the course of planning their programs were the OT, PT, music therapist and the social worker.
Reasoning and logic was used in substantive negotiations when there was conflict about program details, such as conflicting recreation and music therapy program times or locations. Consulting and networking were used to gain support for a new program idea and/or for getting support for specific residents to attend programs. The RTs would consult with the OT or PT to get their ideas and opinions and when necessary they would also network with the OT or PT to get their support and alliance for presenting their argument to, in most circumstances, the nursing staff. For example, the RT obtained the expert opinion and support of the OT to convince the nurse, who has more medical expert power than the RT, but not necessarily than the OT, for a resident to get up for the exercise program. Similarly, the RT solicited the support of the OT, who does swallowing assessments, and the dietician, an expert in nutrition, to convince the medical team that a resident should be able to choose to take the risk of eating on outings even though he was at risk for choking. In another example the RT worked with the social worker to convince the interdisciplinary team to let the residents decide how they wanted to memorialize their friends who had passed on. As these examples illustrate, the RTs used the expert knowledge base of their colleagues to alter the power base in the RTs favour in their negotiations with nursing and medical staff. There were no examples of pressuring or counteracting given in situations involving these stakeholders.

Amongst the recreation staff, where the power relationship was symmetrical, the RTs gave examples of using reasoning and bargaining to negotiate who would organize and implement which programs. The RTs consulted with each other to get ideas and input on current or new programs and to identify solutions to planning challenges, such as programs for cognitively low functioning residents. The RTs would network with and seek the support of the
TR Manager when they needed help trying to negotiate with nursing about a program or a resident for a program.

*Appealing* and *networking* were used by the RTs in their negotiations with family members, volunteers, community groups, administration and funders to solicit physical and material support for their programs. *Networking* was the primary strategy used with these stakeholders. The RTs frequently mentioned the importance of developing a relationship and building rapport with all of the key stakeholders, and particularly with nursing staff, family members and volunteers. The development of good rapport with stakeholders was crucial for obtaining their future support for the RTs' programs. Family members and volunteers that the RT networked with regularly were usually more involved in and supportive of the RT's programs, contributing physical assistance with programs as well as supplies and financial donations.

The use of *pressuring* arose in one example of an RT who applied pressure to get the maintenance department to construct planter boxes. While the RT's pressure tactics got the attention of the maintenance department, they did not act until the TR Manager was brought into the discussion and she provided support for the RT's request. *Pressuring*, in the form of a petition, was also used by the Family Council and Residents' Council in an unsuccessful attempt to engage in meta-negotiations with administration regarding changes to the physical structure of the facility (the addition of a patio to one unit) and regarding an increase in TR staffing.

The administration reacted negatively to being pressured and admonished the TR department for these pressure tactics because the RTs were seen as being complicit due to their close relationship with both the Family Council and the Residents Council. Although the RTs may not have initiated these pressure tactics, they were aware of them and in the case of the residents' patio petition, provided support for their action. Future use of *pressuring* as a tactic by
RTs should be considered carefully because reliance upon it may be destructive to their program plans.

In summary, this study confirms that planning is essentially a “social activity” in which RTs negotiate with nurses, care aides, OTs, PTs, volunteers, families, funders and others about programs, their purpose, participants, format and content. However, how the RTs use influence tactics, and with whom, varies with the RT, the stakeholder and the circumstance. Nonetheless, there appears to be a preferred hierarchy of tactics depending upon the stakeholder and circumstances. All of the RTs used the influence tactics of networking, reasoning, consulting, and appealing. Networking was found in the RTs interactions with all of the stakeholders. The latter three tactics were used primarily with negotiations with nursing staff regarding substantive details about programs and the residents although consulting and reasoning were used with other stakeholders as well. Consulting appeared to be used in a more pro-active manner, such as in anticipation of planning a program, whereas reasoning and then appealing were used in more emergent situations, such as when an RT needed a resident up for a program. Appealing was also used when reasoning was not effective. Bargaining was used amongst the RTs and occasionally with the care aides. Counteracting and pressuring were rarely used and only in situations where none of the other tactics worked.

Yang and Cervero (1998) found that the less power that planners had, the more likely they were to use tactics of networking, reasoning, consulting, and appealing. While the RTs were theoretically on the same reporting level as the nursing staff and allied professionals (e.g., OT and PT), the nursing staff had the power of control over the medical care of the residents and the allied professionals similarly had their own expert medical positions within the organization. Hence, when it came to negotiating with nursing staff about getting residents up for programs,
the RTs held asymmetrical power. Nonetheless, this study shows that power is not a static property connected with the RTs official position in the organization but that it can be acquired and enhanced with the effective use of influence tactics.

A Sociopolitical Framework for TR Program Planning

Therapeutic recreation programs have been a focus of health care since the return of veterans from World War II. However, it was 30 years before a defining theory of TR practice, the Leisure Ability Model, was widely adopted. The Leisure Ability Model has been the dominant model guiding TR practice since Gunn and Peterson published their book, *Therapeutic Recreation Program Design* in 1978. The model was adopted by the U.S. National Therapeutic Recreation Society in 1980, and was subsequently adopted by the Canadian Therapeutic Recreation Association, and the BC Therapeutic Recreation Association and it continues to be used by the Douglas College Therapeutic Recreation program, which is the only TR program in B.C. Program planning as described by the Leisure Ability Model and other similar models that have since come into favour (Austin, 1998; Van Andel, 1998; Wilhite et al., 1999) outline a comprehensive, technical-rational decision making process involving traditional planning steps: assessing needs, developing goals and objectives, identifying resources, selecting and implementing programs and evaluating outcomes.

However, this research has found that the classic model of planning does not represent what really happens in the planning practice of RTs working in an extended care facility. The so-called rational decision making process is fraught with not-so-rational power and interests. As Forester (1989) explains, the sociopolitical factors and context matters because “ignoring the opportunities and dangers of an organizational setting is like walking across a crowded intersection with one’s eyes closed” (p. 7). Planning that does not include awareness and analysis
of the sociopolitical context therefore does a disservice to the residents and other stakeholders depending upon the programs.

Traditionally, RTs have used the Leisure Ability Models’ planning steps as their guide to how planning occurs, but the Leisure Ability Model foregrounds the clinical/technical aspects of planning. I do not suggest that these technical aspects should be replaced by a model that is solely concerned with negotiating power and interests. However, these traditional planning steps are carried out within a political milieu, and to be ethically responsible, RTs should also consider whose interests are being served. Although the Leisure Ability Model provides a thorough theoretical and philosophical foundation for TR planning and the technical details on how to plan programs, it does not address the complexity of the context or the power and interests that permeate the planning process within an organization. Furthermore, it does not include an ethical lens for examining whose interests are being served. This research shows that although the needs of the residents were represented by the RTs in their planning practice, several other less legitimate interests caused programs to be planned.

In residential care, RTs work with people who have diverse ideas about the value of therapeutic recreation for the residents. Many of the staff in residential care believe in the “medical model” of care and do not appreciate the value of a healthy leisure lifestyle for residents who are nearing the end of their life. In these circumstances, RTs can use power and influence tactics to not only provide high quality programs for residents, but to also “challenge the status quo” (Caffarella, 2002, p. 72) in terms of beliefs about the needs, interests and abilities of residents and the value of TR programs.

Furthermore, this research found that there are several different types of factors that frame RTs practice and correspondingly several different types of meta-negotiations occurring
related to these factors (e.g., power relationships, conceptual/ideological frames, material/resource frames). For example, the findings demonstrate that organizational relationships, traditions and structures create a strong conceptual frame for what and how programs are planned in residential care. As Sheila’s comment below indicates, the RTs acknowledged that planning was complex, however they did not have a model or lens with which to see their practice as a social activity within a complex socio-political context.

*Sheila: You have to look at so many different variables to make everything work. The people involved, the staff you work with, the budget you work with, and your time frame that you have.*

Additionally, this research found that RTs employ various negotiation tactics to achieve their planning goals. The current TR models and theories do not address the need for negotiation tactics, or more importantly, the need for ethical negotiation tactics. Although this study found evidence of seven definable tactics, the information was limited to two interviews with each RT and further observations and interviews would doubtless reveal other tactics and also suggest alternative, and perhaps more effective negotiation strategies.

The results of this study suggest that the TR program planning models need to incorporate the sociopolitical dynamics of program planning. The findings suggest a different approach to program planning might be needed if RTs want to address the needs of an increasingly cognitively and physically challenged resident population. Three fundamental assumptions to planning practice are suggested by this study: 1. planning involves complex interactions of organizational priorities, people, tasks and events, 2. RTs plan programs in a social, cultural, political and economic climate and, 3. RTs can learn to be more effective planners by learning from experience and each other and by using various models and
frameworks as guides. RTs need to know that effective TR practice depends upon the effective use of appropriate planning strategies depending upon the context.

A planning framework for TR would be more robust if it included the contextual, ethical and sociopolitical elements of program planning. Drawing upon the adult education (Caffarella, 2002; Cervero & Wilson, 1994a; Sork, 2000; Umble et al., 2001; Yang & Cervero, 2001) and TR literature (Peterson & Stumbo, 2004), and the results of this research, the key features for a question-based planning framework are outlined below.

Starting with the Leisure Ability Model's (Peterson & Stumbo, 2004) comprehensive program planning design as a framework, additional elements are suggested that could be included in the design. Next, adapting Sork's (2000) question-based framework, questions arising from the research and literature are suggested that RTs could ask themselves and each other about their planning practice. Questions should help the RTs examine their philosophy of TR and enable them to take pieces from the planning models, such as the TR models and the socio-political models discussed, that best fit with their philosophy of practice and that will help them achieve their primary goals for their residents. This framework is suggested to be used in conjunction with other models that are rich with technical details, including the Leisure Ability Model, and is offered as a sociopolitical and ethical lens to "guide planning" and to "analyze planning" (Sork, p. 180). The planning elements discussed are:

- Analyzing the Context and Client Population (Environment, Organization, Human)
- Conceptualizing, Justifying and Focusing Planning
- Investigating and Clarifying Intentions
- Determining and Preparing Administrative Plans and Specific Program Plans
- Evaluating Outcomes
Although the planning elements are presented in a linear, step-wise fashion, they are interconnected and may be considered and revisited at any stage of the planning process.

Analyzing the Context and Client Population

The context includes the sociopolitical environment, the organization or agency setting, and the people affected by and interested in TR program planning. As well as asking the technical questions suggested by Peterson and Stumbo (2004), RTs should ask themselves the following questions:

*Environment/Community:*

1. What other sociopolitical factors external to the agency should be considered when planning?
2. What support or opposition to this planning effort can be expected from the community and how can you enhance this support or alter this opposition?

*Organization (e.g., hospital organization, residential care facility, TR department):*

1. What traditions, beliefs and values of the organization positively and negatively influence planning and how can these factors be encouraged or altered to enable planning?
2. What other barriers (e.g., procedural, financial, and physical) exist that influence planning and how can these factors be altered to enable planning?
3. What support or resistance to planning can be expected within the organization or the department and what strategy or tactics are needed to build support and/or overcome resistance?
4. What organizational relationships are cooperative or competitive and how can a base of support for the TR department be built within the organization and the larger community?

5. What organizational barriers (e.g., schedules, procedures, financial, physical and human resources) may prevent or discourage residents’ participation in planning and/or programs and how can these barriers be altered to enable participation?

6. What are the current TR department program commitments, how do they influence planning, and are these commitments still philosophically and ethically supportable?

7. Is the TR program plan ethically congruent with the philosophy of the department?

*Human* (e.g., residents, family, volunteers, nursing staff, support staff, medical staff, administrative and management staff, auxiliary members, community groups and members, residents’ councils, family councils):

1. Who are the other stakeholders in the planning process and what are their interests?

2. Who has power to influence planning, who needs to have power to influence planning, and how can power bases be altered?

3. What tactics can you use (ethically) to influence the planning process and how will you use them?

4. How can residents best be involved in the planning process?
5. Which residents' interests and needs are being met and which residents' interests and needs are not being met and what is the ethical foundation for deciding whose interest and needs will be met?

**Conceptualizing, Justifying and Focusing Planning**

Peterson and Stumbo's (2004) model suggests that the next steps in the planning process should be identifying or conceptualizing the program's goals and purpose. However, Sork's (2000) *Justify and Focus Planning* encourages greater reflection on the purpose(s) of the program(s) by including an assessment of why the program is important and why resources should be expended on the program. In addition to describing the purpose and goals of the program as suggested by Peterson and Stumbo, RTs should ask themselves the following questions:

1. Who do you have to justify your program planning decisions to (including the resources required) and what kind of information will they be satisfied with?

2. Recognizing that needs are socially constructed, which approaches to justifying planning and setting goals will be most suitable to use and are ethically congruent with your philosophy of TR?

3. Whose needs or interests will be met with the goals developed and whose will not and why?

4. What are the decisions underlying the focus or goals of the services and how will you justify them?

5. What sociopolitical issues may be encountered and how will you address them? (e.g., If the focus of the TR department is on functional interventions for residents
with advanced Alzheimer's versus recreation participation for high functioning residents, will there be sociopolitical issues and how will you address them?).

**Investigating and Clarifying Intentions**

Peterson and Stumbo (2004) use the term *investigation* to describe the next step in their comprehensive program planning process, which is to objectify program goals into operational program components. Although the model provides several suggestions for identifying and selecting program components, it does not address the sociopolitical or ethical issues that should also be considered. Additionally, the term *investigation* does not suggest the purpose of this stage, which is to clarify and specify the intentions of the program. At this stage in the planning process RTs should also ask themselves:

1. What sociopolitical insights from the analysis of the organization and the residents might be important to take into account as you identify and clarify intentions?

2. Which stakeholders should be involved in the investigation and clarification stage of planning, why, and if necessary, how can you alter power bases to facilitate their participation?

3. Whose needs and interests are being met with the program components you have selected and whose will not and why?

4. What important ethical issues are involved in the decisions you have made and how will you address them?

5. What important sociopolitical issues might arise as a result of the intentions you have focused on and how will you address them?
6. What barriers might participants encounter in working to achieve the expected outcomes of the program and how can you address them?

Determining and Preparing Administrative Plans and Specific Program Plans

The next stage in Peterson and Stumbo's (2004) planning process is to actually select which programs will be offered followed by planning the specific program design. Sork (2000) separates out preparing the instructional plan (general) from preparing the administrative plans (financial and promotional) and while these elements are technically unique, for the purposes of addressing the sociopolitical and ethical issues they have been combined into Determining and Preparing Administrative and Specific Program Design. While the literature provides excellent technical advice for this stage of the planning process, to guide this step and to help analyze decisions, RTs should consider the following questions:

1. Whose needs and interests are being met with the plans you have developed and whose will not and why?

2. Why was the program selected to achieve this planning goal and what are the sociopolitical and ethical implications of choosing this program over other alternatives?

3. Is the program selected congruent with the philosophy and ethics of the department?

4. Which stakeholders should be involved in this stage of the planning process, why, and if necessary, how can you alter power bases to facilitate their participation?

5. What sociopolitical insights from the analysis of the organization and the residents might be important to take into account as you prepare specific program plans?
6. What support or resistance to the program can be expected within the organization, or the department and what strategies or tactics are needed to build support and/or overcome resistance?

7. What organizational barriers (e.g., schedules, procedures, financial, physical and human resources) may prevent or discourage residents’ participation in the program selected?

8. What important ethical issues are involved in the program selection decisions you have made and how will you address them?

9. What important sociopolitical issues might arise as a result of the activities you have selected and how will you address them?

_Evaluating Outcomes_

Evaluation of residents’ outcomes as well of programs’ outcomes should occur on an ongoing basis as well as summatively. The literature is rich with evaluative tools and methods. However, to guide RTs in developing their evaluation they should ask the following questions:

1. What is the sociopolitical purpose of client/resident and/or program evaluation?

2. Does the evaluation tool further the philosophical and ethical beliefs of the TR department?

3. How will the evaluative information collected be used and by whom and what important sociopolitical issues might arise and how will you address them?

4. Which stakeholders should be involved in the evaluation processes, why, and if necessary, how can you alter power bases to facilitate their participation?
5. How will you identify unanticipated positive and negative client and/or program outcomes and what important ethical and sociopolitical issues might arise from unanticipated outcomes and how will you address them?

6. What other important ethical issues might arise in the evaluation(s) and how will you address them?

7. What other important sociopolitical issues might arise as a result of the evaluation(s) and how will you address them?

The questions suggested above are intended to increase RTs’ awareness and analysis of the sociopolitical context within which they plan programs. Used in conjunction with other TR models and theories of practice, such as the Leisure Ability Model, these questions highlight the power and interests that influence planning and encourage RTs to use a sociopolitical and ethical lens to examine their practice and the context within which they work. This questioning of practice leads to several other recommendations for practice and research that are discussed in the final chapter.

Summary

In summary, this research shows that TR planning is similarly embodied in and influenced by the social setting and goes beyond previous studies by demonstrating the sociopolitical activities of planning within the residential care setting. This research found that several different types of factors, such as traditions, norms, structures and resources, impact RTs’ practice. Similarly, dimensions of the quality of life discourse were problematic for the RTs because of competing interests.

This research goes beyond previous studies of planning practice by showing who has power within the residential care setting, how power influences planning, and how RTs can alter
power relationships to achieve their goals. RTs negotiate with co-workers, family members, volunteers and others about frame factors as well as about what programs are planned, when, and how, and for whom. Furthermore, this research illustrates that RTs have to not only “read the political situation to understand power relationships and legitimate interests, but they also have to identify, modify, and carry out their own interests in the planning process” (Yang et al., 1998, p. 2). This study shows that RTs use various tactics to alter power relationships and power can be acquired and enhanced with the effective use of influence tactics. Drawing upon the adult education and TR literature, and the results of this research, the key features for a question-based planning framework that includes the contextual, ethical and sociopolitical elements of program planning are suggested.

In the next chapter, I present the summary and conclusions of this study followed by recommendations for future TR research and practice.
CHAPTER SIX

SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

Forester (1993) argues that "not only must an adequate account of planning practice be empirically fitting, it must also be both practically appropriate to the settings in which planners work and ethically illuminating, helping planners and citizens understand and assess the ethical and political consequences of various possibilities of action, policy, or intervention" (emphasis in the original, p. 16). However, the TR literature does not adequately address the complex context of TR planning practice in residential care and does not help RTs understand how to navigate through the power and interests that influence planning and the ethical issues that are prevalent in their planning contexts.

Summary of the Research

To develop a deeper understanding of how and why therapeutic recreation programs are planned in residential care facilities and the influence of the context and power and interests on planning, the following research questions were explored:

1. How does the context of extended care influence planning practice? What organizational (structural, political and cultural), environmental, and human, factors influence planning practice?

2. How and why do RTs plan programs in extended care? That is, what do RTs believe about the purpose of TR in extended care and how are programs chosen to be offered?

3. How do organizational, professional, and personal power and interests influence RTs planning practice in extended care? That is, how are needs shaped, agendas
set, populations determined, decisions made, resources allocated and residents chosen?

4. What do RTs know and do – what tactics do they use when planning programs (e.g., reasoning, consulting, appealing, networking, bargaining, pressuring, counteracting, negotiating) and why (that is, what are they attempting to change)?

5. How well do current program planning models help to guide therapeutic recreation practice and help RTs to understand the planning dynamics observed within the extended care context?

A combination of qualitative research methods including interviews and observations of planning meetings and document analysis were used over the course of this study, which took place between February and July, 2004. Eleven RTs were interviewed twice each for approximately one-half to one hour per interview. Three interviews were conducted with the TR Manager and additional shorter interviews, both in-person and by phone, were conducted with various participants to clarify and verify information. Three monthly planning meetings and one TR business meeting were observed and recorded and one TR job action planning meeting was recorded. One or more hours was spent on each unit observing the RTs working and observing the physical environment in which they worked.

Numerous organizational and departmental documents were examined in this research including TR planning meeting minutes, TR standards of practice, organizational charts, mission statements and policies, program protocols and procedures, activity calendars and schedules, residents’ attendance records, Family Council minutes, Residents’ Council minutes and field notes. In addition, theoretical literature, research reports, and other health care related documents were reviewed.
The data was analyzed recursively as it was collected, transcribed, cleaned, coded and re-coded. After formulating and reformulating the data, the data was analyzed for relationships in structures and patterns. These conceptual models were tested and revised repeatedly as the research progressed. The stories of the participants were used to illustrate the results and previous research findings were used to help explain and analyze the data.

Conclusions

The study of the above research questions revealed many facets of the sociopolitical nature TR planning practice in a residential care facility. The context influenced the RTs planning practice on several levels and in several ways, environmentally, organizationally and politically. The impact of other stakeholders on the RTs planning practice was evident in the study. Power and interests influenced RTs’ planning practice and were important factors in the RTs program planning decisions. Different reasons emerged why programs were planned that impacted whose interests were served. The RTs were aware of many of the social activities of planning and their ability to navigate through the sociopolitical elements and negotiate with stakeholders was illustrated by their stories. The beliefs of the RTs provided a foundation for their practice. Most importantly, the residents were central to the RTs planning decisions.

How Does the Context of Extended Care Influence Planning Practice?

The environmental factors that impacted planning decisions included changes to the residential care access policy, the job action/strike and the provincial government’s imposed collective agreement, and facility quarantines due to influenza outbreaks. The tightened access criteria changed the make-up of the resident population as only the most physically and/or
cognitively disabled residents are now admitted. The RTs were struggling to adapt their program plans to the changing residents' needs within a fairly fixed planning structure.

During the research period, the RTs went out on strike, which illuminated the priorities and programs that took precedent when services were severely reduced and restricted. Conflicts with beliefs occurred as RTs had to compromise individualized quality programming for quantity, that is they decided to plan large group activities that would accommodate more residents. To end the strike, the provincial government unilaterally imposed a collective agreement which included an 11% wage cut plus an additional 4% wage reduction in lieu of a longer work week. The wage cut had a negative impact on the morale of the hospital workers, including the RTs. Consequently, the RTs were not as willing to stay late after work on their own time to plan programs, which many of them frequently did.

The quarantines imposed by the influenza outbreak influenced the RTs planning in a similar way that the picket lines did. During a quarantine, of which three occurred during the research period, volunteers and entertainers were not allowed on the unit and family members were discouraged from visiting. However, unlike the job action, the RTs had to cancel large group activities to reduce the risk of further infection, and therefore only implemented small group or one-to-one activities. Although very restrictive, the quarantine and job action freed the RTs from the constraints of fixed programming and enabled them to view their practice through another lens.

The organizational factors that influenced planning were categorized as structural (e.g., policies and procedures, finances, resources, physical plant), cultural (traditions, beliefs and values), and political (the people or organizations that politically impacted the RTs planning: union, administration, Auxiliary, Family and Residents' Councils). This study showed that the
organizational structure and culture directly affected the planning process. The facility’s attachment to an acute care hospital and the subsequent protocols and standards reinforced medical norms which undermined the RTs efforts to implement a holistic planning approach. Similarly, the physical layout of the facility was conducive to medical care but did not lend itself to becoming a home-like environment. The RTs efforts to create a homey atmosphere were thwarted by the need to have medical equipment and carts stored in the hallways and by administration’s renovations, which curtailed the space available for quiet, closed recreation programs.

The unionization of the RTs work framed or structured their work day and restricted how the RTs could use volunteers in their programs. The RTs were cognizant of the restrictions of the collective agreement but they did not perceive that they could substantially alter this frame factor. The reorganization of the facility’s reporting structure was recognized as limiting the TR department’s power base within the organization and examples were given of the RTs efforts to build collaborative relationships with other stakeholders in order to gain support for TR program goals. The Hospital Auxiliary had considerable political influence in the organization and consequently on the RTs planning because of the substantial funding and volunteer services they donated to the hospital and extended care. Using its political clout, the Family Council attempted unsuccessfully to alter structural and human resources that were affecting the TR department. The Residents’ Councils were involved in substantial negotiations with the RTs regarding details of the programs planned.

The “human factors” of the context that influenced planning included the residents, family members, volunteers, administrators, managers, auxiliary members, nurses, doctors, care aides, and other members of the multidisciplinary team. The impact of these stakeholders varied
depending upon their power base and their interests in the TR programs. The medical and nursing staff had the greatest sociopolitical impact as they controlled which residents were available to attend programs and when. Family members, volunteers and auxiliary members influenced program plans by providing support and resources which made many programs possible. RTs developed strategic alliances with various multidisciplinary team members, such as the social worker and the occupational therapist, to shift power bases to achieve their program goals.

_How and Why Do RTs Plan Programs in Extended Care?_

The RTs held strong beliefs about the purpose of TR and its role in contributing to the quality of life of people living in residential care. The quality of life discourse included several elements, such as promoting residents’ right to meaningful activities, facilitating family involvement and a sense of community, helping residents overcome challenges, providing residents with choices, treating them with respect, and promoting a holistic, resident-centred approach. The research found that the RTs ability to plan programs according to their beliefs was hindered in many ways by the organizational context, resources, and culture discussed above.

The overwhelming reason why programs were planned was “to meet residents’ needs and interests.” However, other reasons were found why programs were planned that were not directly related to meeting residents’ needs. Programs were planned to raise money for other programs or because of special interests of other stakeholders, such as family or staff. Programs were often chosen because of tradition or prior commitment or because the resources or equipment were available for a program. The RTs own interests and skills were also central to the programs they were able to plan.
How Do Power and Interests Influence Planning Practice?

Power and interests influenced agendas and decisions, and determined which populations were served, and shaped whose needs were met and who benefited from the programs. Because the lower cognitively functioning residents had been historically under-served, the RTs and their manager consciously tried to bring this group of residents’ needs to the forefront of the planning process. However, the RTs had to struggle to provide for this group as the organizational structure, resources and culture favoured the needs of the higher functioning residents who were more vocal and better able to tolerate larger groups in busy settings.

What Tactics Do RTs Use When Planning Programs and Why?

The RTs used various definably different tactics in planning situations involving power issues in attempting to achieve their planning goals. In the initial coding of the RTs stories, 34 different, but in many respects similar, tactics were found. Further analysis and recoding found that the predominant planning behaviours were similar to those identified in Yang and Cervero’s (2000; 1998) research. Depending upon the circumstances, the power of the stakeholder and the personal style of the individual, the RTs frequently engaged in reasoning, consulting, networking, appealing, and less frequently, in bargaining. Counteracting and pressuring were two other identifiable tactics, but were rarely used and only when the other tactics were ineffective.

How Well Do Current Program Planning Models Help to Guide RTs?

The predominant TR planning model, the Leisure Ability Model (Peterson & Stumbo, 2004), is rich in philosophical and technical details, but does not represent what really happens in residential care planning practice because it does not include an ethical, or a sociopolitical lens
for examining planning practice and TR services. The Leisure Ability Model does not address the complexity of the context, or the power and interests that influence planning. Although adult education planning models are not designed for use in residential care therapeutic recreation planning settings because of their assumptions about learners, the concepts and theories of Cervero and Wilson's (1994a; 1996) negotiation theory, Sork's (2000) planning framework, and Caffarella's (2002) Interactive Planning Model provided useful lenses for viewing TR planning practice in residential care. Consequently, a more robust question-based planning framework for TR is suggested that applies the contextual, sociopolitical and ethical elements of planning to the richly technical and theoretical Leisure Ability Model.

**Recommendations for Future Research**

Several issues and aspects of planning need to be researched further, including:

1. Further research is needed on how the context and power and interests influence planning in other residential care facilities, and in other therapeutic recreation contexts such as group homes, rehabilitation centres, adult day care centres, mental health inpatient and outpatient programs, corrections institutions, and community programs. Findings derived from a small case study of RTs at a single facility might be unique to this setting and these participants. Data collected from RTs working in other residential care facilities or in other TR contexts, could provide evidence to support or contradict the findings in this study or might help us understand other features of planning.

2. Research on the different types of factors that frame practice (e.g., power relationships, conceptual/ideological frames, material/resource frames) and the meta-negotiations employed by RTs is also needed. Additional research focusing on frame factors might
reveal different types of factors depending upon the context as well as different tactics for negotiating them.

3. Further research on what planners do in practice (e.g., what negotiation strategies they use) and an evaluation of effective and successful planning practice is also needed. This could include examining the impact of personal characteristics on the use of influence tactics. For example, further research could explore the impact of age, gender, race, ethnicity, religion, or other personal characteristics on planning practice.

4. Research would be useful on the ethical use of power and influence tactics and their relation to organizational context. For example, ethical justifications for the use of various tactics in response to power differentials could be explored further.

**Recommendations for Practice**

To promote an awareness of and knowledge about the contextual and social-political dimensions of planning TR educators, TR professional associations and practicing RTs should consider the following recommendations.

*Recommendations for TR Educators*

TR Educators should make explicit in their curriculum the impact of power and interests and the context on planning. The curriculum should help students identify and analyze sociopolitical barriers to clients’ participation and provide them with skills for involving stakeholders in the planning process. For example, the curriculum should include negotiation tactics and strategic leadership skills needed for effective practice.
Recommendations for TR Professional Associations

TR professional association, if they want to effectively represent RTs, need to be aware of the sociopolitical issues facing the profession within British Columbia. My study revealed a variety of sociopolitical forces, such as government legislation, that RTs have no control over. To increase their sensitivity to sociopolitical issues, TR associations need to carefully analyze the influences of the broader context on the profession.

Recommendations for Practicing RTs

New RTs should acquire different types of contextual knowledge and negotiation skills because students who only receive technical knowledge and skills may be not prepared for the realities of planning. RTs should critically reflect on their planning context, practice, and ethical beliefs and should continually develop their negotiation and leadership skills. Frequent reflection on practice, particularly with critically supportive colleagues, will help RTs identify and problem-solve issues with power relationships, conflicting interests and other factors that are framing their practice.

Closing Comments

Residential care organizations are undergoing rapid change and the diversity and number of the people who work and live in residential care is increasing. In this time of health care cuts to staff and programs, it is very important that RTs be aware of the political realities influencing their planning practice. A more skilful practitioner has multiple lenses with which to read different situations and multiple sets of tactics to use to further residents’ interests. Increased understanding of power and influence techniques and their use within political contexts will increase RTs understanding and ability to practice more strategically and responsibly.
Therapeutic recreation services for people living in residential care are central to their experiencing some quality of life in their remaining days. As we age (hopefully), it is important to promote the value of recreation therapy and to encourage RTs to reflect upon and improve their practice so that we too may enjoy a quality leisure lifestyle if we end our days in residential care.
APPENDIX A

LETTER OF INITIAL CONTACT

THE UNIVERSITY OF BRITISH COLUMBIA

Department of Educational Studies
Mailing address:
2125 Main Mall
Vancouver, B.C. Canada V6T 1Z4
Tel: 604-822-5374
Fax: 604-822-4244
http://www.edst.educ.ubc.ca

Letter of Initial Contact
A Responsive Model for Therapeutic Recreation Program Planning in Residential Care

February 24, 2004

Dear __________;

I am writing to ask if you are willing to participate in my doctoral study of therapeutic recreation (TR) program planning practice in an extended care facility. After planning and implementing TR programs in extended care for over 15 years, I have a long-standing interest in researching how planning occurs, in critiquing TR models and theories of planning practice, and in developing a new model of TR planning in residential care.

More specifically, I am interested in studying how the residential care context influences how programs are planned, and how, in the process of planning programs, Recreation Therapy Practitioners (RTs) negotiate power and interests in residential care. This study will result in a deeper understanding of how and why therapeutic recreation (TR) programs are planned in residential care facilities and how the prevalent therapeutic recreation program planning theories apply, do not apply, and/or could be developed to better apply to planning practice within this context.

If you agree to participate in this research, I will schedule two or three interviews with you of about one hour each, at a time and place that is convenient for you. The interviews will be semi-structured – guided by general questions about planning practice, and will take place between February and July of 2004. I would also like observe three or more TR department planning meetings during this same time period (February to June of 2004). Your identity will remain completely confidential and you are free to withdraw your participation at any time without prejudice.

Version: Dec 5, 2003
APPENDIX C
INTERVIEW 1 PROTOCOL

a) Thank participant for agreeing to be interviewed
b) Interview will be about 1 hour
c) Explain confidentiality again
d) Ask for permission to start recorder and explain that I’ll be taking notes too
e) Start recorder, stating date, location, and who is present

<table>
<thead>
<tr>
<th>Questions</th>
<th>Probes</th>
</tr>
</thead>
<tbody>
<tr>
<td>1  How long have you worked at Pacific Memorial Hospital?</td>
<td>repeat questions when needed</td>
</tr>
<tr>
<td>2  What do you believe is the purpose of therapeutic recreation in extended care?</td>
<td>Can you provide an example?</td>
</tr>
<tr>
<td>3  Can you please describe how programs are chosen to be offered?</td>
<td>Can you please expand?</td>
</tr>
<tr>
<td>4  How is it determined which resident will attend which program?</td>
<td>What were your thoughts on that?</td>
</tr>
<tr>
<td>5  Please describe how you see the organization (structure, culture, policies/procedures, politics, administration, staff, volunteers, etc) influencing what programs are planned?</td>
<td>When you say ‘______’, what specifically comes to mind to make you say its _____?</td>
</tr>
<tr>
<td>6  How do resources influence which programs are offered?</td>
<td>How so?</td>
</tr>
<tr>
<td>7  How are others involved in the planning process (e.g., other staff, residents, family, volunteers, administrators) or what kind of role do they have in the planning process (i.e., Stakeholders)?</td>
<td></td>
</tr>
<tr>
<td>8  Can you please describe an example of planning a program and how you incorporate planning into your work day? (e.g., specific meetings, obtaining supplies, arranging volunteers, selecting residents)</td>
<td></td>
</tr>
<tr>
<td>9  What other issues do you see as being critical to your planning practice that I have not asked you about?</td>
<td></td>
</tr>
<tr>
<td>10 What other work experience have you had?</td>
<td></td>
</tr>
<tr>
<td>11 Where did you get your TR training? When did you graduate?</td>
<td></td>
</tr>
</tbody>
</table>

f) Thank you very much for your time and interest. Once the interview has been transcribed I am happy to share a copy with you if you are interested. Later on, if I wish to quote a comment you’ve made to illustrate planning practice, I will first check back with you for your permission.
g) Can we schedule a second interview at this time for sometime in late April or early May?
APPENDIX D

INTERVIEW 2 PROTOCOL

a) Thank participant for agreeing to be interviewed
b) Interview will be about 40 minutes
c) Explain confidentiality again
d) Ask for permission to start recorder and explain that I’ll be taking notes too
e) Start recorder, stating date, location, and who is present

<table>
<thead>
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<th>Questions:</th>
<th>Probes</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 In our first interview, you discussed: _______ Could you please give me an example of how this directs, or plays out in your practice?</td>
<td>repeat questions when needed Can you provide an example?</td>
</tr>
<tr>
<td>2 In your essential service planning meeting, how did the decisions about what programs to offer get made?</td>
<td>Can you please expand?</td>
</tr>
<tr>
<td>3 What factors, or whose interests, influenced these decisions?</td>
<td>What were your thoughts on that?</td>
</tr>
<tr>
<td>4 What is the toughest part about trying to do your programming job well?</td>
<td>When you say ‘ _______’ , what specifically comes to mind to make you say its _______? How so?</td>
</tr>
<tr>
<td>5 In the first interviews it became clear that formal assessments in this extended care complex are problematic for many reasons. Are there other parts of the leisure ability model that you find difficult to implement?</td>
<td></td>
</tr>
</tbody>
</table>

f) Thank you very much for your time and interest. Once the interview has been transcribed I am happy to share a copy with you if you are interested. Later on, if I wish to quote a comment you’ve made to illustrate planning practice, I will first check back with you for your permission.
APPENDIX E

B.C. THERAPEUTIC RECREATION ASSOCIATION CODE OF ETHICS BELIEF

STATEMENTS OF RECREATION THERAPISTS

CHOICE

We believe in independence and freedom of choice. We strive to encourage, ensure and support the right of each individual to make his or her own choices regarding leisure and quality of life. We also recognize an individual’s right to freedom of choice in selecting Therapeutic Recreation, recreation and leisure services recommended to meet his or her identified goals.

COMMUNICATION

We believe in communication based on respect, support, cooperation, collaboration, creativity and trust. We further believe that an individual’s leisure and quality of life goals are best facilitated by a positive, person centered team approach.

CONFIDENTIALITY

We believe that all information about an individual, acquired through professional contact, must be managed in accordance with the Freedom of Information and Privacy Protection Act.

ADVOCACY

We believe in public education and advocacy regarding an individual’s right to freedom of choice, independence, leisure and quality of life. This includes public education and advocacy regarding the benefits of Therapeutic Recreation, recreation and leisure participation services in assisting individuals to achieve health and wellness, and meaningful lifestyles.

PROFESSIONAL DEVELOPMENT

We believe in participating, facilitating and promoting education, research and related opportunities that will improve the quality and effectiveness of Therapeutic Recreation, recreation and leisure services.
COMPETENCE

Recreation Therapists are committed to practicing within the scope and boundaries of Therapeutic Recreation as identified by the Standards of Practice.

ACCOUNTABILITY

We believe that Recreation Therapists are responsible for their actions and to the individuals they serve, the profession of Therapeutic Recreation, their employers and society.

LEGALITY

We believe in the importance of understanding and complying with local, provincial and federal policies governing the profession of Therapeutic Recreation.

SAFETY

We believe that all Therapeutic Recreation services must be delivered with due regard to the safety of all individuals involved.

(BC Therapeutic Recreation Association, 2000)
## APPENDIX F

**THERAPEUTIC RECREATION PROGRAM CODES**

<table>
<thead>
<tr>
<th>CODE</th>
<th>PROGRAM</th>
<th>DESCRIPTIONS</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>One-to-one visits</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Physical</td>
<td>Exercise, physical games, hydrotherapy</td>
</tr>
<tr>
<td>3</td>
<td>Cognitive</td>
<td>Mental aerobics, quizzes, bingo, cars, newspaper, literary groups, movies, library, reminiscing, support groups…</td>
</tr>
<tr>
<td>4</td>
<td>Music</td>
<td>Sing-along, entertainment, music therapy</td>
</tr>
<tr>
<td>5</td>
<td>Special meals</td>
<td>Breakfast, lunch, dinner, teas</td>
</tr>
<tr>
<td>6</td>
<td>Mealtime assist</td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>Social events</td>
<td>Pub night, happy hour, birthday party, special-visiting groups, fashion show…</td>
</tr>
<tr>
<td>8</td>
<td>Outings</td>
<td>Vans, walks outside</td>
</tr>
<tr>
<td>9</td>
<td>Pet Visits</td>
<td></td>
</tr>
<tr>
<td>10</td>
<td>Spiritual</td>
<td>Sunday services, Chaplain’s Hour, Communion, Salvation Army, Hymn Sing</td>
</tr>
<tr>
<td>11</td>
<td>Crafts</td>
<td>Traditional, woodworking, ceramics, art, baking/cooking…</td>
</tr>
<tr>
<td>12</td>
<td>Gardening</td>
<td>Indoor and outdoor</td>
</tr>
<tr>
<td>13</td>
<td>Meetings</td>
<td>Residents’ Council, MS Support Group</td>
</tr>
<tr>
<td>14</td>
<td>Sensory</td>
<td>Sensory stimulation, beauty care, grooming…</td>
</tr>
<tr>
<td>15</td>
<td>Assessment</td>
<td></td>
</tr>
<tr>
<td>X</td>
<td>Declined</td>
<td>Refused when invited</td>
</tr>
<tr>
<td>B</td>
<td>Bed</td>
<td>Was not up for program</td>
</tr>
<tr>
<td>I</td>
<td>Ill</td>
<td>Too ill to attend</td>
</tr>
</tbody>
</table>
# APPENDIX G

## QUALITY OF LIFE MODEL

<table>
<thead>
<tr>
<th>BEING</th>
<th>who one is</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physical Being</td>
<td>• physical health&lt;br&gt;• personal hygiene&lt;br&gt;• nutrition&lt;br&gt;• exercise&lt;br&gt;• grooming and clothing&lt;br&gt;• general physical appearance</td>
</tr>
<tr>
<td>Psychological Being</td>
<td>• psychological health and adjustment&lt;br&gt;• cognitions&lt;br&gt;• feelings&lt;br&gt;• self-esteem, self-concept and self-control</td>
</tr>
<tr>
<td>Spiritual Being</td>
<td>• personal values&lt;br&gt;• personal standards of conduct&lt;br&gt;• spiritual beliefs</td>
</tr>
</tbody>
</table>

## BELONGING

<table>
<thead>
<tr>
<th>connections with one's environments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physical Belonging</td>
</tr>
<tr>
<td>• home&lt;br&gt;• workplace/school&lt;br&gt;• neighbourhood&lt;br&gt;• community</td>
</tr>
<tr>
<td>Social Belonging</td>
</tr>
<tr>
<td>• intimate others&lt;br&gt;• family&lt;br&gt;• friends&lt;br&gt;• co-workers&lt;br&gt;• neighbourhood and community</td>
</tr>
</tbody>
</table>
| Community Belonging                                                                 | • adequate income  
|                                                                                 | • health and social services  
|                                                                                 | • employment  
|                                                                                 | • educational programs  
|                                                                                 | • recreational programs  
|                                                                                 | • community events and activities |
| **BECOMING**                                                                    | achieving personal goals, hopes, and aspirations |
| Practical Becoming                                                              | • domestic activities  
|                                                                                 | • paid work  
|                                                                                 | • school or volunteer activities  
|                                                                                 | • seeing to health or social needs. |
| Leisure Becoming                                                                | • activities that promote relaxation and stress reduction |
| Growth Becoming                                                                 | • activities that promote the maintenance or improvement of knowledge and skills  
|                                                                                 | • adapting to change. |

"The Quality of Life model used in research projects carried out by the Quality of Life Research Unit was developed at the Centre for Health Promotion, University of Toronto. It was the development of this model and a request by the Ontario Ministry of Community and Social Services to carry out Quality of Life research that led to the formation of the Quality of Life Research Unit." (Quality of Life Research Unit, 2004)
REFERENCES


PMH Therapeutic Recreation Department. (n.d.). Therapeutic recreation: Helping people get the most out of life! [Brochure]. Fraser Health Authority, BC: PMH Therapeutic Recreation Department.


