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Understanding the Context and Social Processes that Shape Person- and Family-Centered Culture in Long-Term Care: The Pivotal Role of Personal Support Workers

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Antioch University - PhD Program in Leadership and Change

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Understanding the Context and Social Processes that Shape Person- and Family-Centered Culture in Long-Term Care: The Pivotal Role of Personal Support Workers

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Dissertation

Submitted to the Ph.D. in Leadership and Change Program of Antioch University in partial requirement for the degree of Doctor of Philosophy

April 2020
Dissertation Committee

- Elizabeth Holloway, PhD, Committee Chair
- Donna Ladkin, PhD, Committee Member
- Madelyn Law, PhD, Committee Member
Acknowledgments

The inspiration for this work came from my father’s need for increased care as he suffered from the debilitating effects of Alzheimer’s disease and was placed in a long-term care facility in 2013. That experience instilled in me the wish to improve the care experience for the residents and families who would come after him. I found a way to do so within Antioch University’s Leadership and Change doctoral program. The program’s design to take learning into workplaces and communities to help make positive change, improve outcomes, and engage individuals in ways that benefit the common good have come to life for me in this work. I want to thank the many people who have made it possible for me to undertake this journey.

I want to start by thanking the participants in this study, whose names have been kept confidential. This study was made possible through the sharing of your experience and your generosity, deep caring, and time. Thank you for opening your doors, hearts, and rooms so generously to me. More importantly, thank you for treating the residents in your home like family and for letting me come along on your journey to improve care for those who need our help.

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Dedication

In memory of my dad, Antonius Melis, whose lifelong caring and later life need for caring inspired me to undertake this work.
Abstract

This single, exemplar case study explored the context and social processes that shape person- and family-centered culture in a long-term care (LTC) home, using grounded theory and situational analysis for the data collection and analysis. Findings revealed one core dimension: needing to be heard, valued, and understood, and five key roles: personal support workers (PSWs), executive director (ED), senior leadership, nurse managers, and residents and families, which informed five dimensions, each focused on enhancing care for residents: (a) attending to residents’ daily care needs (PSWs), (b) advocating strategically (ED), (c) translating vision into programs and policies (senior leadership), (d) ensuring quality of care on the unit (nurse managers), and (e) seeking social connection and meaningful stimulation (residents and families). These interactions left PSWs with little autonomy, feeling rushed, focused on tasks, and prevented from building relationships with residents. The PSW perspective was often missed in decision-making, as decisions were made for this group rather than with them. A complex theoretical model of the interactions and the systemic blind spot they have unintentionally created is presented in the discussion. The results suggest that empowering PSWs is pivotal to improving quality of care in the LTC sector. Further research is needed to determine which methods of empowerment are most meaningful and effective. Future studies could also explore LTC homes of different sizes and with different types of governance, the competencies required by the different roles to foster a person- and family-centered LTC culture, and the criteria for relational practice and leadership in LTC. This dissertation is available in open access at AURA: Antioch University Repository and Archive, http://aura.antioch.edu/ and OhioLINK ETD Center, https://etd.ohiolink.edu/, and is accompanied by one supplemental file.
Keywords: long-term care, person-centered care, personal support workers, relational care, relational leadership, leadership development, organizational culture, culture change, complex adaptive systems, grounded theory, situational analysis
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Theoretical model integrating the complexities of system and organizational influences on the pivotal role of personal support workers in the provision of person-and-family centered care in long-term care.
Chapter I: Introduction

For many people, long-term care (LTC) decisions dictate the last chapter of their biographies—the chapter that should make sense of the story. LTC shapes where people live, how they live, whom they see, what they do, and the relationships transpiring within families and communities. How we choose to view LTC as a society, therefore, entails considering subjects as profound as the meaning of life. LTC is intimate care, and how it is given, when it is given, and by whom it is given shapes the biography of the LTC consumer and, by extension, the biography of family caregivers and the collective biography of the whole family. (Kane, 2001, p. 294)

This critical case study explores the social processes (micro), organizational contexts (meso), and system elements (macro) that shape person- and family-centered culture in an LTC setting. Specifically, this work seeks to understand what is happening within the complexity of providing person- and family-centered care in an LTC setting in Ontario and provides insight into how relationships between people at different levels and across different parts of the organization shape culture. In addition to these social factors, this work will also examine the organizational and system factors that play a role.

To date, the research on person- and family-centered care has identified the essential elements of implementing person- and family-centered care in LTC. These elements are action-oriented and describe the required actions that organizations need to enact to create a person- and family-centered approach to care. Rather than starting from the perspective of what needs to be done to implement person- and family-centered care, this study examines what happens in these complex interactions that allows a person- and family-centered culture to be alive in an organization. This study seeks to gain a better understanding of the elements beyond
actions that interact to shape organizational culture in an exemplar person- and family-centered LTC facility in Ontario. These elements include social processes between individuals and may also include external factors, such as ministerial and regulatory guidelines, physical design of the facility, stories that are told, metrics that are tracked, or influence of power and position. Results from this study will deepen our understanding of the lived experience of those working in the complex and changing culture of LTC and how this relates to patient-and-family-centered care.

LTC in Ontario is distinct in that it provides specific guidelines for care and is prescriptive in how care is funded. The remainder of this chapter positions LTC within Ontario’s health system and defines person- and family-centered care to contextualize the prominent features of the current system, in which this study is embedded. Later sections introduce the research question the study will address and describe the relevant literature, methodology, and the significance of this study to the field.

**LTC in Ontario**

For many people living with dementia, severe disabilities, or other afflictions that necessitate around-the-clock care, living in an LTC facility is the only affordable option. In the province of Ontario, LTC is funded and regulated by the province with strict guidelines on how homes are funded, how much residents can be charged, who is admitted, what the requirements for care are, and the setting of standards by which facility performance is measured. In this section, I describe a system that is stretched to its limits as it tries to meet increasing and complex population needs.

LTC facilities fall under Ontario’s Long-Term Care Homes Act (LTCHA; 2007), which outlines the regulations for all LTC homes and sets guidelines for homes’ physical environments, requirements for care plans, resident programming, as well as nursing and personal support
services. It also sets requirements for falls prevention, skin and wound care, continence and bowel management, pain management programs, and approaches to responsive behaviors and altercations. Furthermore, the Long-Term Care Homes Act provides guidelines on restorative care, recreational and social activities, nutrition and personal care, medical services, religious and spiritual practices, accommodation services, pets, volunteers, prevention of abuse and neglect, reporting and complaints procedures, and the use of restraints. It makes residents’ councils mandatory and outlines inspection schedules. While these comprehensive guidelines aim to improve quality of care in LTC homes, they can also restrict innovation and growth in the sector (Long Term Care Innovation Expert Panel, 2012).

In 2018, care was provided to over 100,000 individuals in 627 LTC homes licensed and approved to operate in Ontario, providing over 79,000 long-stay beds, 708 convalescent care beds for short-term care as a bridge between hospitalization and more appropriate care, and 362 respite beds for family members who needed a break from caring for their loved ones (Ontario Long Term Care Association, 2019a). In 2018, the wait list for LTC was over 32,000, with an average placement time of 160 days, which was an increase from 103 days in 2016 (Ontario Long Term Care Association, 2016b). With an aging population, wait times are expected to continue to increase, and those who require additional care from a home care system that is stretched to its limits might be at increased risk for health complications, admission to hospital, early death, or high levels of stress and uncertainty.

In 2006, the Ontario Ministry of Health and Long-Term Care created 14 Local Health Integration Networks (LHINs) that are responsible for managing their local health systems, which together, serve all Ontarians. The LHINs plan and manage performance in the acute care, LTC, community service, and mental health and addictions sectors. They bring together health
care partners from the hospital, community care, community support services, community mental health and addictions, and LTC sectors to develop solutions for more timely access to quality services for residents of Ontario (Ontario Ministry of Health and Long-Term Care, n.d.). In 2016, as part of the Patients First Act (2016), the LHINs became responsible for the integration of home and community care services, as well as for primary care (Ontario Ministry of Health and Long-Term Care, 2015).

Changes are ahead for the health care system in Ontario. An interim report from the Premier’s Council on Improving Healthcare and Ending Hallway Medicine (Devlin, 2019), acknowledges that patients and families have difficulty navigating the complex health system and that the system experiences capacity issues, and identifies the need for a more coordinated, integrated, and efficient health system. In 2019, the provincial government launched an open invitation to providers from across the continuum of care to become Ontario Health Teams, “groups of providers and organizations that are clinically and fiscally accountable for delivering a full and coordinated continuum of care to a defined geographic population” (Ontario Ministry of Health and Long-Term Care, 2019, p. 2). The intent behind creating Ontario Health Teams is “to alleviate constraints and allow providers to deliver better, faster, more coordinated and patient-centred care” (Ontario Ministry of Health and Long-Term Care, 2019, p. 4). According to the provincial government, the first Ontario Health Teams they create will demonstrate the impact of this new model and provide critical lessons for implementing the model across the rest of the province. It is unclear how the LTC sector will be integrated into the Ontario Health Teams, especially given that some homes are privately operated, some operate under a not-for-profit model, and others are municipally operated.
Cost, Spending, and the Funding Model

In 2018, the government of Ontario spent $4.28 billion on LTC, which represented 7% of the overall health care budget. According to the Ontario Long Term Care Association (2019b), for each person in LTC, this works out to approximately $100.91 a day for personal and nursing care, $12.06 for specialized therapies, recreational programs, and support services, and $9.54 for the cost of ingredients for food. The government does not pay the full cost of LTC and expects residents to pay a portion of their “room and board” to the LTC home. Daily co-payment rates, which are the same for public and privately funded homes, are set by the government and range from $39.34 for a short stay, $60.78 for a basic room, and as much as $86.82 for a private room. All homes accept residents, regardless of their ability to pay, and subsidies are available for those who cannot afford the co-payment amount. Residents must also pay for any medication and services not covered by their private insurance plans or the provincial drug benefit program, which currently requires those living in LTC to pay up to $2 per prescription.

Resident Eligibility and Referral Process

Since July 1, 2010, when the LTCHA came into full effect, only people with high or very high care needs are eligible for placement in LTC (Ontario Long Term Care Association, 2019a). At the time, the province also updated its Aging at Home Strategy, which made more funding available for in-home care. Consequently, residents of LTC facilities in Ontario have more complex needs than in the past. The majority (90%) have cognitive impairment, with one-third severely affected, and two out of three residents have Alzheimer’s disease or other dementias (Canadian Institute for Health Information, 2010, 2016).

To be eligible to live in an LTC home, individuals must be 18 years of age or older, have valid Ontario health insurance, and have care needs that require 24-hour care, frequent assistance
with activities of daily living, or on-site supervision or monitoring. Community-based services must be exhausted before persons are eligible for LTC (Ontario Ministry of Health and Long-Term Care, 2018). All applications must be submitted to the local LIHN, which assigns a case worker to assess need. Candidates can apply to up to five homes and are assigned to a waiting list depending on level of need and whether the type of bed requested is private, semi-private, or basic. If a bed becomes available, applicants have up to five days to move in. If an offer is refused, the entire application is cancelled and candidates cannot re-apply for 12 weeks, unless there is a significant change in their condition or circumstance (Ontario Ministry of Health and Long-Term Care, 2018). Applicants feel pressure to choose multiple homes and are often forced to choose ones that are suboptimal or far from home. Low-income seniors are disadvantaged as they have little choice but to take placements they can afford. The shortage of beds has also resulted in inappropriate placement of older adults living with mental health issues (Ontario Human Rights Commission, n.d.). Furthermore, the underfunded system places those with complex needs at risk because it is unable to provide personalized care. Elderly couples are often forced to separate due to placement rules, resulting in anxiety, stress, and loneliness (Ontario Human Rights Commission, 2001). Though care provision is expected to be person-centered, the referral process is out of sync with the principles of person- and family-centered care.

**Staffing**

Most care in LTC facilities, such as help with toileting, eating, hygiene, and dressing, is provided by personal support workers (PSWs), also referred to as personal care workers or health care aides, who work under the supervision of registered nurses (RNs) and registered practical nurses (RPNs). Both RNs and RPNs are responsible for skin and wound care, medication
administration, tube feeding, ostomy care, and ventilation assistance. RNs are also responsible for assessments, care planning, scheduling, and charting. Nutritionists, social workers, pharmacists, physiotherapists, and occupational therapists may be available to residents in some facilities on an as needed basis. While availability of medical care is a requirement, there is no requirement for a staff physician (Ontario Long Term Care Association, 2019a).

**LTC Homes Performance Standards**

The LTC sector is tightly regulated and closely monitored. Health Quality Ontario, the province’s advisor on health care quality, has been reporting on LTC home indicators since 2006. LTC home administrators and operators, measurement experts, resident councils, and other sector experts review the indicators and make recommendations for public reporting (Health Quality Ontario, 2015). Historically, over 30 indicators were reported, but they were decreased to the following 12 in 2012:

1. Waiting for a place in LTC home
2. Lost-time injuries on the job in LTC
3. Anti-psychotic medication use among LTC home residents without a diagnosis of psychosis
4. Diminished physical functioning among LTC home residents
5. Improved physical functioning among LTC home residents
6. Worsened symptoms of depression among LTC home residents
7. Improved behavioral symptoms
8. Potentially avoidable emergency department visits by LTC residents
9. Pressure ulcers among LTC residents
10. Pain among LTC residents
11. Falls among LTC residents

12. Use of physical restraints on LTC residents

While these indicators measure quality of care and well-being of LTC residents, none are direct measures of person- and family-centeredness or satisfaction with care. These indicators can yield positive ratings in homes where residents are not seen as individuals having value, where their personhood and dignity are not respected, where their unique needs are not met, where choices of residents and families are not considered, or where decisions are made without consultation, which are all hallmarks of person-centered care (Brooker, 2003; Kitwood, 1988).

**Accreditation and Person-Centered Care**

Accreditation of LTC facilities is carried out by Accreditation Canada or by the Commission on Accreditation of Rehabilitation Facilities (CARF). In contrast to the mandatory reporting on performance standards, accreditation is a voluntary process that LTC homes may use to assess their services and help improve quality, safety, and efficiency. CARF accredits day programs and LTC programs with or without a dementia care specialty program, and has accredited 269 homes in Ontario (CARF, 2018). Ontario homes that are accredited by either organization receive an accreditation premium (Ontario Ministry of Health and Long Term Care, 2010). CARF’s *Aging Services Standards Manual* contains several standards related to person-centered care, including leadership, having a documented person-centered philosophy, strategic planning that includes a person-centered component, input from users, performance improvement, and appropriate program and service structures (CARF, 2017).

**Criticism and System Challenges**

With an increasing number of residents with complex needs, an average resident age of 85, nine out of 10 residents exhibiting some sort of cognitive impairment, over 40% of residents
exhibiting aggressive behavior, and one in three residents being completely dependent on staff for activities of daily living, the burden on Ontario’s LTC sector is heavy (Ontario Long Term Care Association, 2016a). This pressure will only continue to increase in a province where the number of seniors aged 65 and over is projected to almost double from 2.4 million (16.7% of the population) in 2017, to 4.6 million (24.8% of the population) by 2041 (Ontario Ministry of Finance, 2018). System challenges include an out-of-date infrastructure, not enough homes in rural communities, difficulties around managing the behavioral concerns associated with dementia, and the lack of transparency and unpredictability of funding.

In 2011, the Conference Board of Canada released a report on the state of the LTC sector and options for renewal entitled, *Elements of an Effective Innovation Strategy for Long Term Care in Ontario*, which was commissioned by the Ontario Long Term Care Association and included the following statement:

Long-term care is struggling to meet current requirements and is ill-prepared for the challenges that will emerge over the next two decades. Unless significant steps are taken to prepare the sector to operate more effectively within an integrated system of care for older adults, Ontarians will be left with an unsustainable system that fails to provide the care they require in their final years. (Conference Board of Canada, 2011, p. 27)

The Ontario Public Service Employees Union (OPSEU) represents 130,000 workers across Ontario, including 3,000 LTC home workers. The union has expressed deep concerns about chronic understaffing, low care standards, and cuts to services. In an article responding to Bill 160, the Strengthening Quality and Accountability for Patients Act, OPSEU argued that when residents have higher levels of need, it leads to staff who are overworked, rushed, and expected to do more with less, putting both staff and residents at risk (OPSEU, 2017).
The concerns raised by the Conference Board of Canada and OPSEU highlight a system under pressure. The LTC context in Ontario is a challenging one, where the demand for services is growing, resources are limited, and public expectations are high. It is within this challenging context that efforts to implement person-centered care—and this study—are taking place.

**Person- and Family-Centered Care**

Roles and responsibilities for Canada’s publicly funded health care system are shared between provincial or territorial governments and the federal government. Provinces and territories are responsible for the management, organization, and delivery of health care services to their residents. The federal government sets national standards for the health care system and provides some funding support. Health reforms currently underway in Canada fall under provincial jurisdiction and aim to improve quality of care and better address the needs, wishes, and choices of Canadians. The approaches to health care reform in each province are therefore somewhat different. The shift from a medically-focused health care system to a person-centered one is desired across the spectrum of care, including the LTC sector (British Columbia Ministry of Health, 2014, 2015; Dagnone, 2009; Ontario Ministry of Health and Long Term Care, 2015).

Dimensions of person-centered care now form the basis of institutional policies and health care reforms (Groene, 2017) and the Canadian Medical Association (2010) has defined person-centered care, from a medical system perspective, as:

Seamless access to the continuum of care in a timely manner, based on need and not the ability to pay, that takes into consideration the individual needs and preferences of the patient and his/her family, and treats the patient with respect and dignity. (p. 6)

Similar elements also apply to person- and family-centered care approaches in LTC and to those living with dementia (Kitwood, 1988; Sabat, 2001). Person-centered care in relation to
those with dementia has four major elements (Brooker, 2003; Kitwood, 1988). The first is valuing people with dementia and those who care for them, which includes seeing persons with dementia as worthy of respect, as persons who can still make things happen in the world, and as valued members of society. The second is treating people as individuals, which includes seeing the uniqueness of individuals and ensuring care meets the needs of individuals rather than a group. The third is looking at the world from the perspective of the person with dementia in order to better understand their needs. The last element is creating a positive social environment in which the person with dementia can experience relative well-being. This ensures that persons with dementia have the opportunity for social and loving relationships with those around them and emphasizes the importance of care relationships that are built over time through day-to-day interactions (Brooker, 2003).

Although there is no single definition of person- and family-centered care, for the purposes of this research, I will use the following definition, derived from a compilation of the literature: Person- and family-centered care in LTC is organized around the resident; respects the resident’s values, preferences, and needs (physical, medical, social, emotional, and spiritual); is integrated throughout care; and is provided in partnership with the resident and family, as desired (Brooker, 2003; Canadian Medical Association, 2010; Frampton et al., 2008; Kitwood, 1988; Lines et al., 2015).

In the context of this study, the term family refers to individuals who are related to (biologically, emotionally, or legally) or have close bonds with (friendships, commitments, shared households and child rearing responsibilities, and romantic attachments) the person receiving health care. A person’s family includes all those whom the person identifies as
significant in his or her life, such as parents, caregivers, friends, substitute decision-makers, groups, communities, and populations (Registered Nurses’ Association of Ontario, 2015).

**Rationale for the Study**

To date, much of the research on person-centered care has focused on the key elements required for the implementation of person-centered care. Studies have identified elements such as the importance of a clear vision for person- and family-centered care (Kirkley et al., 2011; Luxford et al., 2011; Miller, Lepore, et al., 2014; Shaller, 2007); strong leadership that is collaborative, participatory, and empowers staff; inclusion of residents and family in decision-making (Brownie & Nancarrow, 2013; Engle et al., 2017; Flieger, 2017; Kirkley et al., 2011; Luxford et al., 2011; Scalzi et al., 2006; Shaller, 2007); and a supportive work environment with appropriate policies, internal feedback systems, and systemic measurements of progress (Engle et al., 2017; Luxford et al., 2011; Scalzi et al., 2006; Shaller, 2007). Some of the barriers to implementation identified in the literature include the difficulty of a cultural and mental model shift from one that is provider- or system-focused to one that is person- and family-centered, a focus on compliance, a mismatch of incentives and rewards, competing and conflicting goals, and leadership challenges (Engle et al., 2017; Luxford et al., 2011; Scalzi et al., 2006).

Shifting organizational culture from one that is focused on providers and on facilities’ routines to one that is person- and family-centered is complex and requires a creative, organic approach that considers both organizational and human factors (Chapin, 2008, 2010; Liberati et al., 2015). What is not well described in the literature are the human and nonhuman interactions at the micro, meso, and macro levels that shape such a person- and family-centered culture. It is also not clear how, in a province like Ontario, with regulations that are the same for all organizations, some organizations are able to foster a thriving person- and family-centered
culture while others appear to struggle. This study examines what happens in these complex interactions that allows a person- and family-centered culture to *be alive* in an organization.

The literature review reveals that much is known about the dimensions of implementing person- and family-centered care, both from a system (Canadian Medical Association, 2010; Fooks et al., 2015) and an organizational (Alzheimer Society of Canada, 2011) and professional perspective (Registered Nurses’ Association of Ontario, 2015). Many of the enablers, such as engaged senior leadership, a collaborative approach, staff empowerment, a supportive work environment, and support for personal and organizational learning are relational in nature (Brownie & Nancarrow, 2013; Flieger, 2017; Kirkley et al., 2011; Shaller, 2007). The barriers to implementing a patient- and family-centered culture include factors that are also relational in nature, such as conflicts between individuals, poor teamwork, and a medically-focused mind-set (Engle et al., 2017). However, these are not the only barriers. Organizational factors such as conflicting regulations, resources, staffing, patient acuity, rigid bureaucracy, and mismatched incentives are also described in the literature (Engle et al., 2017; Luxford et al., 2011; Scalzi et al., 2006).

In addition to these barriers, it is important to note that culture change takes time, is complex, creative, organic, and is influenced by leaders as well as organizational policy and procedures, and requires personal and organizational learning (Chapin, 2008; Schein, 2017).

As outlined in Chapter II, previous studies have focused on what leaders need to do to implement person- and family-centered care, but they have not identified the critical elements of a person- and family-centered culture from a relational, interpersonal perspective (the micro level), how the organizational environment shapes this culture (meso level), or what role the health system plays in this area (macro level). The literature review will explore the evolution of
person- and family-centered care in LTC, implementation elements, as well as organizational culture and climate as they apply to person- and family-centered care.

**Research Questions**

The two overarching research questions for this study are: (a) How is person- and family-centered culture shaped in LTC? and (b) What are the relationships among factors that influence the desired culture? In addition, the following questions also shape the study:

- What allows an LTC facility to be successful in implementing a person- and family-centered approach in an environment that is highly regulated?
- How is this approach lived throughout the organization by its employees?
- What interactions between individuals at the senior, middle management, and point-of-care levels make a person- and family-centered approach possible and help embed it in attitudes, behaviors, and mental models?
- What barriers must be overcome in order for a patient- and family-centered approach to thrive in an LTC facility?

I am most interested in understanding the interconnecting complexities of human and nonhuman elements that contribute to this culture. To achieve this, I will explore these questions in an organization that has deliberately implemented a person- and family-centered care approach. This lends itself to an exploratory exemplar case study approach (Yin, 2014). A grounded theory, situational analysis methodology (Clarke, 2005) is appropriate to investigate the complex environment of person- and family-centered culture at the levels of individual (micro), organizational (meso), and system (macro) interactions.
Approach and Methodology

This study seeks to understand the interactions that shape person- and family-centered culture in LTC. It is not only social processes that shape this culture; organizational and system factors play a role as well (Chapin, 2008, 2010; Liberati et al., 2015). I will use an exploratory critical case study approach with a grounded theory and situational analysis methodology, in which each method will build on the findings of the other to create an integrated understanding of the societal, organizational, and interpersonal forces that shape the culture of care in the exemplar case.

Case Study Approach

To conduct this research, I have selected a case study design, which is used to explore a how-or-why question in the real world, over which the researcher has little control (Yin, 2014). The case study takes the micro, meso, and macro contexts of one organization into consideration and enhances the interpretive power of the study (Holloway & Dezenberg, 2018). The uniqueness of this study design is that the outcome concerns organizational culture, which is contributed to by the behaviors, attitudes, and perceptions of individuals as well as by organizational design, regulations, and policies (Schein, 2017). The case study approach will assist in defining the bounded context within which the grounded theory and situational analysis methods for data collection and analysis will be used, and it will increase rigor by contextualizing the experience within this defined context (Holloway & Dezenberg, 2018).

Grounded Theory

This study examines what happens in a setting that has implemented a person- and family-centered care approach. Leadership and the interaction between individuals play an important role in this approach, and grounded theory’s aim “to develop explanatory theory
concerning common social life patterns” (Annells, 1996, p. 380) fits well with the purpose of this study. Grounded theory is used to move from describing what is happening to understanding the social processes by which it is happening (Strauss & Corbin, 1990).

**Situational Analysis**

Understanding person- and family-centered culture goes beyond understanding social interactions and therefore needs to take the complexity of the bigger picture into account. Whereas the guiding metaphor for grounded theory is the *action-centered basic social process*, in situational analysis, the *situation* is the key unit of analysis (Clarke et al., 2017). Situational analysis is used to make sense of dense complexities by creating three types of maps to frame and analyze the situation of inquiry: “situational maps, social world/arenas maps, and positional maps” (Clarke et al., 2017, p. 86). The situational maps lay out the “major human, nonhuman, discursive, affective, geopolitical and other elements in the research situation of inquiry and provoke analysis of relations among them” (Clarke et al., 2017, p. 86). A social world/arena map describes the major actors and the “arena(s) of commitment and discourse with which they are engaged in ongoing negotiations in the situation of inquiry” (Clarke et al., 2017, p. 86). The positional maps “lay out the major positions taken and not taken in the discussions, debates, and extant discourse materials in the situation of inquiry vis-à-vis particular axes of differences, concern and controversy about important issues” (Clarke et al., 2017, p. 86). Any documents, cultural objects, or social media content are part of the analysis, contrary to grounded theory methods.

**Positionality of the Researcher**

Charmaz recognized the importance of the researcher’s positionality in grounded theory and that there is “an obligation . . . to recognize our taken for granted assumptions about the
world and how they influence our actions as researchers” (Birks & Mills, 2015, p. 53). My clinical background is in physiotherapy and, having worked in a hospital, I understand the clinical environment (Birks & Mills, 2015). I completed a Master’s degree in rehabilitation science, focusing on the use of assistive devices by persons with spinal cord injuries who were learning to walk with functional electrical stimulation. After my clinical work, I taught physiotherapy at a Canadian university and subsequently worked in research funding organizations. That is when I became interested in how leadership contributes to the optimal functioning of organizations and the role leaders play in providing quality health care. I completed my executive coaching certification and became interested in the interaction between individuals from a leadership perspective. Currently, I have an independent coaching and leadership development practice and work as an independent consultant in health care organizations.

I am interested in assessing the organizational culture and climate as it pertains to person-centered care for two reasons: (a) it relates directly to the work I do, and (b) it relates to my personal experience with LTC. Much of my leadership development work in health care focuses on fostering the development of individual leaders. What I have seen in organizations is a disconnect between what organizations want their leadership and organizations to be about and what actually happens. Schein (2017) refers to this as the difference between espoused values (conscious strategies, goals, and philosophies) and lived values (unconscious, taken for granted beliefs, perceptions, thoughts and feelings, and the ultimate source of values and action). I am interested in better understanding the different aspects of organizational culture and climate and how I can help organizations close the gap between organizational espoused values and lived values.
I am particularly interested in organizational culture and climate as it relates to person- and family-centered care, in part because of what much of Canadian health system reform is about but also for personal reasons. My family’s experience with LTC was not person- or family-centered. My father had Alzheimer’s disease and was admitted to an LTC facility in the summer of 2013. He could not speak for himself and his voice was not heard—nor was my family’s. We experienced care that was provider- and health system-centric, which was not only emotionally difficult for my family but it also resulted in errors in care and ultimately, my father’s death four months later. Since then, I have been searching for a way to contribute to improving care for residents in LTC facilities. With this work, I have an opportunity to help organizations, residents, and families.

I am a white, cis-gendered, heterosexual, first-generation Canadian. I was born and raised in the Netherlands. At 18 years of age, I moved to Montreal and attended McGill University the following year. Dutch society is generally quite positivist; working hard is rewarded and talking about feelings is avoided. It gave me my work ethic and strong organizational skills. Coming to Canada, to a cosmopolitan city, opened my world to a variety of cultures, and speaking French allowed me to appreciate Quebec culture. In fact, being fluent in four languages has made me realize how culture and language influence how we experience the world. Completing my executive coaching certification made me aware of concepts like motivation, emotional intelligence, world views, and how our assumptions influence the way we interpret the words and actions of others. I was comfortable with a positivist worldview as a young adult; now I see the world from a constructivist point of view. The hallmark of the constructivist worldview is that it presumes that all social reality is “relative to the individuals involved, and to the particular context in which they find themselves” (Lincoln & Guba, 2013, p. 39). It means that I am aware
of and take into consideration how my own knowledge, values, and assumptions influence my interactions and how I make meaning of the world around me. Ontologically, it means that concepts exist because a group has decided to define a concept a certain way; constructivism presupposes relativism. Epistemologically, it means that each person’s reality is context specific and therefore, I need to be aware of the validity of each of these perspectives in my data collection and analysis. Methodologically, it means that I will use methods that allow for individual meaning making to surface and I will seek out varying perspectives. The qualitative methods—particularly grounded theory and situational data analysis methodology—are aligned with the constructivist view.

**Ethical Considerations**

Confidentiality is the biggest ethical concern in this study, as participants may feel that their employment or relationships could be at risk as they share their experiences of implementing person- and family-centered care. All participants will come from the same organization and publishing direct quotes in the study might identify individuals. Throughout the research process, I will ensure the identity of individuals remains confidential; during interviews, memo-writing, transcription, and in working with the transcription team.

I have obtained ethical approval through Antioch University’s Institutional Review Board (IRB) and through certification from the Collaboration Institutional Training Initiative (CITI) program. Participation in the study was voluntary. Each study participant was asked to sign a consent form (see Appendix B), had the opportunity to ask questions, and was able to withdraw from the study at any point in time without any negative consequences. I also signed a confidentiality the organization’s confidentiality agreement, which binds me not to divulge any confidential information.
Why This Study Matters

Understanding what happens in the relationships between individuals within an LTC organization, as well as the interconnectedness of the complexities that are part of LTC in Ontario, contributes to our understanding of how we can create sustainable change in LTC to create a more dignified, safe, and quality environment for those who are dependent on others for their care. This work will contribute to practice at three levels: the social relational level, the organizational level, and the health system level.

This research builds on previous work that sought to understand the facilitators and barriers to person-centered care that have illustrated the importance of staff empowerment, collaborative leadership, and coordination across departments (Caspar et al., 2009; Engle et al., 2017; Scalzi et al., 2006). Rather than assessing predetermined factors that influence a person- and family-centered culture, I sought to understand what is happening within the complexity of an LTC organization in Ontario that has been deliberate about providing person- and family-centered care. Rather than extrapolating across organizations or sites, my work focuses on one environment and provides theoretical concepts based on the interaction of personal, organizational, and system interconnectivity. It will allow for a deeper and more detailed understanding of a person-centered approach from the perspective of those who live it in their daily work lives.

Results of this study will help leaders in LTC organizations become more aware of this interconnectedness and foster better conversations, leading change toward a person- and family-centered culture. Results of this study will also be of interest to policy makers and health system planners working to effect system change.
Chapter II: Literature Review

Person-centered care has become a central component of health care reforms in Canada, including a focus on person- and family-centered care in the LTC sector. Creating a person- and family-centered culture is complex and requires a creative approach that is organic and influenced by organizational and human factors (Chapin, 2008). This literature review discusses the research that informs person- and family-centered care, its implementation in the LTC setting, and the scholarship of organizational culture and climate. This chapter is divided into five sections. In the first, I provide an overview of the different terms and concepts used when discussing person- and family-centered care. Next, I discuss the literature regarding the practices and barriers to implementing person- and family-centered care. In the third section, I provide a brief discussion of the culture change movement. This is followed by a discussion of the literature on organizational culture and climate in general. Finally, I discuss the literature on organizational culture and climate in health care and how it pertains to person- and family-centered culture in LTC specifically.

Person- and Family-Centered Care

Patient-centered care is a term frequently used in health care. In fact, many of Canada’s health reform initiatives have focused on the concept of patient-centered care (Canadian Medical Association, 2010). Related terms, such as person-centered and person-directed care, have often been used interchangeably, as have terms like patient engagement and patient experience. However, these terms have different underlying concepts and various interpretations, which can be confusing (Fooks et al., 2015; Lines et al., 2015). Patient-centered care is an approach that can be understood from a systems perspective and from an organizational perspective, both of which are provided below. This section outlines the different terms used in patient- and person-centered
care, followed by the eight dimensions of person-centered care (organizational perspective) (Registered Nurses’ Association of Ontario, 2015) and the elements of the charter of patient-centered care (Canadian system perspective; Canadian Medical Association, 2010). Table 2.1 provides an overview of the different terms associated with patient- and person-centered care.

**Table 2.1**

*Definitions of Person- and Patient-Centered Care*

<table>
<thead>
<tr>
<th>Term</th>
<th>Definition</th>
<th>Source</th>
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<tbody>
<tr>
<td>Patient-centered care</td>
<td>Care that is respectful of and responsive to the preferences, needs, and values of the individual, ensuring that the recipient’s values guide all clinical decisions. A model in which providers partner with patients and family to identify and satisfy the full range of patient needs and preferences. Seamless access to the continuum of care in a timely manner, based on need and not the ability to pay, that takes into consideration the individual needs and preferences of the patient and his/her family, and treats the patient with respect and dignity. Patient-centered care is about the overall philosophy and approach that ensures that everything individual providers or healthcare organizations do clinically or administratively is based on patient needs and preferences. This covers planning, care, evaluation and research, training and staff recruitment.</td>
<td>Institute of Medicine, 2001, p. 3 Frampton et al., 2008, p. 4 Canadian Medical Association, 2010, p. 6 Fooks et al., 2015, p. 9</td>
</tr>
<tr>
<td>Patient engagement</td>
<td>Patient engagement is the way in which individual providers or healthcare organizations solicit patient needs and preferences to ensure they are delivering patient-centered care (p. 9).</td>
<td>Fooks et al., 2015, p. 9</td>
</tr>
</tbody>
</table>

Fooks et al. (2015) defined the concept of patient-centered care from a Canadian health system perspective as being about the overall philosophy and approach to care provision. In other words, it is about ensuring that administrative and clinical functions are based on patient needs and preferences. This permeates the organization and includes not only patient care, but also areas such as planning, research, evaluation, training, and staff recruitment. Two related concepts are *patient engagement* and *patient experience*. Fooks et al. defined patient engagement as “the way in which individual providers or healthcare organizations solicit patient needs and preferences to ensure they are delivering patient-centered care” (p. 9). They explained that patient experience relates to how patients perceive and experience their care, which involves the ability “to hear what is being said, measure the experience and develop capacity to use the
Fooks et al. provided recommendations for improvements in all three areas and highlighted the fact that better patient care is facilitated by better system integration, increased ability to share electronic records, and a reexamination of the way providers are funded. The authors suggested that improvements for patient engagement were needed at the direct care, organizational design, and governance levels. Finally, they provided suggestions for a patient experience that includes patients and families (if desired) in decision-making, access to health records, considers differences of needs in rural versus urban areas, considers changing conditions and policies in LTC facilities, and sees families as valuable partners and knowledgeable sources of information and care. Similar to the three spheres outlined by Fooks et al., the focus of the present research project is not only on what happens at the point of care but also on exploring person- and family-centered care at the philosophical, organizational, and systemic levels. The research methods used in this study match the need to understand the complexity at these three levels that shape person- and family-centered culture in LTC.

The Institute of Medicine (US) Committee on Quality of Health Care in America (2001) defined patient-centered care as care that is “respectful of and responsive to the preferences, needs, and values . . . [and] ensuring that the recipient’s values guide all clinical decisions” (para. 17). One study indicated that person-centered care focuses on the entire person, not just his or her medical condition, and aims to know the whole person and their experience of health over time (Olsson et al., 2013). Another study suggested that person-directed care puts the individual in control of their care, emphasizing not only their medical diagnosis and physical and medical needs but also their social, mental, emotional, and spiritual needs (Lines et al., 2015). A third study explained that person-centered care extends the perspective of patient-centered care
by considering the whole person; the goal of person-centered care is a meaningful life, while that of patient-centered care is a functional life (Håkansson Eklund et al., 2019). In the broadest sense, according to Lines et al. (2015), person-centered and person-directed care approaches represented a paradigmatic shift away from the biomedical approach, emphasizing social, mental, emotional, and spiritual needs, as well as individuals’ strengths, weaknesses, preferences, and values.

Person-first language originated in the disability community, where individuals wanted to be recognized as whole persons, rather than for their conditions or illnesses (Snow, 2009). The term person-centered first surfaced in clinical psychotherapy, when Carl Rogers (1961) introduced client-centered psychotherapy, in which he viewed clients as the experts on themselves. Since then, it has been applied at the health system, health care setting, and at the health professional levels.

The origins of person- and family-centered care can be traced to the development of concepts related to patient-centered care. A key book on patient-centered care, Through the Patient’s Eye: Understanding and Promoting Patient-Centered Care (Genteis et al., 1993), focused on hospital care and, for the first time, described how the organization of hospital systems impacted the quality of care from the perspective of patients and their families. It was the result of a five-year project by the Pickering-Commonwealth Program for Patient-Centered Care and drew on information from focus groups, survey data, site visits, and literature reviews. Many of the book’s practical suggestions have been addressed in institutional policies and health care reforms (Groene, 2017). The book identified seven dimensions of patient-centered care, which the Picker Institute then expanded upon by adding access to care as the eighth element, and in 1987, these dimensions became the eight Picker Principles of Patient-Centered Care.
(Picker, n.d.). As shown in Table 2.2, the Registered Nurses’ Association of Ontario (2015) adopted these eight principles in their dimensions of the more holistic person- and family-centered care.

**Table 2.2**

*Eight Dimensions of Patient-Centered Care*

<table>
<thead>
<tr>
<th>Dimension</th>
<th>Description</th>
</tr>
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<tbody>
<tr>
<td>Respect for patients’ values, preferences, and expressed needs</td>
<td>Treating individuals with respect, in a way that maintains their dignity and demonstrates sensitivity to their cultural values. Keeping individuals informed about their condition and involving them in decision-making. Focusing on the person’s quality of life, which may be affected by their illness and treatment.</td>
</tr>
<tr>
<td>Coordination and integration of care</td>
<td>Coordinating and integrating clinical and patient care and services to reduce feelings of fear and vulnerability.</td>
</tr>
<tr>
<td>Information, communication and education</td>
<td>Providing complete information to individuals regarding their clinical status, progress, and prognosis; process of care; and information to help ensure their autonomy and their ability to self-manage, and to promote their health.</td>
</tr>
<tr>
<td>Physical comfort</td>
<td>Enhancing individuals’ physical comfort during care, especially with regard to pain management, support with the activities of daily living, and maintaining a focus on the hospital environment (e.g., privacy, cleanliness, comforts, accessibility for visits).</td>
</tr>
<tr>
<td>Emotional support and alleviation of fear and anxiety</td>
<td>Helping to alleviate fear and anxiety the person may be experiencing with respect to their health statute (physical status, treatment, and prognosis), the impact of their illness on themselves and others (family, caregivers, etc.), and the financial impacts of their illness.</td>
</tr>
<tr>
<td>Dimension</td>
<td>Description</td>
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<tr>
<td>---------------------------------</td>
<td>-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Involvement of friends and</td>
<td>Acknowledging and respecting the role of the person’s family and friends in their health care experience by:</td>
</tr>
<tr>
<td>family</td>
<td>• Accommodating the individuals who provide the person with support during care</td>
</tr>
<tr>
<td></td>
<td>• Respecting the role of the person’s advocate in decision-making</td>
</tr>
<tr>
<td></td>
<td>• Supporting family members and friends as caregivers, and recognizing their needs</td>
</tr>
<tr>
<td>Continuity and transition</td>
<td>Alleviating anxiety about the person’s ability to self-manage after discharge by:</td>
</tr>
<tr>
<td></td>
<td>• Providing information regarding medication, physical restrictions, nutrition, etc.</td>
</tr>
<tr>
<td></td>
<td>• Coordinating ongoing treatment and services and sharing this information with the person and their family</td>
</tr>
<tr>
<td></td>
<td>• Providing information regarding access to supports (e.g., social, physical, and financial) on an ongoing basis</td>
</tr>
<tr>
<td>Access to care (added element)</td>
<td>Ensuring, mainly with respect to ambulatory care:</td>
</tr>
<tr>
<td></td>
<td>• Access to multiple health care settings and services</td>
</tr>
<tr>
<td></td>
<td>• Availability of transportation</td>
</tr>
<tr>
<td></td>
<td>• Ease of scheduling and availability of appointments</td>
</tr>
<tr>
<td></td>
<td>• Access to specialists and specialty services when needed</td>
</tr>
</tbody>
</table>


**Patient-Centered Care**

The Picker Institute, which was established in 1994 and is dedicated to evidence-based patient-centered care, defined patient-centered care broadly as care that is organized around the
patient (Frampton et al., 2008). In their Patient-Centered Care Improvement Guide, Frampton et al. (2008) described patient-centered care as “a model in which providers partner with patients and family to identify and satisfy the full range of patient needs and preferences” (p. 4). They also stated that in order for patient-centered care to succeed, staff experience must be included; staff must feel cared for as well. The authors emphasized the importance of building a patient-centered culture and developing strong foundations through the engagement of leadership, staff, physicians, volunteers, patients, and families. They pointed out that the interactions that occur within health care are the drivers of any effective patient-centered approach, including interactions between staff, physicians, administration, volunteers, board members, as well as families and patients. Furthermore, Frampton et al. (2008) suggested that leaders build credibility through leading by example, modeling the organization’s values and expecting the same from others, and by creating a respectful environment with strong teams that are accountable for and meet behavioral expectations.

In Canada, patient-centered care has been discussed in various contexts. The Canadian Medical Association (2010) defined it as:

Seamless access to the continuum of care in a timely manner, based on need and not the ability to pay, that takes into consideration the individual needs and preferences of the patient and his/her family, and treats the patient with respect and dignity. (p. 6)

The Canadian Medical Association proposed a Charter for Patient-Centered Care that would form the foundation of a culture of patient-centered care. The seven elements of the charter are outlined in Table 2.3. It is important to note that these elements were provided from a Canadian health system lens and built on the five founding principles of Canadian Medicare, which are:
• universality (all insured residents are entitled to the same level of health care);
• accessibility (all insured persons have reasonable access to health care facilities);
• comprehensiveness (all necessary health services, including hospitals, physicians and surgical dentists, must be insured);
• portability (a resident that moves to a different province or territory is still entitled to coverage from their home province during a minimum waiting period); and
• public administration (all administration of provincial health insurance must be carried out by a public authority on a non-profit basis; The Canada Health Act, 1984).

Table 2.3

Elements of the Charter for Patient-Centered Care

<table>
<thead>
<tr>
<th>Elements</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dignity and respect</td>
<td>All persons are treated with compassion, dignity and respect. Health care is provided in an environment that is free from discrimination and/or stigma of any kind. Health care services respond to individual needs and give consideration to personal preferences.</td>
</tr>
<tr>
<td>Access to care</td>
<td>Access to and timeliness of appropriate medical and psychiatric services is determined by health need. Access to appropriate services is not limited by the patient’s ability to pay. Care is continuous between health care providers and across settings.</td>
</tr>
<tr>
<td>Safety and appropriateness</td>
<td>Care is provided in accordance with the applicable professional standard of care, by appropriately qualified health care providers, regardless of the location of service. Care is based upon the best available evidence and is provided in the safest possible environment. The quality of all health care services is evaluated, monitored and improved proactively. Care is informed and influenced by lessons learned from any critical incident or adverse event and by patient experiences.</td>
</tr>
<tr>
<td>Elements</td>
<td>Description</td>
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<td>--------------------------------</td>
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</tr>
<tr>
<td>Privacy and security of information</td>
<td>Personal health information is collected, stored, accessed, used, disclosed and accessible to patients in accordance with applicable law and professional codes of ethics. Providers and recipients of care share responsibility for the accuracy and completeness of information in personal health records.</td>
</tr>
<tr>
<td>Decision-making</td>
<td>Patients participate actively with providers in decisions about their medical care and treatment. Personal support and assistance with communication is available when required. Patients may appoint another person (proxy decision-maker) to act on their behalf and to be aware of their personal health information. Decisions for care are made with full disclosure of all relevant information. Patients may consent to or refuse any examination, intervention or treatment, and may change or vary their decisions without prejudice. Individuals may decline to participate in research without prejudice.</td>
</tr>
<tr>
<td>Insurability and planning of health services</td>
<td>All parties use health care resources appropriately. Recipients and providers are informed and are able to be involved directly, or through representatives, in the planning, organization, delivery and evaluation of health care services. Decisions about the provision and insurability of drugs and all other treatments or services are made in accordance with evidence and best practices. Government decision-making with respect to the planning, regulation and delivery of health care products and services is transparent.</td>
</tr>
<tr>
<td>Concerns and complaints</td>
<td>Patients may comment on any aspect of their personal health care and have concerns investigated and addressed without repercussions. Patients receive timely information and an expression of regret and sympathy if there is any adverse event during their care, regardless of the reason for such event. Providers speak publicly and advocate on behalf of Canadians for the provision of high quality care.</td>
</tr>
</tbody>
</table>

There is considerable overlap between the system elements identified by the Canadian Medical Association and the practical implementation dimensions of the *Picker Principles of Patient-Centered Care* (Picker, n.d.). Dignity and respect, involvement in decision-making by persons and families, and the concept of integrated and accessible care are woven through both perspectives. These same threads are also applied to person-centered care approaches in LTC.

**Person-Centered Care**

The term, person-centered care, was first used in dementia care by Kitwood (1988) as a way to emphasize communications and relationships necessary to maintain personhood for those living with dementia. Kitwood described personhood as “a standing or status that is bestowed upon one human being, by others, in the context of relationships and social being. It implies recognition, respect and trust” (p. 161). Sabat (2001) was also influential in contributing to the understanding that persons with dementia have selfhood. As mentioned in Chapter I, person-centered care in relation to those with dementia has four major elements: (a) valuing people with dementia and those who care for them, (b) treating people as individuals, (c) looking at the world from the perspective of the person with dementia in order to better understand their needs, and (d) fostering a positive social environment in which the person with dementia can experience relative well-being (Brooker, 2003; Kitwood, 1988).

The person- and family-centered care literature recognized that families, however defined, are essential to a person’s health and well-being and are allies for quality and safety in the health system (Frampton et al., 2003; Genteis et al., 1993; Johnson et al., 2008). Furthermore, House (2002) suggested that the very young, the very old, and those with chronic conditions are those most dependent on families, while Johnson et al. (2008) asserted that families are more than surrogates; they are essential members of the caregiving team.
Implementation of Person- and Family-Centered Care

In 2011, the Alzheimer Society of Canada published Guidelines for Care: Person-Centred Care of People with Dementia Living in Care Homes Framework, which defined a person-centered philosophy as a “focus on the individual rather than the condition, and on the person’s strengths and abilities rather than losses” (p. 10). The philosophy recognized that individuals have unique values, personal histories, and personalities, and that “each person has an equal right to dignity, respect, and to participate fully in their environment” (p.10). It presented a holistic approach that takes the specific needs of each person into account with the ultimate goal of creating a partnership among staff, residents, and their families to enhance quality of life and quality of care and to optimize health outcomes for residents. The guidelines recommended that services and supports be designed and delivered in an integrative, collaborative, and mutually respectful way.

Key person- and family-centered care implementation practices have been documented across settings by several authors (Brownie & Nancarrow, 2013; Engle et al., 2017; Flieger, 2017; Kirkley et al., 2011; Luxford et al., 2011; Scalzi et al., 2006; Shaller, 2007; Tellis-Nayak, 2007) and included: (a) having a strong senior leadership and a clear vision; (b) a collaborative approach; (c) capacity-building at all levels of the organization that includes person and organizational reflection and learning; (d) a supportive work environment with fitting policies, feedback mechanisms, evaluation practices, communication, and conflict resolution; and (e) the inclusion of residents and families in decision-making. Some of the barriers that were identified include the acuity of residents, a mismatch of support and incentives, and difficulty shifting toward a person-centered mind-set from one that has been provider- or system-focused. Table
2.4 outlines the key practices and barriers to implementing person- and family-centered care that were identified in the literature.

**Table 2.4**

*Implementation Practices and Barriers to Implementing Person and Family-Centered Care*

<table>
<thead>
<tr>
<th>Key concept</th>
<th>Sources</th>
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<tbody>
<tr>
<td><strong>Implementation practices</strong></td>
<td></td>
</tr>
<tr>
<td>A clear vision and organization-wide definition of person- and family-</td>
<td>Kirkley et al., 2011; Luxford et al., 2011;</td>
</tr>
<tr>
<td>centered care for the organization.</td>
<td>Miller, Lepore, et al., 2014; Shaller, 2007</td>
</tr>
<tr>
<td>A senior leadership team that champions, values staff, values and models</td>
<td>Brownie &amp; Nancarrow, 2013; Engle et al.,</td>
</tr>
<tr>
<td>person and family-centered care, and models a participative leadership</td>
<td>2017; Flieger, 2017; Kirkley et al., 2011;</td>
</tr>
<tr>
<td>style.</td>
<td>Luxford et al., 2011; Scalzi et al., 2006;</td>
</tr>
<tr>
<td></td>
<td>Shaller, 2007</td>
</tr>
<tr>
<td>A collaborative leadership approach that is inclusive and that empowers</td>
<td>Flieger, 2017; Shaller, 2007; Tellis-Nayak,</td>
</tr>
<tr>
<td>staff.</td>
<td>2007</td>
</tr>
<tr>
<td>Capacity-building at all levels that includes leadership development, the</td>
<td>Engle et al., 2017; Luxford et al., 2011</td>
</tr>
<tr>
<td>ability to hold and understand multiple perspectives, communication,</td>
<td></td>
</tr>
<tr>
<td>coaching skills and conflict resolution.</td>
<td></td>
</tr>
<tr>
<td>A supportive work environment that includes policies that include patient</td>
<td>Engle et al., 2017; Luxford et al., 2011;</td>
</tr>
<tr>
<td>and family-centered care, adequate resources and staffing, an internal</td>
<td>Scalzi et al., 2006; Shaller, 2007</td>
</tr>
<tr>
<td>feedback system and incentives and reward systems fostering person and</td>
<td></td>
</tr>
<tr>
<td>family-centered care and includes systemic measurement of progress.</td>
<td></td>
</tr>
<tr>
<td>Time for personal and organizational reflection and learning.</td>
<td>Flieger, 2017; Kirkley et al., 2011</td>
</tr>
<tr>
<td>Inclusion of residents and families in decision-making.</td>
<td>Luxford et al., 2011; Scalzi et al., 2006;</td>
</tr>
<tr>
<td></td>
<td>Shaller, 2007</td>
</tr>
</tbody>
</table>
### Key concept

#### Barriers

| The difficulty of a cultural and mental model shift from one that is provider or system-focused to one that is person- and family-centered. | Engle et al., 2017; Luxford et al., 2011; Scalzi et al., 2006 |
| A focus on compliance, a mismatch of incentives and rewards, and competing and conflicting goals. | Engle et al., 2017; Luxford et al., 2011; Scalzi et al., 2006 |
| Procedural, systems, regulatory and leadership challenges. | Engle et al., 2017; Luxford et al., 2011; Scalzi et al., 2006 |
| Acuity of residents. | Engle et al., 2017; Luxford et al., 2011; Scalzi et al., 2006 |

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**Clear Vision and Definition of Person- and Family-Centered Care**

Luxford et al. (2011) found that setting a clear vision for and definition of person- and family-centered care was essential to implementation success. Strong, committed senior leadership and communication of the strategic vision were also important. Furthermore, Miller, Looze, et al. (2014) determined that it was vital to have an organization-wide common conceptualization of person-centered care, along with a shared understanding of what that meant from different perspectives within the organization.

**Senior Leadership Team Engagement**

Shaller (2007) identified several strategies that were critical to the uptake of client-centered care, including the role of senior leadership (i.e., the CEO and the board of directors) in supporting the organizational change to a person-centered care model. Specifically, Shaller focused on senior leadership’s role in unifying and sustaining the organization in a common, person-centered care mission and translating this into desired behaviors across the organization. Flieger (2017) described the implementation process at nine primary care practices...
in New Hampshire that became patient-centered medical homes (PCMH). The study combined complex adaptive systems theory with relationship-centered organizations theory to provide insight into the process of becoming a PCMH. Flieger found that buy-in from senior leadership (in terms of additional resources and support) and from physicians and staff were important in fostering momentum and new ideas. Quality communication among leadership was also deemed critical. The transition to team-based care included structural team clarification as well as new team functioning. The team approach was seen as an opportunity to empower staff and cultivate a learning environment without blame and with an opportunity to experiment. Moreover, Flieger found that a physician-centered approach to care delivery created a barrier to effective team-based care.

**Collaborative Approach and Staff Empowerment**

One study found that adequate resources and staffing were essential to implementing person-centered care, as was leadership that is focused on relationships and empowering staff and is flexible and adaptive in nature (Engle et al., 2017). In addition, Scalzi et al. (2006) found that participative leadership that supported culture change, shared values of respect, enhanced relationships, and quality of work life improved staff morale and facilitated culture change. Quality communication among leadership and setting aside time for reflection and sensemaking encouraged relationship-building, fostered understanding of different roles, and offered opportunities for effective problem-solving and widespread empowerment (Flieger, 2017). A critical mass of “change champions” (Scalzi et al., 2006), a management style congruent with the values of person-centered care such as respect for others, and the enhancement of relationships and community also facilitated person- and family-centered care. In a study on the role managers play in creating the work setting during the transition to person-centered care, Tellis-Nayak
(2007) showed that management approach and the work environment were powerful predictors of certified nursing assistants’ satisfaction, loyalty, and commitment to person-centered care. This underscored the importance of middle level managers and their interactions with those who provide care.

**Supportive Work Environment**

The literature showed that a supportive work environment included an adaptive leadership style that empowered staff, strengthened interdisciplinary functioning, and improved ability to understand and integrate conflicting perspectives, but it also included aligned regulatory and reimbursement guidelines (Engle et al., 2017; Flieger, 2017). Engle et al. (2017) also found that it required attention to the evaluation of organizational culture and morale. In addition, Luxford et al. (2011) indicated that a sustained focus on employee satisfaction (including recognition for achievements), regular measurement and feedback reporting to identify areas for improvement, and adequate resources for care delivery redesign (including new patient scheduling systems, facilities for families, and 24/7 access) were part of a supportive work environment. Furthermore, accountability and incentives, including incorporating patient ratings with employee performance reviews and board scorecards that included patient care experience metrics helped organizations focus on person-centered care (Luxford et al., 2011). Finally, Shaller (2007) identified systematic measurement and feedback, a quality physical environment, supportive technology, and practical tools to implement care at the point of service and management level as part of a supportive work environment.

**Capacity-Building at all Levels**

Previous research provided suggestions for capacity-building at all levels, including providing staff with education and skill development specific to the delivery of person-
family-centered care and ways to interact with patients and families, especially when potential conflicts may exist (Engle et al., 2017). Other suggestions included training in coaching skills, communication skills, patient-centered care values, customer service, and leadership skills (Luxford et al., 2011). The importance of including physicians, nurses, and other health professionals was also noted in the same study.

**Time for Personal and Organizational Learning**

Flieger (2017) found that the transformation into a person-centered organization is not linear and implementation through a formal structural perspective is not enough, suggesting that it was important to make time for reflection, sensemaking, and learning throughout implementation. Flieger argued that this time helps build mutual understanding, relationships, and trust among staff and leadership and fosters a shift toward a mental model that is more collaborative and facilitates problem-solving and learning across multiple roles. Research also found that a culture strongly supportive of change and learning, with a shared vision of what is possible, and that is based on values and collective learning from failures was beneficial in the implementation of person-centered care (Luxford et al., 2011).

**Inclusion of Residents and Family in Decision-Making**

In their study, Luxford et al. (2011) showed that the engagement of patients and families, ranging from organizational decisions to engagement at the point of care, was integral to implementation of person- and family-centered care.

In 2011, the Alzheimer Society of Canada released its guidelines for care, which assessed six leading-practice LTC homes that were determined to be typical homes that represented LTC homes across Canada. Though each of the homes approached the path to person-centered care differently, some common approaches were identified. The importance of a collaborative
leadership team that modeled desired behavior and championed a person- and family-centered culture surfaced as a theme. Incorporating the care approach into formal strategic and operational planning processes was important as was ensuring that the homes were learning organizations (Vaill, 1996). The Alzheimer Society of Canada (2011) also identified the involvement of residents and family members in planning and decision-making, flexible staff scheduling, and a physical environment designed to be as home-like as possible as themes in their study. These findings were similar to those outlined in the literature above, which validates the application of those findings in the Canadian context.

**Barriers to Person- and Family-Centered Care**

Barriers to implementation have been found to fit into five categories: (a) staffing, (b) resources, (c) acuity of residents, (d) conflicts between person-centered care and quality of care, and (e) regulations (Engle et al., 2017). High-performing sites reported fewer barriers overall, but cited difficulty coordinating person-centered care across departments as the major barrier. Low-performing sites reported additional barriers, such as administrator turnover, a prevailing culture that caused low morale and difficulty providing person-centered care, difficult patient and families, family members without legal authority trying to influence care, and rigid bureaucracy (Engle et al., 2017). This research underlined the complexity of person- and family-centered care and the interplay between organizational factors, regulations, and expectations of families. It is important to understand these contextual factors, as well as the leadership perspectives at each level, when assessing organizational culture.

Luxford et al. (2011) identified the difficulty in changing the mind-set from a provider-focus to a patient-focus and the realization that culture change takes longer than anticipated as barriers in organizations with a reputation for successfully implementing
patient-centered care. In their study on nursing homes, Scalzi et al. (2006) identified the exclusion of nurses from the culture change training and activities, competing or conflicting goals, and the high turnover of administrators as barriers to culture change. Staff perceived that the corporate emphasis was more on compliance, regulation, and the bottom line than on the values of respect, empowerment, and choice for residents. Scalzi et al. also found that rewards and incentives were matched with corporate performance, not resident-centered care.

The literature supported the notion that LTC organizations are learning organizations that enhance internal capacity by learning from past events (Engle et al., 2017; Scalzi et al., 2006; Senge, 2006). The organizations that successfully implemented person- and family-centered care took a long-term strategic approach and demonstrated the importance of both quantitative and qualitative data to improve care.

Implications for practice include the recognition that the process of person- and family-centered transformation is not linear; that implementation through a formal structural perspective is not enough; and that time should be made for reflection, sensemaking, and learning throughout implementation (Flieger, 2017). Consequently, this study aims to better understand which and how interactions contribute to shaping these learning processes.

The Culture Change Movement

In carrying out a literature review on person-centered care in LTC homes, the term culture change surfaced numerous times. It is important to explain the origin of this term and how the culture change movement came about because it has significant influence on practical and academic person-centered care conversations in the U.S.

Culture change is often recommended in discussions about implementing or leading change in LTC but few actually describe what it means and how to go about culture change.
Koren (2010) ascribed the origins of the culture change movement for nursing home residents to the work of the National Citizens’ Coalition for Nursing Home Reform, which was concerned with the quality of care in nursing homes. When they released “A Consumer Statement of Principles for the Nursing Home Regulatory System” (Holder, 1983), it was supported by more than 60 organizations and was presented to the U.S. Department of Health and Human Services. Further work included a report on the consumer perspective on quality of care (Holder & Frank, 1985). This report, in turn, informed the Institute of Medicine (US) Committee on Improving Quality in Long-Term Care (1986) report, *Improving the Quality of Care in Nursing Homes*, which recommended changes to regulatory policies that would put more emphasis on the care aspects of nursing homes. The Nursing Home Reform Act of 1987 required that each nursing home resident “be provided with services sufficient to attain and maintain his or her highest practicable physical, mental, and psychosocial well-being” (as cited in Koren, 2010, p. 2). This law made nursing homes the only sector of the health care industry that had an explicit statutory requirement for providing what is now called person-centered care (Koren, 2010). The culture change movement espoused a set of principles that encompassed residential care practices such as residents directing care as much as possible, creating a home-like atmosphere, fostering close relationships and quality improvement processes, as well as human resource practices and design of the nursing home’s physical environment (Koren, 2010; Rahman & Schnelle, 2008).

The initiatives that have sprung from this movement include the Eden Alternative, the Neighborhood model, the Wellspring nursing home alliance, the Green House Project and the Pioneer Network, to name a few (Koren, 2010; Robinson & Gallagher, 2008). Each initiative has used a slightly different approach to culture change, but common elements include staff entering a caregiving relationship based on the needs and desires of the client; residents and staff
designing schedules that reflect their personal needs and desires; the environment reflecting a home setting; spontaneous activities available around the clock; a sense of community and belonging; and staff having consistent assignments (Misiorski & Kahn, 2006).

The most comprehensive nursing home culture change models are the Eden Alternative (Brune, 2011; Ransom, 2000; Weiner & Ronch, 2003) and the Green House models (Rabig et al., 2006). Many nursing homes have not implemented all aspects of culture change but have implemented certain elements based on their needs and local contexts (Chapin, 2008).

The Green House model has been shown to be associated with increased levels of quality of resident care and quality of life (Kane et al., 2007) and greater family satisfaction (Lum et al., 2008). Research has also found that staff empowerment and supportive leadership are factors of culture change (Loe & Moore, 2012; Lum et al., 2008).

Wellsprings Innovative Solutions for Integrated Health Care, a voluntary coalition of 11 not-for-profit nursing homes in Wisconsin, was established in 1994 and used clinical experts to integrate resident-directed care, quality indicators, and new leadership paradigms to improve staff life, care outcomes, and staff satisfaction and efficiency (Kehoe & Van Heesch, 2003). Along with a clinical component of care, Wellsprings emphasized building trust and cooperation between nursing homes. Within each home, the program trained all top and middle managers to become coaches, mentors, and enablers of culture change, with a focus on staff empowerment, change management, coaching, and problem-solving. Although each facility adapted the model according to their needs, observational and interview results indicated an improved quality of life for residents and improved quality of interaction between residents and staff (Stone et al., 2002). Participating facilities carefully aligned the Wellspring philosophy with their administrative, operational, and management structures. One key element of successful implementation and
sustainability was the commitment of staff nurses to work with and mentor nursing assistants. However, enabling more decision-making at the point of care proved a difficult cultural transition. The important role of leadership was acknowledged, but a description of how these interactions shape culture was lacking (Stone et al., 2002).

The uptake of patient-centered care in nursing homes has been impressive and the culture change movement is well known in the U.S. In a 2007 Commonwealth Fund survey of 1,435 homes, only 34% of facilities reported being unfamiliar with the movement (Doty et al., 2008). In a more recent study, 85% of facilities reported being involved in some type of culture change, but interestingly, only 13% of directors of nursing reported that culture change had “completely changed the way they care for residents” (Miller, Looze, et al., 2014). This could be related to the fact that many nursing homes only implement certain culture change practices or because culture change is difficult and requires deliberate organizational effort and strong leadership. Furthermore, there has been little evidence on the complex interactions that contribute to culture change to date, thus limiting the opportunity for others to learn and make subsequent changes in their organizations.

In case studies of exemplary culture change in LTC, Chapin (2008) revealed the following four insights: (a) the mental mode shift from a medical or systems models of LTC to one that was person-centered was difficult; (b) the physical environment transformation played a role in creating culture change; (c) culture change is an organic, creative, complex, and holistic process which has not been accurately described in most culture change processes; and (d) the creation of a learning organization is the result of culture change transformation.

Early criticism of the culture change movement was that, despite its popularity, the movement was founded on very little empirical research (Rahman & Schnelle, 2008). Rahman
and Schnelle claimed that, although the movement was well described and funded, little was known about the impact of culture change and the innovations were mostly untested. They called for research that addressed the impact on resident outcomes, quality of care benefits for residents of different cognitive ability, and research on the impact on staffing mix. In their systematic review, Brownie and Nancarrow (2013) evaluated the evidence of the impact of person-centered interventions on aged-care facility residents and nursing staff. The studies examined in this review incorporated a range of different outcome measures to evaluate the impact of person-centered interventions on aged-care residents and staff. Several aspects were found to be typical of patient-centered interventions, including elements of environmental enhancement, opportunities for social stimulation and interaction, leadership and management changes, staffing models focused on staff empowerment, assigning residents to the same care staff, and an individualized philosophy of care. However, due to the complexity and the range of outcomes Brownie and Nancarrow assessed, it was difficult to make generalizations about the impact on residents and nursing staff, which highlighted the importance of using a common language to define patient-centered care, the importance of context, and the difficulty in assessing the impact of person- and family-centered care across organizations.

Research has found that nursing homes implement culture change practices to varying degrees, depending on needs, resident need, and the context of the nursing home (Shield et al., 2014). One study, which looked at the degree of culture change practice implementation, found significant improvements in some care processes and outcomes in nursing homes with high practice implementation (Miller, Lepore, et al., 2014). This included a decrease in the prevalence of restraints, tube feeding, and pressure ulcers; an increase in the proportion of residents on bladder-training programs; and a small decrease in the number of hospitalizations. Despite their
structured approaches, research and evaluation for subscription-based models were limited, ad hoc, and fragmented (Petriwskyj & Parker, 2016).

The culture change movement and the models of care it has fostered represent a movement toward a person-centered care approach with practice elements that have been implemented in LTC homes to different degrees. This varied approach has made it difficult to draw system-wide outcomes and effectiveness conclusions. Furthermore, care implementation practices only account for part of the literature on the larger concept of organizational culture and climate. The next section will explore these concepts in more detail.

Organizational Culture and Climate

Developing an organization-wide approach to person- and family-centered care requires a shift in organizational functioning. Organizational climate and culture are two concepts that have been described in the literature as important to organizational functioning (Schneider et al., 2013) and will therefore be explored in this research. While these two concepts are different in their definitions, theoretical origins, and the ways in which they are measured, there is also interplay between them. In fact, Denison (1996) posited that climate and culture may not be different phenomena but rather different points of view that examine “the internal social psychological environment of organizations and the relationship of that environment to individual meaning and organizational adaptation” (p. 625).

The application of this work into practice reflects the difficulty in distinguishing between the two concepts. A variety of applications, questions, and methods can be found in the literature. This section focuses on the literature related to the concepts of organizational climate and culture generally, as well as their application to health care and patient- or person-centered care in particular.
Organizational Climate

Schneider et al. (2013) defined organizational climate as “the shared perception of and the meaning attached to the policies, practices and procedures employees experience and the behaviors they observe getting rewarded and that are supported and expected” (p. 362); Ashkanasy et al. (2011) defined it as “the configurations of attitudes and perceptions by organization members that, in combination, reflect a substantial part of the context of which they are a part and within which they work” (p. 8); Schein (2017) described organizational climate as “the feeling that is conveyed in a group by the physical layout and the way in which members of the organization interact with each other, with customers or with outsiders” (p. 3); and Denison (1996) described it as a “shared perception” or a “shared set of conditions” and suggested that it is often presented as “relatively temporary, subject to direct control, largely limited to those aspects of the social environment that are consciously perceived by organizational members” (p. 624).

A major debate in the 1970s and 1980s focused on whether organizational climate was an individual interpretation or an organizational/unit construct (Denison, 1996; Schneider et al., 2013). More recently, there has been a shift toward a consensus that it is an attribute of the group or organization and instead of focusing on the individual level, research should concentrate on the organizational or subunit level (Glick, 1985; Schneider et al., 2013).

Organizational climate examines the perception of the social context and its impact. It refers to a situation and its links to thoughts, feelings, and behaviors of organizational members and it has mostly been measured quantitatively. Climate research grew out of Lewinian field theory (Lewin, 1951; Lewin et al., 1939), which asserted that individuals interact with their environment and that influences their behavior. However, as Denison (1996) pointed out, this
implies that management creates the climate and employees, workers, and subordinates are subject to that system; they do not create it. The field theory interpretation left out the process by which the social environment is constructed. Awareness of this process allows for comparison between organizations and also for studying organizational changes and its members’ reactions to it.

Schneider et al. (2013) suggested that organizational climate measures should match the focus of the desired outcome and introduced the notion of a focused climate rather than a generic or global climate. Some climate research has focused on customer service and safety climates (Schneider et al., 2005), while others examined ethical climate, empowerment climate, voice climate, and climate for initiative (Schneider et al., 2013).

**Organizational Culture**

Like organizational climate, organizational culture has been studied by anthropologists and sociologists, resulting in many definitions and models (Schein, 2017). Schein (2017) defined the culture of a group as:

> The accumulated shared learning of that group as it solves its problem or external adaptation and internal integration; which has worked well enough to be considered valid and, therefore, to be taught to new members as the correct way to perceive, think, feel, and behave in relation to those problems. This accumulated learning is a pattern or system of beliefs, values and behaviors that come to be taken for granted as basic assumptions and eventually drop out of awareness. (p. 6)

This is a dynamic definition, one that is contextual and evolves over time. According to Ashkanasy et al. (2011), culture has allowed us to “understand the systems of meanings, values,
and actions that characterize whole societies” (p. 8) with a focus “on judgement and values, rather than perceived practices and procedures” (p. 1028).

Schein (2017) identified three levels of culture: (a) artifacts (phenomena that are visible, including the physical environment, structure, processes, and observed behaviors); (b) espoused beliefs and values (the ideas, goals, values, and aspirations of an organization); and (c) basic underlying assumptions (unconscious, take-for-granted beliefs and values that determine behavior, perception, thought, and feelings). Schein claimed that basic underlying assumptions are shared in the collective and reinforced by the experience of repeated success in implementing certain beliefs and values. There is little variation of these assumptions within social units and those within a unit will feel most comfortable with others who share the same assumptions. They will feel more vulnerable with those who do not share them.

In addition, Schein (2017) identified primary and secondary ways in which leaders embed and transmit culture. The primary mechanisms included what leaders pay attention to, measure, and control on a regular basis; how leaders react to critical incidents and control on a regular basis; how leaders allocate resources; how they model, teach, and coach; how they allocate reward and status; and how they recruit, select, promote, and excommunicate. The secondary reinforcement and stabilizing mechanisms Schein identified were organizational design and structure; organizational systems and procedures; rites and rituals of the organization; design of physical space; façades and buildings; stories about important events and people; and formal statements of organizational philosophy, creeds, and charters. Many of these leader behaviors align with the enabling factors associated with implementing person- and family-centered care, pointing to the pertinence of studying the interaction of human and nonhuman factors and the complexity of embedding a person-centered culture.
Two different interpretations of culture were presented in the literature: one stated that an organization has a culture, the other that an organization is a culture (Schneider et al., 2013). Research conducted from the perspective that an organization has culture has tended to focus on how organizations are different from one another and studies have typically been comparative, using survey tools. The epistemological assumption is positivist, built on the belief there is one coherent culture that is directed by senior staff. In contrast, research conducted from the perspective that organizations are cultures (also referred to as seeing culture as a metaphor) has attempted to understand and describe that culture, including how members make meaning and come to share assumptions. The epistemological assumption is phenomenological, and this interpretation is one where subcultures can coexist and where cultural conflicts can lead to change (Scott et al., 2003a). In this approach, which is usually qualitative and is considered contextual to the organization being studied, the culture is influenced by managers and other organization members.

Martin (1992) described three social scientific perspectives of organizational culture: integration, differentiation, and fragmentation. From an integration perspective, norms, values, and behaviors are shared by all members within an organization. The differentiation perspective identifies subcultural boundaries and is resistant to the claims of one organization-wide interpretation of culture. The fragmentation perspective focuses on complexity and ambiguity and fits with constructivist assumptions about organizational culture.

What quantitative measures of organizational culture and climate cannot do is explore the underlying beliefs, values, and assumptions that are part of organizational culture, nor can they explore the multiple perspectives and interpretations of organizational symbolism (Schein, 2017). As such, quantitative methods remain superficial; they can be insensitive to subcultures
and can give the impression that culture change is simplistic and easy (Yauch & Steudel, 2003). They are often used because they are easier to administer, require less time, and can examine a large sample of the organization (Jung et al., 2009).

When used in organizational research, qualitative methods provide a rich account of cultural dynamics and the complexity that exists within organizations. They also provide a picture that is grounded in reality (Sackmann, 2001). Furthermore, qualitative approaches lend themselves to a detailed and meaningful analysis of an organization’s underlying values, beliefs, and assumptions (Yauch & Steudel, 2003).

This research project is focused on the interactions of the elements that shape a person- and family-centered culture as experienced in an organization that has successfully implemented such a culture. It explores what happens in these interactions that contributes to a person- and family-centered culture, including human and nonhuman elements.

**Climate and Culture in Health Care**

The concepts of organizational climate and culture have been applied to and described in the health care literature (Gershon et al., 2004; Scott et al., 2003a). Some have focused on a safety climate or culture (de Wet et al., 2010; Singer et al., 2009; Vlayen et al., 2012) or on a culture of transitions (when patients transfer from one type of care to another within a hospital) (McClelland et al., 2015). Others have related leadership style to culture (Casida & Pinto-Zipp, 2008) or have measured how culture changed after an intervention (Korom-Djakovic et al., 2016; Manley, 2000).

Several culture and climate tools have been used in health care. In their systematic review of organizational culture and climate studies, Gershon et al. (2004) found 12 quantitative tools that were used in health care. They noted that there were inconsistencies in the terminology used
to describe the dimensions of climate. The sub-constructs from the 10 studies Gershon et al. examined fell into four major dimensions: (a) leadership characteristics (degree of supervision, degree of trust, type of leadership hierarchy, etc.), (b) group behaviors and relationships (such as interpersonal interactions, group behavior, perception of coworker trust, group cohesion, etc.), (c) communications, and (d) structural attributes of quality of work life (such as rewards, working conditions, hours, job security, etc.).

In a systematic review of climate tools used in health care, Scott et al. (2003b) described a variety of dimensions with little agreement on terms used. As they noted: “None convincingly addresses those unspoken assumptions that guide attitudes and behavior and form the stable substrate of culture” (Scott et al., 2003b, p. 928). The authors recognized the limitation of quantitative studies in uncovering the underlying assumptions and beliefs that are important in understanding organizational culture.

Scott et al. (2003a) highlighted the debate regarding whether organizational cultures can be shaped by external forces. They identified factors that negatively affect culture change, including constraints imposed by external stakeholders and professional allegiances, perceived lack of ownership, and subcultural diversity within health care organizations and systems. They also found that fostering change required a critical mass that buys into the change, diversity of implementation strategies with realistic timeframes, and alignment with the values of external stakeholders or a concurrent change in culture of these stakeholders. Leadership styles that included transactional and transformational were identified as important, as was the ability to shift the mental model of those working in the organization to a patient-centered model. Scott et al. (2003a) concluded that transforming culture at the health system level takes place over a number of years, and is a complex, multi-level process with uncertain outcomes that requires a
range of linked strategies and supporting tactics. This work underscored the importance of research methods that take a holistic, systems approach to understanding organizational culture.

**Person- and Family-Centered Culture and Climate in LTC**

Culture change in LTC is an innovation anchored in values and beliefs that return the locus of control to residents and those who work closest with them. According to the Alzheimer Society of Canada (2011), the ultimate vision of culture change has been to create a culture of aging that is inclusive, life-affirming, satisfying, humane, and meaningful. LTC environments will become places where residents can continue to live and, most importantly, make their own choices and have control over their daily lives. The transformation accompanying culture change requires changes in organizational practices, physical environments, workplace practices, and relationships. In their LTC improvement guide, Frampton et al. (2010) referred to culture change as “the progression from institutional or traditional models of care to more individualized, consumer-directed practices that embrace choice and autonomy for care providers and recipients” (p. xiii).

Because the term culture change has also been used to describe the movement of organizations toward implementation of a person-centered care approach in the United States (Koren, 2010), some of the literature focused on the implementation of care. Nevertheless, the existent literature on person- and family-centered culture in LTC included both quantitative and qualitative studies. The quantitative studies provided a group of pre-determined descriptions of organizational culture (Banaszak-Holl et al., 2013; Scott-Cawiezell et al., 2005), whereas the qualitative studies provided insight into what happens between individuals as they interpret what is happening around them (Chapin, 2008; Tyler & Parker, 2011).
A quantitative study, using the competing values framework, defined four cultural quadrants: (a) those dominated by a demonstration of values, goals, and cohesion (group); (b) the ability to adapt quickly to new opportunities (developmental); (c) the formalization of structure (hierarchy); and (d) a focus on profitability, competitiveness, and productivity (Cameron & Quinn, 2005; Scott-Cawiezell et al., 2005). Results revealed differences in perceptions of culture between team members and leaders. Those in leadership positions focused on hierarchy while team members described the culture as group- and relationship-focused. The use of situational analysis in my study will seek out differences rather than assuming culture is a homogenous, agreed upon perspective (Clarke et al., 2015).

Killett et al. (2016) examined links between organizational culture and residents’ experience of care and identified seven elements of care home culture that are associated with quality of care. They included four key values attitudes or behaviors supporting three observable practices (artifacts). The key values, attitudes, and behaviors were: (a) a shared purpose in providing best possible person-centered care, (b) management mediating external pressures so as not to negatively impact care, (c) staff empowered to take responsibility for resident well-being, and (d) staff and managers being open to change for the benefit of residents. The observable practices were: (a) a sense of community between all involved in the home, person-centered activity; (b) engagement that is integral to care work and supported by consistent organizational policies, procedures, knowledge, and skills; and (c) a care home environment that is actively used to the benefit of residents. These elements were dynamically linked with each other and contributed to two different levels of culture: that of values, attitudes, and behaviors, and that of artifacts visible in the daily operations of the home. Killet et al. (2016) emphasized that care home organizational culture is “locally produced, contextual, shifting and delicate” (p. 185) and
shaped in the day-to-day solutions that are developed. A particular organizational culture in a care home cannot be achieved simply by importing a set of organizational values or the “right” leader or staff. Rather, it is necessary to find methods to resolve the everyday demands of practice in ways that are consistent with espoused values.

Kirkley et al. (2011) studied the impact of organizational culture on the delivery of person-centered services in organizations providing respite care and short breaks for people with dementia. The views of person-centered care expressed by participants, although generally positive, highlighted a range of understandings. This analysis suggested that there was no shared, common understanding of person-centered dementia care, which is a prerequisite for an organization-wide person-centered culture.

In their research, Tyler and Parker (2011) argued that teamwork was a key component of equipping staff to make more independent decisions as part of providing patient-centered care. High levels of teamwork were associated with positive attitudes between staff and managers, while low levels of teamwork were associated with negative attitudes between staff and with staff seeing themselves and their units as different from others and having a negative attitude toward those on other units. Tyler and Parker suggested that teamwork and culture form a feedback loop and underscore the importance of managers modeling the behavior and attitudes that support teamwork. They also observed that maintaining high levels of teamwork is an ongoing process.

Chapin (2008) found that prevailing medical mental models of LTC contributed to the difficulty experienced in creating cultures of LTC and that transformation of the physical environment played a role in creating culture change. Chapin concluded that culture change is an organic, creative, complex, and holistic process that is not accurately described in most culture
change processes and that creating a learning organization is the result of culture change transformation.

In a subsequent study, Chapin (2010) proposed the following definition of person-centered culture change in LTC that incorporated the complexity of the LTC environment with the multiple aspects of culture:

Culture change in long-term care is a longitudinal, systemic, holistic process of transforming a long-term care organization (people, culture, beliefs, actions) and its physical surroundings, from being embedded in a traditional institutional medical model or philosophy to operating as a holistic therapeutic community based upon resident-centered care and dignified workplace practices. Culture change is a multitude of efforts aimed at transforming the psycho-social, organizational, operational and physical environment in order to enhance quality of care, quality of experience, quality of life and create a viable sustainable business through developing a triadic setting that is simultaneously a healthy, positive, enjoyable workplace, a loving, supportive home and a thriving community that meets resident-identified physical, social, emotional, and spiritual needs as well as facilitating a high quality of life for all individuals involved. (p. 192)

Summary

The literature review revealed that much is known about the dimensions of implementing person- and family-centered care, both from a system (Canadian Medical Association, 2010; Fooks et al., 2015) as well as an organizational (Alzheimer Society of Canada, 2011) and professional perspective (Registered Nurses’ Association of Ontario, 2015). Many of the enablers—such as an engaged senior leadership, a collaborative approach, staff empowerment, a
supportive work environment, and support for personal and organizational learning—are relational in nature (Brownie & Nancarrow, 2013; Flieger, 2017; Kirkley et al., 2011; Shaller, 2007). The barriers to implementing a patient- and family-centered culture included factors that were relational in nature, such as conflicts between individuals, poor teamwork, and a medically-focused mind-set, but these were not the only barriers identified. Organizational factors such as conflicting regulations, resources, staffing, patient acuity, rigid bureaucracy, and mismatched incentives also surfaced (Engle et al., 2017; Luxford et al., 2011; Scalzi et al., 2006).

The research also confirmed that culture change takes time, is complex, creative, organic, and is influenced by leaders as well as by organizational policy and procedures, and requires personal and organizational learning (Chapin, 2008; Schein, 2017). In this study, I explore and seek to better understand the complexity of the social processes and nonhuman elements that shape person- and family-centered culture in an LTC facility in Ontario that has been deliberate about providing person- and family-centered care.
Chapter III: Methodology

The methodology used in this study is a single, exemplar case study (Yin, 2014) that employs grounded theory and situational analysis for data collection and analysis (Clarke et al., 2017). In this chapter, I present the methodological fit and methods for data collection and analysis. Together, grounded theory and situational analysis will enable the exploration and understanding of the complex interaction of social and nonhuman elements, including socio-political, regulatory, historical, and health system contexts (Clarke et al., 2017) that contribute to a person- and family-centered culture in an LTC facility.

Case Study Design

The use of a case study design is appropriate when the research question explores a “how” or “why” question about a contemporary event over which the researcher has little or no control (Yin, 2014). Case studies explore events in the real world. Contextualizing the micro, meso, and macro contexts of one organization enhances the interpretive power of a study (Holloway & Dezenberg, 2018). These levels also correspond to Yin’s (2014) unit of analysis and allow for the context to sample the social processes between individuals as well as organizational and systems contributions. According to Yin, the organization is the unit of analysis for the single case design, where the context is holistic and refers to the organization, which makes this is a fitting design for this study. Yin (2014) also stated that:

A case study allows investigators to focus on a “case” and retain a holistic and real-world perspective—such as in studying individual life cycles, small group behavior, organizational and managerial processes, neighborhood change, school performance, international relations, and the maturation of industries. (p. 4)
Because I am exploring organizational culture, the single organization setting is key to understanding the interactions that shape organizational culture. The case study approach assists in defining the bounded context in which grounded theory and situational analysis methods are used and helps increase rigor by contextualizing the experience within this defined context (Holloway & Dezenberg, 2018). Furthermore, a case study design allows for analysis on three levels: interrelational, organizational, and system.

**History of Grounded Theory and Situational Analysis**

The foundations of grounded theory and situational analysis can be traced to the work of Barney B. Glaser and Anselm L. Strauss in the 1960s (Bryant & Charmaz, 2007). Others have built on the ideas of Glaser and Strauss, expanding on the theory and providing different epistemological perspectives and methods.

**Symbolic Interactionism**

The roots of grounded theory lie in symbolic interactionism, which can be traced back to George Herbert Mead (Charon, 1985). Mead was a pragmatist who believed that humans interpret the world around them, that knowledge and objects are always judged for their usefulness, and that we interpret the action of others by what they do. Dewey, James, Thomas, and Cooley were also pragmatists working around the same time as Mead, and they contributed the ideas that humans are self-aware, able to take different perspectives, and that they create meaning through social interactions (Heath & Cowley, 2004). Blumer (1956) defined the term *symbolic interaction* and developed the interactionist approach that emphasized the role of concepts and patterned relationships rather than definitions. Blumer put forward three basic premises: (a) that humans act on the basis of the meaning things have for them and interpret the world through symbols, (b) that meaning arises from interaction between individuals, and (c) that
the assigned meaning is always changing and is modified through interpretive processes, depending on a person’s encounters.

Glaser and Strauss (1967) defined what is now referred to as classic grounded theory in their book, *The Discovery of Grounded Theory*. After this initial work, Glaser and Strauss wrote separately, and their approaches to grounded theory differed. Strauss and Corbin (1990) contributed details on procedures and techniques and Glaser (1992) focused on grounded theory analysis. The core difference between Glaser and Strauss was in whether verification should be the outcome of grounded theory analysis or not (Heath & Cowley, 2004). Strauss (1987) claimed that induction, deduction, and verification were “absolutely essential” (p. 12), whereas Glaser (1992) claimed that grounded theory was inductive only. However, in later work, Strauss and Corbin (1998) no longer included verification in their approach, instead defining validation as “a process of comparing concepts and their relationships against data during the research as to determine how well they stand up to scrutiny” (Strauss & Corbin, 1990), and leaning toward abduction. Later contributions by Charmaz (2006, 2014) and Clarke (2003, 2005)—so-called second-generation grounded theorists (Morse et al., 2016)—brought a constructivist and postmodern perspective to grounded theory. The following section briefly describes the epistemological differences between these grounded theory contributors.

Grounded theory is used when moving from describing what is happening to an understanding of the process by which it is happening (Strauss & Corbin, 1990). Early criticism of the work of first-generation grounded theorists like Glaser, Strauss, and Corbin, aimed at their emphasis on methods, rather than methodology or philosophy (Birks & Mills, 2015). In later years, Strauss’s work was built on pragmatism and symbolic interactionism (Corbin & Strauss,
Glaser (2007), however, has rejected naming any underlying philosophy, stating that doing so would reduce the potential of grounded theory.

The underlying premise of grounded theory research is to be *grounded* in the data. Glaser (1978) discussed the importance of not diving into the research topic beforehand, so as to stay open and sensitive to the data. Strauss and Corbin (1998) stated that previous research should identify the research topic and acknowledged that researchers bring their previous knowledge with them. The constant comparison method proposed by Glaser and Strauss (1967) emphasized ongoing reflection and analysis through coding (Heath & Cowley, 2004). Glaser and Strauss were writing about grounded theory at a time when there was tension between qualitative and quantitative research. They concentrated on methods of analysis and focused on developing theories from the data. The dominant paradigm at the time was positivism, which focused on objectivity and quantifiable variables and discovering causal explanations of a knowable world (Charmaz, 2014). In their influential book, Glaser and Strauss set out key components of grounded theory: simultaneous data collection and analysis; constructing codes from the data; using the constant comparison method during each stage of analysis; advancing theory development during each step of analysis; memo-writing; theoretical sampling; and conducting a literature review and independent analysis (Charmaz, 2014). Their method combined Columbia University positivism (Glaser) and Chicago school pragmatism (Strauss).

**Epistemology**

Grounded theory strategies can be used in different research approaches; the underlying assumptions and how they are used determine the epistemological and ontological stances (Bryant & Charmaz, 2007; Charmaz, 2014). Grounded theory methodology has evolved from the early work by Glaser and Strauss to the current work of second-generation grounded theorists. There have been epistemological shifts from postpositivist (Glaser & Strauss, 1967; Strauss & Corbin, 1990) to constructivist (Charmaz, 2014) to postmodern (Clarke, 2005).

For this study, I took a constructivist position in my application of grounded theory methodology and a postmodern position for my situational analysis. The constructivist approach to grounded theory emerged in the 1990s and built on the work by Glaser and Strauss (1967), in that it adopted an inductive, comparative, emergent, and open-ended approach. It also emphasized the pragmatist notion of the focus on action and meaning and included Strauss’s iterative logic (Charmaz, 2014). The constructivist approach answered numerous criticisms about earlier versions of grounded theory. According to Charmaz (2014), “constructivist grounded theory highlights the flexibility of the method and resists mechanical applications of it” (pp. 12–13). Instead of seeing the researcher as neutral, the researcher’s position, privilege, background, perspectives, and interactions are also taken into account. It is the difference in foundational assumptions that shapes the studies of different grounded theory methods (Charmaz, 2014).

For early constructivists, knowing and learning were embedded in social life. Charmaz (2014) built on this and outlined nine researcher actions that are key to grounded research: (a) conducting data collection and analysis simultaneously in an iterative process, (b) analyzing actions and process rather than themes and structure, (c) using comparative methods, (d) drawing
on data, (e) developing inductive abstract analytics categories through systematic data analysis, (f) emphasizing theory construction rather than describing the application of current theories, (g) engaging in theoretical sampling, (h) searching for variation in the studied categories of process, and (i) pursuing development of categories rather than covering specific empirical topics. Charmaz stressed the importance of researchers showing evidence that they have conducted grounded theory sampling and that they have constructed theory because these actions generate an awareness of assumptions throughout the process and a recognition that researchers should be reflexive of their own understanding of the phenomena being explored.

Early grounded theory work and Glaser’s continued work on the topic (1978, 1992, 2007) emphasized the generation of theory from the data, without theoretical preconceptions, through induction. “Induction starts with a collection of given cases and process by examining their implied results to develop inference that some universal rule is operative” (Timmermans & Tavory, 2012, p. 171). Abduction is the creative production of hypotheses based in surprising evidence (Timmermans & Tavory, 2012). Charmaz (2014) included abduction as secondary to the initial inductive analysis of data and suggested using it after intriguing findings, then returning to the data and to the field to check conjectures. Others have proposed using abduction as the primary analytical approach. According to Timmermans and Tavory (2012), “abduction refers to the inferential creative process of producing new hypotheses and theories based on surprising research evidence. [Thereby the] researcher is led away from old to new theoretical insights” (p. 170). In this study, I used both inductive and abductive reasoning to make meaning of the participants’ perceptions of their experiences and the situational forces of LTC.
Situational Analysis

Adele Clarke, who was a student of Anselm Strauss, first published on situational analysis in 2003 (Clarke, 2003). This was followed by several books on situational analysis as she attempted to frame the roots of situational analysis in grounded theory and build on them with other theoretical and methodological developments (Clarke, 2005; Clarke et al., 2015). Clarke (2005) identified several shortcomings with traditional grounded theory methodology, such as lack of reflexivity, oversimplification, and lack of analysis of power. Clarke et al. (2015) maintained that situational analysis included “theorizing on historical, narrative, and visual discourses,” and delving into complexity (p. 91). Situational analysis also takes the nonhuman elements explicitly into account, since the nonhuman and the human are co-constitutive: constituting the world and each other. Power is analyzed through the mapping of social worlds and arenas, where implicated actors (present or not present) and actants (implicated nonhuman actors) and their actions are reflected in relation to the consequences for the less powerful.

Situational analysis is grounded in the concept of the situation, as well as in interactionism. Moreover, it brings in additional theoretical foundations, such as the work of Michel Foucault, and acknowledges taking the nonhuman into account, positioning it as posthumanist (Clarke et al., 2017). Situational analysis adds a critical social justice edge to analysis and broadens the analytical focus of grounded theory because its methodology seeks relations between individuals, collectivities, organizations, institutions, nonhuman objects, cultural symbols, images, and so on.

Whereas the guiding metaphor for grounded theory was the action-centered basic social process, in situational analysis, according to Clarke et al. (2017), the situation is the key unit of analysis. Clarke et al. (2015) claimed that situational analysis seeks to reconfigure the social
focus and reposition the analytical focus at all levels of complexity. They also suggested that it is used to make sense of dense complexities by creating three types of maps to frame and analyze the situation of inquiry: (a) situational maps, (b) social worlds/arenas maps, and (c) positional maps. Situational maps lay out the “major human, nonhuman, discursive, affective, geopolitical and other elements in the research situation of inquiry and provoke analysis of relations among them” (Clarke et al., 2015, p. 86). Social worlds/arena maps describe the major actors and the “arena(s) of commitment and discourse with which they are engaged in ongoing negotiations in the situation of inquiry” (p. 86). Positional maps “lay out the major positions taken and not taken in the discussions, debates, and extant discourse materials in the situation of inquiry vis-à-vis particular axes of differences, concern and controversy about important issues” (Clarke et al., 2015, p. 87). Memo-writing is important to capture the analyses that provoke further inquiry. Any documents, cultural objects, social media, and so on, are also included as part of the analysis, contrary to grounded theory methods.

**Methodological Fit**

There has been a growing interest and recognition of the usefulness and value of qualitative research in organizational research (Birkinshaw et al., 2011; Booysen et al., 2018; Wergin, 2018). Several methods have contributed to our understanding of organizations, including narrative inquiry (Gertsen & Søderberg, 2011), discourse analysis (Balogun et al., 2011), ethnography (Moore, 2011; Westney & Van Maanen, 2011), and phenomenology (Lamb et al., 2018). As methods of data collection and analysis, grounded theory and situational analysis have explored the complexity of organizational culture and climate, which was described as “the internal social psychological environment of an organization and the relationship of that environment to individual meaning and organizational adaptation” (Denison,
1996, p. 625). This dynamic definition is contextual and has evolved over time. One study described the focus of inquiry as “understand(ing) the systems of meanings, values, and actions that characterize whole societies” (Ashkanasy et al., 2011, p. 8). Qualitative approaches have provided a way to conduct a detailed and meaningful analysis of the underlying values, beliefs, and assumptions in an organization and to offer a rich account of the cultural dynamics and complexity that take place within organizations (Yauch & Steudel, 2003).

In contrast, quantitative measures of organizational culture and climate have not facilitated exploration of the underlying beliefs, values, and assumptions that are part of organizational culture (Schein, 2017), nor have they explored the multiple perspectives and interpretations of organizational symbolism. Some researchers have claimed that quantitative methods can be insensitive to subcultures and can give the impression that culture change is simplistic and easy (Yauch & Steudel, 2003). Others have argued that quantitative methods are more expedient because they are easier to administer, require less time, and can examine a large sample of the organization (Jung et al., 2009). However, the use of qualitative methods in organizational research can provide a rich account of the cultural dynamics and the complexity within organizations. Grounded theory is well positioned to explore organizational culture from the perspective of those who live it, going beyond demographics, policies, and programming (Holloway & Schwartz, 2018) and creating a rich detailed picture of organizational life grounded in reality (Sackmann, 2001).

Although grounded theory is a good fit for this study because it explores social interactions, person- and family-centered culture goes beyond social interactions and includes socio-political factors (Engle et al., 2017); organizational factors, such as incentive and rewards (Scalzi et al., 2006); organizational learning (Flieger, 2017); and the physical environment
(Koren, 2010), which reflects a more complex, holistic process (Chapin, 2008) that cannot be understood through social interactions alone. Situational analysis has facilitated the exploration of the interaction of these elements, has provided a way to make sense of the dense complexities of culture, and has broadened the analytical focus of grounded theory.

**Study Design**

For this study, I used an exemplar case study design with grounded theory and situational analysis methodology to explore what contributes to the creation of a person- and family-centered culture within an LTC facility. This section describes the process I used for the exemplar case study selection, outlines the selection of study participants, and describes data collection and analysis methods.

**Case Selection and Inclusion Criteria**

Choosing a facility that exemplified a person- and family-centered LTC home was foundational to this study. However, no standardized list of LTC homes that use a person-centered approach to care exists in Ontario. To determine the criteria and receive suggestions for selecting an LTC facility that typified a strong and deliberate person- and family-centered approach, I contacted and communicated with individuals from the following organizations: Alzheimer Society of Canada, Accreditation Canada, CARF, the Ontario Long Term Care Association, AdvantAge Ontario, and several researchers in this field. The resulting search criteria were for a facility that:

- followed the person-centered practice guidelines (Alzheimer Society guidelines, 2011);
- had a person-centered philosophy that focused on individuals rather than their conditions, and that focused on a person’s strengths and abilities rather than loss;
valued a person-centered care philosophy of care;

• had leadership that supported a person-centered care philosophy;

• included care components that were person-centered; and

• had person-centered care as part of its strategic priorities.

In addition, homes considered for the study also had to be not-for-profit, hold accreditation status, and be actively involved in improving person- and family-centered care, as identified in the Quality Improvement Plans available on the publicly accessible website of Quality Care Ontario (https://www.hqontario.ca).

I limited the search for facilities to Ontario. In Canada, each province has its own guidelines for the provision of LTC, which can differ significantly, and it was therefore important to study a facility within one province. After I reviewed homes on the Quality Care Ontario website to determine their not-for-profit status, positive accreditation status, and explicit focus on person- and family-centered care, I selected a 245-bed, accredited, charitable, not-for-profit LTC facility in Ontario. The home was founded over 130 years ago under the auspices of the Ministry of Community and Social Services, and with roots in the welfare system. However, when Bill 101, the Long Term Care Statute Law Amendment Act, passed in 1993, the home became an LTC facility under the Ministry of Health and Long-Term Care.

Participants

A total of 24 participants were interviewed as part of this study. As a starting point, I interviewed individuals from across the organization, including senior and middle management, point-of-care staff, and residents (only those with the requisite cognitive abilities were interviewed). All individuals were 18 years of age or older. Due to the cognitive difficulties that I anticipated many residents would have, I also interviewed family members. In Table 3.1, I have
listed the number of interviewees in each category. Although I collected each participant’s age, gender, number of years in service, unit worked at, and ethnic background, I have not shared this information in order to protect the participants’ confidentiality. I continued the interviews until saturation of theoretical hypotheses was reached.

Table 3.1

Roles of Interview Participants

<table>
<thead>
<tr>
<th>Participant Role</th>
<th>Number of Participants</th>
</tr>
</thead>
<tbody>
<tr>
<td>Executive Director (ED)</td>
<td>1</td>
</tr>
<tr>
<td>Senior Leadership Team Members</td>
<td>3</td>
</tr>
<tr>
<td>Program Staff</td>
<td>2</td>
</tr>
<tr>
<td>Nurse Managers</td>
<td>3</td>
</tr>
<tr>
<td>Personal Support Workers (PSWs)</td>
<td>9</td>
</tr>
<tr>
<td>Residents</td>
<td>4</td>
</tr>
<tr>
<td>Family Members</td>
<td>2</td>
</tr>
</tbody>
</table>

Data Collection

Data collection methods followed the theoretical sampling method and were iterative, based on what emerged from the data. My research interest was in the interaction of elements across the organization as they related to the creation of a culture of person- and family-centered care. Participants who worked in the LTC home were invited to engage in an interview regarding their experience of providing care for the residents and their everyday interactions with other staff and with residents’ family members. Participants who were family members of residents were asked about their experience of the care provided to their family member. In addition to the interviews, I collected organizational data, including the home’s strategic plan, policies and procedures, newsletters, website information, and other documents that were relevant to the organizational context.


**Interviewing**

All of the interviews took place in a quiet and private boardroom at the facility, except for one that was conducted by telephone (see Appendix B for the initial interview question). All interviews were scheduled during a time that was convenient for participants and took their operational responsibilities into consideration. All participants were provided with a brief description of the study and its purpose, had the opportunity to ask questions, and were free to participate or withdraw from the study at any point in time. Each participant signed and was given a copy of the signed consent form (see Appendix B).

**Analytical Methods**

Interviews were coded using an emergent coding approach, as appropriate for grounded theory analysis. I read through the informational resources that were in the public domain, such as the organization’s website and strategic plan, and made notes and memos about relevant facts. My observations were documented through detailed field notes.

**Coding and Data Analysis.** Each interview was recorded and transcribed. As part of the essential methods of grounded theory, I, along with a coding team of two other people who were experienced in grounded theory coding methods, performed the initial or open coding as a first step of data analysis using the software NVivo (Birks & Mills, 2015; Charmaz, 2006). This involved identifying important words or groups of words and labeling them accordingly. *In vivo* codes were used to preserve the participants’ language (Charmaz, 2014). During this initial coding, the goal was to stay open to all theoretical directions that were part of the data (Charmaz, 2006). As Charmaz (2014) pointed out, initial codes are “provisional, comparative, and grounded in the data” and recommends, to the degree possible, coding in action (p. 48). Glaser (1978) made use of gerunds (verbs used as nouns that end in “ing”) to help detect processes and to
remain grounded in the data. In this study, the data was initially coded for incidents, such as recurring actions, characteristics, experiences, phrases, explanations, images, and sounds (Birks & Mills, 2015). I also used line-by-line coding to remain flexible, which allowed me to gain insight into what the participants said and to make note of their emotions. This led to the development of theoretical categories (Charmaz, 2006), which helped to crystallize each participant’s experience and deepen my understanding. Thousands of codes were identified in the initial coding process. These were gathered into approximately 20 theoretical categories that served as the basis for the creation of my final six dimensions. The coding process informed my on-site observations and which participants to invite for further interviews. It also informed the collection of staff, resident, and family satisfaction surveys, accreditation reports, and resident and family newsletters.

**Concurrent Data Collection and Analysis and Theoretical Sampling.** Part of the unique methodology of grounded theory is that some data is analyzed before subsequent data is collected. Theoretical sampling is “the process of data collection for generating theory whereby the analyst jointly collects, codes, and analyzes his data and decides what data to collect next and where to find them, in order to develop his theory as it emerges” (Glaser & Strauss, 1967, p. 45). In this study, I collected data through interviews, from the organizational documentation I reviewed, and from observations made on-site. I used a constant comparative analysis process until I reached saturation, the point at which my categories were fully developed and collecting more data did not provide any new concepts within in the categories.

**Theoretical Integration or Reconstructing Theory.** Birks and Mills (2015) defined theory as “an explanatory scheme comprising a set of concepts related to each other through logical patterns of connectivity” (p. 108). Theoretical propositions are developed through an
identified core category, theoretical saturation of major categories, and through analytical memos. For this study, rather than using a positivistic theoretical approach that sought causes, deterministic explanations, and universality, I used an interpretive theoretical approach that recognized multiple, emergent realities, viewed facts and values as linked, and acknowledged subjectivity in the generation of theory (Charmaz, 2006).

**Writing Memos.** “Memos in grounded theory research are records of thoughts, feelings, insights and ideas in relation to a research project” (Birks & Mills, 2015, p. 39). I wrote field notes before and after each of the interviews and wrote extensive memos throughout the research process (Birks & Mills, 2015). I also wrote memos throughout the analytical process to capture my thinking while developing categories, during the constant comparative process, and during the intermediate coding and the identification of the core category and theoretical integration. Memo-writing added logic and rigor to the analytical process. Charmaz (2006) described the importance of memo-writing as follows:

> Memo-writing is the pivotal intermediate step between data collection and writing drafts of papers . . . Memo-writing constitutes a crucial method in grounded theory because it prompts you to analyze your data and codes early in the research process. (p. 72)

The use of memos increased the level of abstraction of ideas. The grounded theory field guides provided specific questions to explore in memo-writing at different stages of the coding process (Birks & Mills, 2015; Charmaz, 2006).

**Situational Analysis Mapping**

In addition to the traditional grounded theory analysis previously described, I used three types of situational maps, which allowed me to situate the research in different ways, such as individually, collectively, organizationally, culturally, physically, symbolically, visually, and
historically (Clarke et al., 2015). The first of these maps was the messy situational map, which was meant to provoke reflection on the complex relationships between the different human and nonhuman elements at play. The messy maps were deliberately designed to be open and were compiled multiple times during the research process.

Next, moving back and forth between what the data revealed and more abstract thinking facilitated the generation of an ordered situational map (Clarke et al., 2015). Over time, both the messy and ordered maps changed as the data informed them, which in turn informed further data collection. The data sources I used for the situational analysis included health system documents, organizational documents such as the strategic plan, policies and procedures, accreditation report, staff, resident, and family satisfaction surveys, as well as on-site observations. Reviewing these different data sources allowed the relationships between elements of the situation to become visible.

**Social Worlds/Arenas Maps.** The social worlds/arenas analysis focused on making social groups (Clarke, 2005). These types of maps provided analysis at the meso level of social interaction, not the aggregate of individuals (Clarke, 2005), and focused on which social worlds were operating, why they came together, what their perspectives were, what nonhuman elements played a role, and what constraints and opportunities were provided. The analytical work was in identifying social worlds and arenas, and their segments or areas of overlap, as revealed by actions, structures, or discourses (Clarke, 2005). Understanding was fostered by asking questions about the commitment of the social worlds, on what is happening between the worlds, and how process and structure influenced people and other elements doing things together. Initially, my search for situational forces came from the interviews I conducted with participants. However, as my research progressed and the theoretical coding categories were
generated, it became clear that health care system policies as well as the LTC home’s policies and guidelines, strategic plan, accreditation results, and resident, family, and staff satisfaction surveys were key to understanding the larger context in which care provision took place.

In each map, I looked for theoretical saturation, as with the grounded theory saturation. Each map was an analytical tool for reflection. Because all of the mapping tools I used are inherently relational, they assisted me in staying open to what was not immediately visible in the data, or not immediately visible because of my own world views, values, or ways of thinking.

**Ethical Considerations**

The ethical considerations for this study concerned the participating facility as well as the individuals who participated in the interviews. In compliance with the IRB requirements, the identity of individual participants was kept confidential. All participants were 18 years of age or older and, as mentioned earlier, only residents with the necessary cognitive abilities were interviewed. Many of the LTC home residents had cognitive impairments, which made them part of the vulnerable population group.

Participants were informed of the scope and purpose of the study in writing, had the opportunity to ask questions, and were free to participate or withdraw from the study at any point in time without repercussions (see Appendix B for the consent form). Risks to participants were minimal, although some participants may have felt vulnerable about identifying factors that hindered the provision of person- and family-centered care, especially if relational aspects played a role. I took care to avoid using any direct quotes when writing up the research that could have identified a particular participant or person referred to in the interviews.

From the facility point of view, I was unable to guarantee complete confidentiality because LTC homes in Ontario are well connected and it is likely that homes know about the
specific efforts undertaken by different facilities in the province. In the write-up of this study, I have chosen not to share the gender, age range, years of experience, or unit worked on as part of the description of participants. Due to the sensitivity to identification that was expressed by participants, in an organization with only eight units where staff know each other, only the participants’ roles are identified. Furthermore, I have not revealed the city in which this LTC home is located in order to protect the confidentiality of participants.

I chose a facility with which I do not have a current or recent (less than one year) consulting relationship, and I did not accept payment for any part of this study from the facility. This was to avoid any real, potential, or apparent conflict of interest.

In the chapters that follow, I will describe the grounded research methodology results (Chapter IV) that form the micro level foundation for the situational analysis results of the contextual meso and macro elements discussed in Chapter V.
Chapter IV: Findings of the Study—Dimensional Analysis

In this chapter, I use dimensional analysis to discuss the first part of my findings, which I have expressed as dimensional concepts that give rise to an understanding of “What all is going on here?” in the complex social processes that shape a person- and family-centered culture in an LTC home (Schatzman, 1991). The research questions I explored in this study are: (a) How is person- and family-centered culture shaped in LTC? and (b) What are the relationships among factors that influence the desired culture? The findings described in this chapter represent the lived experience of those living, supporting, and working in an LTC home and yield the conditions that underpin this culture. In Chapter V, I use situational analysis to discuss the second part of my findings, which are the meso (organizational) and macro (health system) contexts that surfaced as impactful in shaping this LTC home culture. Situational analysis goes beyond social processes and focuses on differences and complexities using a range of data, including nonhuman elements (Clarke et al., 2015). The findings of the human experience of the study participants, communicated in this chapter through the lens of dimensional analysis, combined with the analytical perspective of situational analysis, tell the story of the complexity of fostering a person- and family-centered LTC culture.

Dimensional Analysis

Dimensional analysis is grounded in the experiences of individuals and provides a framework that maximizes conceptual possibilities of complex phenomena (Kools et al., 1996). This iterative process builds on the categories identified in the coding process and is refined as these categories become saturated. The resulting matrices move beyond description and provide a structure and context for explanation (Kools et al., 1996). In this study, the core dimension of needing to be heard, valued, and understood was relevant to all roles, from residents and
families, PSWs, and nurse managers to the senior leadership team and the ED. The primary dimensions emerged from the particular perspectives of these different roles. Explanatory matrices for each of the dimensions are discussed in the following sections.

**Core Dimension: Needing to be Heard, Valued, and Understood**

Above all other dimensions, the need to be heard, valued, and understood emerged from the data as the core dimension in this study. Table 4.1 lists the properties of this core dimension. Even though the need for residents to be heard, valued, and understood, and for work to center on them, is at the heart of LTC work, the need to be heard, valued, and understood surfaced as the core dimension across the organization and across roles. It informed “the way we do things around here”; shorthand for organizational culture (Schein, 1996).

**Table 4.1**

*Properties of the Core Dimension: Needing to be Heard, Valued, and Understood*

<table>
<thead>
<tr>
<th>Dimension</th>
<th>Context</th>
<th>Conditions</th>
<th>Process</th>
<th>Consequences</th>
</tr>
</thead>
<tbody>
<tr>
<td>Needing to be heard, valued, and understood</td>
<td>Shared motivation of intense caring and shared vision</td>
<td>Roles influence perspectives</td>
<td>Seeking social connection and meaningful stimulation (residents and families) Caring for residents’ daily needs (PSWs) Ensuring quality of care on the unit (nurse managers) Translating vision into programs and policies (senior leadership) Advocating strategically (ED)</td>
<td>Failing to see, understand, and connect perspectives, creating paradoxes and disconnects</td>
</tr>
</tbody>
</table>
The core dimension is dual in nature, in that it is at the heart of all that connects and all that disconnects. It reflected the human need of being heard, valued, and understood (Morelli et al., 2014) at all levels of the organization. Viewed through the filter of person- and family-centered care, each perspective within the organization is working to optimize the resident experience from a perspective of deep caring, as described below by a PSW:

Yes, for me personally, residents to me—the way how I treat them and the respect that I have for them, they’re like a part of my family. The minute the resident moved in and it doesn’t matter what condition, like, you know, whether they’ve dementia, or they are cognitively impaired, that person becomes to me like my own family, like my mom, my grandfather, or my aunt. That’s the way I feel about it. (PSW participant)

This same sentiment was shared at the most senior level of the organization. The ED similarly expressed the idea that residents are to be seen as family members as opposed to clients to be cared for.

**Context: Shared Motivation of Intense Caring and Shared Vision.** Participants across organizational levels agreed on what person-centered care means: a focus on the needs of the resident, putting the resident first, seeing the person as a person of value and with history regardless of cognitive ability, and having choice (Brooker, 2003; Kitwood, 1988). The following was one nurse manager’s answer to the question of what person-centered care means:

Means to me putting the resident first, right? Where it should have been the entire time. Just focus on the resident and what's, you know, how they want to live their life and their last days and their—what they want to do and how they want to do it, how they want to live. (nurse manager participant)
One resident expressed this plainly as: “I wanted them to treat me as a person.” As one senior level leader explained, it means moving away from the institutional model of LTC that is pervasive (Engle et al., 2017) and seeing the LTC facility as a person’s home where they can maximize their quality of health and wellness in order to live their best lives. The participant added that they want to partner with families to provide care for those who have been entrusted to live in the home.

Person-centered care requires everyone to be aligned and requires excellent communication between staff members, as thoughtfully expressed by one PSW:

Well, you must have knowledge, you must have experiences, you have to have respect, you have to have good communication skills, you have to have good listening skills, you have to have good observational skills, and you have to have good communication skills, so, your nurses, your team leaders can document what you’re trying to relate to them about what you observe from your residents (PSW participant).

Care that is centered on residents must take the whole person into consideration, including their past. This was reinforced by the volunteer coordinator who, during volunteer orientation sessions, shares: “don’t define or don’t relate to the person and the position they are currently in because that is not who they are, that is the result of a disease or dementia.” She also encourages all volunteers to find out a residents’ story because stories “define who we ultimately become” (senior leadership team participant).

This vision of person- and family-centered care includes planning that is co-created with residents’ families. However, as one family member’s response highlighted, this vision does not always translate into practice: “It definitely looks great on paper but it doesn’t always translate
into reality” (family member participant). This disconnect is what I explore through the dimensional analysis in this chapter.

**Conditions: Roles Influence Perspectives.** The major roles within the organization determined the perspective from which person-centered care was viewed and influenced actions and interactions. The need to be heard, valued, and understood was different for each of the roles. The unique context and conditions for each role gave rise to particular processes and consequences with enough explanatory power for the roles to form an integral part of the five primary dimensions in this study, which are: (a) seeking social connection and meaningful stimulation (residents and families), (b) caring for residents’ daily needs (PSWs), (c) ensuring quality of care on the unit (nurse managers), (d) translating vision into programs and policies (senior leadership team), and (e) advocating strategically (ED). Each role lives within its own context and gives rise to the necessity to acquire further information related to different concepts, which will be expanded upon using situational analysis methodology in Chapter V.

In the LTC setting, residents seek and families advocate for social connection and meaningful stimulation in the place that residents now call home. Caring for the residents’ daily needs falls on the shoulders of the PSWs, who are responsible for toileting, bathing, dressing, and feeding, as well as for transportation to activities and programs (Personal Support Worker Registry of Ontario, 2018). Supporting roles are provided by volunteers and program staff, who play an important part in providing meaningful programming aimed to enhance quality of life for residents. Ensuring quality of care on the unit is the responsibility of the nurse managers, and includes responsibility for staffing, quality of care, coordination of care, linking with families, and problem-solving with all stakeholders. Senior leaders translate the organizational vision into programs and policies that are centered on the needs of residents and are informed by families.
The role of advocating strategically is mostly carried out by the senior organizational administrator (the ED) and involves creating visibility at the provincial ministry level and with potential donors in the hope that being heard and understood by these external actors will lead to increased organizational funding to improve person- and family-centered care across the organization. Each of these perspectives is described in the primary dimensions section later in this chapter.

**Condition: Perspective Focus Limited to Immediately Adjacent Perspective.** The roles or perspectives outlined above are linked to and influence each other. In practice, each role only receives direct input from the adjacent role. Figure 4.1 is a visual rendition of the way the roles interact.

**Figure 4.1**

*Direct Relationships and Interaction of Roles*
The direct interactions of the outward-facing strategic advocacy role, carried out by the ED, reaches the senior leadership and to some extent the nurse managers, but does not reach those who care directly for residents (the PSWs). Similarly, the senior leadership role does not directly interact with the residents or PSWs. As depicted in Figure 4.1, the families, program staff, and volunteers overlap with several roles. For example, some families overlap with their loved ones (residents) as well as with direct care providers (PSWs), nurse managers, senior leadership, and at times, program staff and volunteers. The PSWs interact with residents directly and continuously, report to the nurse on the floor, and have some interaction with families, program staff, and volunteers. Family members are the bridge between residents and staff and have formal input into senior management through the family council. Residents do so through the resident council.

**Condition: Methods for Perspective Integration are Absent.** Each of the roles worked from the same premise—to improve the quality of life for residents living in the home. However, direct connection and input methods were absent. One program staff member related her wish for inclusion in decision-making with senior leadership.

But I’m not at their meetings, I’m not always consulted on things and that’s fine. I don't necessarily think that would be the right place for me in terms of my role, but I would like it if we had the opportunity a little bit more before big changes were made not just for those conversations to happen in management to actually just happen in other places before the decision is made. (program staff participant)

The lack of formal input methods into decision-making or meaningful feedback mechanisms has created a disconnect between the different roles and the perception that the
different levels do not understand the lived reality of other levels. One family member talked about this disconnect as follows:

They think it’s ideal but as part of the family connections here, where there is a bit of—to me, it’s been a disconnect, is because of the staff are doing certain things, they are—they are fairly active and doing what they are supposed to do and then you got the management trying to override and then of course you have people like myself, family, as saying, hey, what’s—what’s happening, what’s going on, what can we change? (family member participant)

**Process: Roles as Primary Dimensions.** As discussed above, the perspectives provided by the roles within the organization emerged as the primary dimensions in this study. Each role seeks to be heard, valued, and understood, but does so from a different perspective and toward a different audience. Residents and families seek social connection and meaningful stimulation, PSWs care for residents’ daily needs, nurse managers ensure quality of care on the units, members of the senior leadership team translate vision into programs and policies, and the ED advocates strategically.

Rather than presenting the dimensions in a way that followed the organizational hierarchy, I have presented the dimensions from the perspective of the resident outward. This surfaces the pivotal role that PSWs play in the integration of all perspectives at the point of care and amplifies the effect of failing to integrate this group’s perspective.

**Consequences: Failing to Understand and Connect Perspectives, Creating Paradoxes and Disconnects.** Even though the different roles had a shared motivation and vision for caring, the context resulted in a disconnect between the roles and a failing to truly understand
and connect perspectives. At the PSW level, this surfaced in the form of not knowing what the senior roles were, as well as a feeling of being misunderstood:

Workload has gotten heavier, it’s much heavier like the care time wise, everything’s time. Feel like they’re taking staff from us. And this place like—this nursing home I find there’s more chiefs and Indians. I’d say there’s people here, I don’t even know what they do in these rooms, you know, like nurse, the management rooms, there’s people I don't know. And I don't know what they’re doing exactly. Maybe somebody is doing my pay or something, I don't know. I have no idea. (PSW participant)

The lack of perspective integration created paradoxes within the organization, which resulted in the intention of certain actions being misinterpreted. Without meaningful interaction and a clear understanding of roles, the perception becomes that the organization is top heavy and money for those salaries could be better invested in direct care, where the lack of staff meant increased workload and stress. One PSW participant, who indicated that she sees the ED only twice a year, wanted senior leadership not just to be visible but to also connect and establish a personal connection: “Introduce yourselves or something somehow, come see us. . .”

Innovative programs that receive outside attention are sometimes perceived to be wasteful when they do not improve the working conditions for those providing care. This was shared by one participant as follows:

I myself at times feel, it feels like everything some days, they come up with some new idea which is nice but then they have to take from somewhere and it always feels like it’s being taken from nurses and it’s come—it’s taken from everybody, the residents and nurses also. (PSW participant)
An example of this was the innovation of creating space for the local college to teach PSWs directly inside the facility. The long-term goal of this program is to support the education of more PSWs who are exposed to a person- and-family-centered philosophy in the hope of being able to hire more qualified staff in the future. However, the room that was transformed into the classroom was the lunchroom space where PSWs created social connections across the organization. The result was a further disconnect that left PSWs feeling undervalued:

Staff would sit there and have their lunches, we would interact with the residents, their family members at times. And it was a space. I understand what they’re doing this, why they are doing it, but—it just felt like it was taken—staff didn’t have anywhere where we could go, except for down in the basement and to me it feels like a dungeon, there’s no window to look out, no brightness. (PSW participant)

**Summary of the Core Dimension**

In this study, a deep caring for residents and agreement on the vision for person- and family-centered care was at the core of the actions and interactions across all of the different roles. Individuals within each role expressed the core dimension and human need to be heard, valued, and understood by those in other roles. In practice however, the lack of integration of perspectives created paradoxes and disconnects at multiple levels, and in particular by those providing direct care.

**The Primary Dimensions**

This section provides an overview of the five primary dimensions, based on the roles identified: (a) seeking social connection and meaningful stimulation (residents and families), (b) caring for residents’ daily needs (PSWs), (c) ensuring quality of care on the unit (nurse managers), (d) translating vision into programs and policies (senior leadership team), and (e)
advocating strategically (ED). In the following sections, I provide detailed evidence and discussion of each dimension and its explanatory matrix. The primary dimensions “represent emerging pathways that possess some explanatory power” (Kools et al., 1996, p. 317) and integrate the perspectives of the study participants. The explanatory matrices provide a framework for moving from the descriptive interview data to explanations and interpretations in a systematic manner.

**Primary Dimension 1: Seeking Social Connection and Meaningful Stimulation (Residents and Families)**

At the heart of what residents seek and what families advocate for is social connection and meaningful stimulation. This takes place within the context of living at the LTC facility out of necessity in an environment where much of the day is programmed, leaving few opportunities for choice, and where residents and families do not want to be a burden to those who care for them (see Table 4.2). This context often leads to residents and families trying to lighten the load on PSWs, trying to balance gratitude for care received with advocacy for oneself or on behalf of a loved one, and having to problem-solve directly with nurse managers. The consequences of this process make residents and families reluctant to ask for what they need, so residents needs go unmet, and opportunities to integrate the perspectives and insights of PSWs are missed.

**Table 4.2**

*Residents and Families: Seeking Social Connection and Meaningful Stimulation*

<table>
<thead>
<tr>
<th>Dimension</th>
<th>Context</th>
<th>Conditions</th>
<th>Process</th>
<th>Consequences</th>
</tr>
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<tbody>
<tr>
<td>Residents and families seeking social connection and</td>
<td>Living at facility out of necessity</td>
<td>Few opportunities for choice Not wanting to be a burden</td>
<td>Wanting to lighten the workload for PSWs Balancing gratitude for care with advocacy</td>
<td>Reluctance to ask for what is needed Needs for social interaction and meaningful</td>
</tr>
</tbody>
</table>
Context: Living at Facility out of Necessity. For many people, moving into an LTC facility is a necessity rather than a choice. On average, residents are on a waiting list for up to 9 months (Health Quality Ontario, 2019). When a room becomes available, residents and families have 24 hours to decide whether to take the bed and to move into the home. This sudden decision and the transition that follows is unsettling for residents and families and is accompanied by a loss of social connection, loss of familiar surroundings, and feelings of loss in terms of choices and daily routines. One family member expressed this when speaking about her elderly mother’s move into the home:

The only thing that was available when she moved in was a semi-private room and she had to share a bathroom which made her wild. So, you know, it wasn’t a cheapest move, I think it cost me about $450 or $550 to take the stuff there. We get it there and they say, but she can’t keep this, she can’t keep this, she can’t keep this. I said, why, you know, like why not? Already she [her mother] said, I gave up my car, I gave up my independence, you know, I gave you managing my pills, I gave up managing my money, and now you are asking me to give up my favorite easy chair and my—my beautiful TV stand. Oh! She was just—there was no consoling her for weeks, she was so depressed. But people are giving up so much and then you are asking them to give up the last of their few possessions. (family member participant)

The transition also leads to feelings of vulnerability, and sometimes fear, especially for those with communication difficulties, like one resident who is deaf (comments were translated
by a student staff member with knowledge of American Sign Language). This resident shared that when other residents found out he was deaf, they were frightened and discontinued any conversation, leaving the individual isolated and misunderstood.

Another resident, upon moving into the facility, was faced with the reality that her ability to make choices would be limited in a somewhat brusque fashion:

That’s something I think you have to live here to understand. Because one day one [PSW] was pretty tough to me. She said, “You are in a nursing home now, so you have to do as we say.” (resident participant)

**Condition: Few Opportunities for Choice.** Once a room becomes available, residents initially have no choice but to accept the room they are assigned. Although there are efforts made to group residents with similar abilities together during mealtimes, there is often a mix of abilities at the table, which can leave residents feeling disconnected from others. However, those who are mobile and have higher cognitive abilities can find meaningful connections. As one resident participant in this study shared: “There are several people here that I talk to and I know I feel that are friends. I feel that there are enough people here for me to feel at home.”

Other participants had a much harder time finding connections and recognized that it affected their well-being and long-term cognitive ability. One resident described her experience:

That’s the hard part of it because I used to sit with some people after dinner, we were sitting and we talked about what was going on outdoor and news—yeah, but now I can, I feel I am getting to a standstill this way. Because I can’t talk to anybody about it.

(resident participant)

A family member talked about the pain that this social isolation brings her mother:
My mom keeps hoping she will find a best friend but no, hasn’t happened. She talks about that almost every day. She hasn’t been able to make—she hasn’t been able to form any friendships and my mom is the friendliest person in the world. (family member participant)

**Condition: Not Wanting to be a Burden.** In this study, residents and families noticed and felt the burden placed on the PSWs who carry out the personal care. Especially in times of staff shortage on floors, residents expressed the desire to not be a burden for staff, even though they needed care for most activities. This is how one resident expressed it:

So, I don’t need a lot of help. I mean I need to be—I can’t walk anymore. I can’t stand up. My knees being replaced three—been replaced twice. So, they have to do everything for me, lift me in bed. Stand me up for the bathroom, take clothes down, get me to toilet. They have to do everything. The nurse [meaning PSW] would provide most of my care. She gets me up in the morning. And then into the bathroom where she dresses me. And then she’ll take me up to breakfast. This morning I went up myself because they’re short, short staff. She had to get someone. But that’s fine, I can go myself. (resident participant)

Residents identified with staff, felt their burden, and even when staff interactions became more curt, there was understanding:

They should have more staff. Because the kitchen is so short staffed and I think it’s a shame for your staff and for your residents too. I see it in like this morning there was only one person and we are 32 persons to come, she has to make different breakfast for all of us. We don’t all eat the same. And it is a big job. And it’s too much for one person. I wouldn’t like to be her. And it happens that when there is only one person, she gets a little bit snappy at the end. And it’s difficult for her. So, I said down there this morning to
meet him. I said it would help your residents and it would help people in kitchen, it would—I am not talking just to get help for myself, I think we should have help in the morning everybody. And they’re good to come and help us up and get us down but then there is when we have finished the breakfast or a meal, we have to sit there for ages.

(resident participant)

**Condition: Social Interaction and Stimulation is Limited.** In this study, social events and programming were available to residents on a daily basis, as depicted in the sample monthly calendar of events in Figure 4.2. The LTC home’s art program was a source of pride and the art created by residents could be found in the hallways. The home also offered therapeutic recreation and activities, a music and memory program, and spiritual care. Therapeutic services were offered to those residents in need of these services, as assessed by staff.

**Figure 4.2**

*Anonymized Sample Calendar of Events*

<table>
<thead>
<tr>
<th>Sunday</th>
<th>Monday</th>
<th>Tuesday</th>
<th>Wednesday</th>
<th>Thursday</th>
<th>Friday</th>
<th>Saturday</th>
</tr>
</thead>
<tbody>
<tr>
<td>9:00 PM Sunday</td>
<td>10:00 AM</td>
<td>11:00 AM</td>
<td>12:00 PM</td>
<td>1:00 PM</td>
<td>2:00 PM</td>
<td>3:00 PM</td>
</tr>
<tr>
<td>9:00 PM</td>
<td>10:00 AM</td>
<td>11:00 AM</td>
<td>12:00 PM</td>
<td>1:00 PM</td>
<td>2:00 PM</td>
<td>3:00 PM</td>
</tr>
</tbody>
</table>

Note: Reprinted with permission from participating organization (anonymized).
While the home offered a variety of events, cognitive ability and variation in individual preferences meant the options were limited for some residents. One family member participant shared: “There is nothing—nothing that is going on in this floor. Other than painting and that sort of thing and I think that’s probably the same with all the rest of the floors too. . .” Another family member participant described it as “severe lack of stimulation of any sort,” feeling that the home “play to the lowest common denominator” on a floor with residents of varying abilities and individual needs.

**Process: Wanting to Lighten the Load for PSWs and Balancing Gratitude With Advocacy.** Families and residents felt the need to lighten the load for PSWs, especially during times of staff shortages, and minimized their own needs. One family member participant compared the workload on different floors and commented that on the floor with few ambulatory residents, the workload was high: “It seemed to me that the staff just don’t have enough time to do what’s necessary.” She described how she lightened the load in her own way:

> So, and I often will go in, mom’s bed isn’t made and though I think she makes her own bed most of the time but I straighten the room every day, you know, and then that’s fine, I don’t—I have no objections to doing that, it’s something that we do together but I just get the impression that there is just—but somehow or the other it could be done differently.

Family members expressed gratitude that their family member was safe, cared for, and clean and balanced this with advocating for the needs of their loved one. As one family member shared: “I am not complaining because my mother is clean, she is fed, you know, she never smells, she is 96.”
Process: Problem-Solving Directly With Nurse Manager. In this study, family members expressed attending to the social interaction and meaningful interaction needs of their loved one more reluctantly as wishes or “nice to haves” rather than as expectations. Family members were proactive in solving problems related to direct care and did so with the nurse manager on the floor or the director of care. At times, this directly involved the PSW, but during staff shortages or when temporary staff were on the floor, problem-solving was done with the nurse manager.

You see, family comes in all the time and they tell you this is what you’re supposed to do. And the resident is telling you, no, this is what she wants. Like, even recently we have a family that—a daughter and a mother. Yeah, well, it’s kind of tricky because then you have to keep going back and forth, dealing with the nurses saying, well, this resident is saying that and then the family wants this, so then what do you do? Well, when there’s a problem like that we go to the nurse and the nurse is the one that most of the time would go back to the family member and say, well, this is what the resident is saying. If it’s a resident that can’t speak for themselves then we just have to comply and go by what the family wants. (PSW participant)

Even though the PSWs were closest to the residents, issues were often raised with the nurse or the director of care. One family member related that if he saw something, he would raise it immediately. Sharing that he knew most of the “big players” in the facility, he explained that he would usually talk to the director of nursing care directly to take care of issues. Although the PSWs provide the daily care and assist with feeding, it is the nurses who liaise with family members regarding food intake, and it is the nurses who share with the family how much the
resident ate for breakfast or lunch and what to look for at supper time (family member participant).

**Consequences: Reluctance to Ask for What is Needed, Resident Needs go Unmet, PSW Perspective is Missed.** Residents and family members were reluctant to ask for what they needed, especially in relation to social connection and meaningful stimulation. It was not that they were unable to express their needs, but the conditions in the home have created a climate where asking for what is needed is not even an option and is simply not done. One resident expressed it as follows:

But they don’t have time. It’s short staff we have. The way I feel sometimes, when I feel they do that, you know, the treat me like a baby. (resident participant)

The consequences of the process and conditions in this home not only resulted in certain residents’ needs for social interaction and for meaningful stimulation going unmet but it also resulted in their expectations in this area ebbing away. Furthermore, because family members typically raise issues directly with the nurse managers, any valuable, firsthand input from PSWs is missed, which I will discuss in greater detail in the next section.

**Primary Dimension 2: Caring for Residents’ Daily Needs (PSWs)**

The pivotal role that PSWs play in providing person- and family-centered care in the LTC home setting is the focus of this primary dimension. Within the context of being responsible for providing care for up to eight residents on a unit that was frequently understaffed, the burden of staff shortages was disproportionately felt and carried by PSWs (see Table 4.3). Although they managed as best as they could, the PSWs became task oriented and felt rushed in their interactions with residents.
Table 4.3

Personal Care Workers: Caring for Residents’ Daily Needs

<table>
<thead>
<tr>
<th>Dimension</th>
<th>Context</th>
<th>Conditions</th>
<th>Process</th>
<th>Consequences</th>
</tr>
</thead>
<tbody>
<tr>
<td>PSWs caring for residents’ daily needs</td>
<td>Primary care responsibility of eight residents on a unit that was frequently understaffed</td>
<td>Burden feels heavy and is disproportionately carried by PSWs</td>
<td>Managing as best they can</td>
<td>Becoming task oriented and feeling rushed</td>
</tr>
</tbody>
</table>

**Context: Being Frequently Understaffed.** The role of PSWs in an LTC home includes attending to the daily care needs of residents and is carried out under the supervision of a regulated health professional. In this particular home, this was the nurse manager’s responsibility. Each PSW had the primary care responsibility of up to eight residents in a unit. Many of the residents required significant help with dressing and bathing, which requires PSWs to work in teams.

And that’s number one there. Communication. Oh, like if I’m going to give shower, I let my team know. She [peer team member] knows and then she knows she has to come and help. And like giving shower, you need two persons, she has to be there to help and when you’re finished you ring the bell or you do this and that person is right there. So, it’s communication. We do share work. It’s among us. As team. Yeah, we do work as a team.

(PSW participant)

I saw this ease of teamwork firsthand during my observations on the floor. In the morning, I observed one PSW cheerfully offering to help transfer residents to their wheelchairs. The PSWs often help each other out when one is behind schedule. One PSW shared that when
she was battling a medical condition, sometimes her colleagues would have already taken care of the residents on her list to help lighten her load.

In these teams, working with others was essential. However, as in any team, a willingness to help was not always evenly distributed:

Teamwork is very important, very, very important because without teamwork one person you cannot go anywhere, especially dementia floor, even some of the residents, you cannot do care by yourself, you need somebody. We just have to call somebody who is willing to help you and who is willing to do the work. Yeah. (PSW participant)

Being aware of the individual needs of residents was imperative for providing safe care. Having a relationship with residents, and making a human connection, not only helped with completion of the work, but it also filled the need for resident and staff social connection. In this study, the residents had complex needs and varying cognitive abilities, making for work that was unpredictable and could take longer than average, depending on the ability of residents to understand and to express themselves, their moods, and their physical conditions at a given moment. For example, some residents were unable to walk fast, others did not want to eat one day, some rang the bell frequently, and some residents were kind, while others weren’t:

So, you meet some very kind ones and you meet some that are not so kind and want to get things done now and sometimes you’re not able to provide that now and they’re not exactly kind, there’re the aggressive kind and there’re the kinds that are calm and, you know, you just—it’s just hard to deal with time to, you know, to work with a certain amount of time when you have residents that are of different characters. (PSW participant)
The PSWs I interviewed in this study wanted to spend time with residents, wanted to connect with them and provide care that responded to residents’ individual needs. However, PSWs’ workloads did not always allow for this, as explained by one participant:

But you have an assignment to tackle, to finish and if certain resident is, say for instance, agitated and some kind of responsive behavior, showing some responsive behaviors, you wanted to know what causes that. So, you want time. So, to me that is—I find it difficult because then your partner is waiting for you and needed your help too. So, to me that is my biggest challenge because even just talking to the resident who is upset of something, they lost something and they can’t find it and you want the time to show that you really care and you want to find what they’re looking for. You know, it’s bothersome to me because you are always saying I’ll be right back, I’ll be right back, but that very moment is important for that resident and yet you keep telling them, you will be right back.

Oftentimes they will say “I hope so,” you know? (PSW participant)

Several times a week, there was not a full staffing complement and work had to be completed with one staff member less, or with a staff member who was not aware of the routines on the floor, the needs of residents, or how teams preferred to function.

Well, I think the time is probably the main factor and we all know that the PSWs are often working short. So, if it’s a day when, you know, one of your colleagues is on the floor and all of a sudden you have four more residents than you usually do and you are just trying to get through it all, I think that’s probably the biggest driver but I also think that compassion fatigue is huge. (program staff participant)

Residents recognized that staff felt this burden and expressed sympathy for the PSWs who have “race around” to get tasks done. As recognized by one of the resident participants:
“Because there aren’t enough PSWs to meet the demands of the residents. It is clear. That’s why people wait a long time. Yeah, very long time.” There was also recognition by other colleagues that this is a system issue:

Well, I think that again a systemic issue and I think PSWs do get a lot of criticism about how they work, but I think that they’re set up for that or our system sets them up for that. They’re overworked and there’s not enough of them and I think problem is filtered down to that level that are addressed in other areas and I don’t see PSWs getting enough support because I think their job is probably the most important job here. So, I’d like to see us elevate them a little bit more and get to know them a little bit more and have them be able to talk about their roles and talk about caregiver burnout and caregiving fatigue, things that I think are really, really important to acknowledge. (program staff participant)

When a PSW connected with a resident, the connection was meaningful and added to the quality of life for residents in ways that were observed by family members.

Yeah, [resident] will speak softly to them, I love you and—you know, mannerisms and what she will say, and then PSWs will tell me that [resident] was talking this morning, yeah, but she is very soft spoken, you really got to pay attention. Yeah. Because she will smile. And be more relaxed and then more willingness to a degree well to just try to communicate when she can but she will try. Yeah, and she will say thank you and that sort of thing. (family member participant)

The context for delivering direct care in an LTC home is one of considerable workload that varies depending on the needs of residents and the available staffing.

**Conditions: Burden Feels Heavy and is Disproportionally Carried by PSWs.** The burden of providing daily care to residents is a heavy one for PSWs, from both a physical and a
mental perspective. Awareness of all that needs to be done is omnipresent, as are the expectations that there are requirements that need to be met. Whereas a unit cannot function without a nurse manager on the floor, PSWs are expected to complete the same amount of work on days when there are staff shortages. With the increased complexity of residents’ care needs in recent years, the load on PSWs is heavy and the pace is relentless. One PSW participant shared that work in the mornings was most challenging because they have to dress residents and get them ready for breakfast. This is followed by snack time and lunch. The evening shift includes only one meal and the pressure on PSWs appears to be lower during this shift. The increased pressure of morning shifts was expressed by two other participants:

They are asking us to have the residents up and in the dining room for breakfast for 8:30 and we start at 7:00 and there’s also different shifts that are changing over right now these shifts. So, there’s people that are coming in at 8:00 and how you do a whole team in 30 minutes, that’s impossible. It feels like there is time pressure. It does. (PSW participant)

So, on our floor 32 residents divided by four, okay? I have the same number of residents that the person at 6 o’clock starting, they have two and a half hours to do their care. My expectation, I start at 8, they want everybody in the dining room at 8:30. I have six total cares, I have transfers and I am supposed to help my partner. Can you tell me how you can do that in half an hour? And that’s their ex—that is the expectation. It doesn’t happen. I mean I’ve been injured this year because I’ve been rushing so much, I was on modified for two months. (PSW participant)

**Process: Managing as Best They Can.** Many PSWs work in the LTC field because of their love for the work. It’s this dedication to their work and their relationships with their peers
that bring PSWs to work every day. When asked what brought her to LTC work, a PSW participant answered: “My God, my love for the elderly. This staff are wonderful and I love my job.” Another PSW expressed her joy in her work as follows:

But now I have the compassion, I have the care, like I play with them like even some of them I call them “grandma.” Oh, yeah, and one of their family member said, oh, I love that, you always call my mom that! Some of them if you call them, she would tell you oh, don’t call me that, I am not your grandma. I say, okay I’m sorry, and I go my way. I just have fun and I do everything what I can do for them. Yeah. To make them happy. (PSW participant)

PSWs feel the effects of the heavy workload and pressure of their jobs. For some, this comes with a sense of responsibility for all residents on the floor. “It’s not only the six or seven that’s on your team, but you are responsible for all residents. That’s my belief and that’s what we should do” (PSW participant). On certain days, that means that PSWs manage as best they can; they work around the rules to provide what they know residents want and need.

Like for example if there’s a resident who doesn’t matter—who doesn’t really care what time they get in bath because sometimes they have that, then for me I would say to my supervisor, sometimes I just do it without even telling them because it’s, you know, you just have to do—I believe in doing what the resident wants. So, I would change maybe one of my peers that I have worked with and said, would you like to do Mr. So-and-so now since he doesn’t care what time he gets his bath and then we do the other lady who wants to have her bath in the evenings. What we do we have two different shifts. Teamwork is very, very important. That way the residents are happy because they come first, the family are happy, and our supervisor has less headache. (PSW participant)
PSWs’ intimate knowledge of residents’ likes, dislikes, and habits allow them to make decisions to meet residents’ needs. While most of the problem-solving happens with the nurse manager on the floor, in times when that support is not received, PSWs will “sneak” in a bath at an unusual time. Sometimes they feel they get into trouble for doing so (nurse manager).

**Consequences: Becoming Task Oriented and Feeling Rushed.** The complexity of residents’ needs and the timelines to complete tasks lead to PSWs being task oriented and feeling rushed. The unease with this is expressed as a regret by PSWs and is at odds with the kind of care they wish to provide to residents. There was some awareness of this at the senior level:

But that’s interesting when you think about what a personal care worker is and how we have really changed the role of the personal care worker to very robotic. Kind of breakfast, change them, shower them, lunch. Document how much did they drink, how much did they eat, you know, weigh them, you know, as opposed to what care used to be like, you know, and that’s what—our staff said that. If you look at our staff satisfaction surveys, we want more time with our residents. We want to get to know them. We want to spend time with them. It’s an almost—I think well since I’ve been here, every single staff survey, I have seen that comment, you know, we want more time. (senior leadership team participant)

At the senior leadership level, there was also awareness of the wisdom that PSWs bring to resident care conferences (multi-disciplinary team meetings with residents and family members regarding care that must take place at least once a year): “We don’t have them always come to care conferences and it will be amazing if they always came to care conferences. But again, the darn day gets in the way. Right?” (senior leadership team participant).
However, at the same time, when PSWs’ rushed behavior is observed by others in the organization, the intention driving it is often misinterpreted. Rather than seeing this behavior as an undesirable consequence of the system that has been created within the organization, the behavior is seen as a flaw in the ability of PSWs to be flexible and solve problems. For example, when asked what could be done differently, one mid-level manager answered: “Maybe just slowing down. I think they are like an automatic—like an automatic frenzied pace” (nurse manager participant). One PSW described what it felt like to be misunderstood:

Yeah, like I’ve come to think that this is it, it’s four staff and we don’t care what you think, we don't care this is the way it’s going to be because we want you guys to be flexible and be able to—because it’s your fault that you can’t manage your time because it comes back on us and it’s well, you’re just not managing your time right. Well, that’s not the case at all. How many years have I been doing this? It’s not my—my organizational management skills. (PSW participant)

Over the last few years, staff have noticed a change in the amount of time they have available to spend with residents:

Yeah, we used to have more time, we used to sort of sit down and have a cup of tea sometimes or you could sit and chat a little bit with residents, like it used to be a little more relaxed and we used to laugh and have fun and like things have gotten very, very rigid and scheduled. (PSW participant)

This decrease in available time has affected the quality of care they are able to provide: “I cannot give the care that these residents are entitled to” (PSW participant). In addition, there have been changes to the staffing levels over the last year. On some floors, care is now provided by four full-time staff without flexible coverage. The expectation was that this would create more
flexibility and more permanent staffing opportunities. However, on the floor, the experience has been one of frustration. Staff expressed regret about how things have changed over the last few years and a desire to feel valued and appreciated again.

Yeah, to feel valued, to feel appreciated, it doesn’t feel like you’re being appreciated that way. I used to love working here. It used to be great, like we used to interact with everybody, we used to have parties for the staff, parties for the residents, staff were invited. It seems like it’s just all slowing down now like everybody—Halloween’s coming up, everybody used to dress up. We used to go floor to floor showing our outfits. Now, you know, barely anybody does it. I don’t feel as good much lately, I find. A big part of it is management and I’m sure they have a lot on their plates also from ministry. (PSW participant)

Furthermore, the daily pressure of this work environment has made it difficult for some staff to turn it off at the end of their shifts: “And I don’t know how to turn off work, you know, like leave work at work and not take it home” (PSW participant).

So, if it’s a day when, you know, one of your colleagues is not on the floor and all of a sudden you have four more residents than you usually do and you are just trying to get through it all, I think that’s probably the biggest driver but I also think that compassion fatigue is huge. Even if your workload was relatively manageable, you’ve been doing it for so many years and you just keep feeling sad that you might eventually start to be closed off to feeling sad because it’s really hard to do that. I’ve felt that in myself sometimes when you’re just like, this is a lot [laughs]. (program staff participant)

Not only does a stressful work environment affect staff well-being but it also affects residents by extension. What the PSWs in this LTC home wanted was to be seen, heard, and understood and
to be recognized for their hard work, which comes from the heart: “So, and see the way we work and you give me that, you put me down. The moment I see that you put me down, I don’t have the will to do something. I feel sad” (PSW participant).

**Primary Dimension 3: Ensuring Quality of Care on the Unit (Nurse Managers)**

The nurse managers who oversee the floors in an LTC home ensure quality of care on the unit while also integrating medical care, personal care, and program needs. They are called on to manage relationships and solve problems across a spectrum of perspectives, often doing so on behalf of others (see Table 4.4). In solving issues for direct care providers instead of with them, nurse managers reinforce PSWs’ task-oriented focus.

**Table 4.4**

*Nurse Managers: Ensuring Quality of Care on the Unit*

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<th>Dimension</th>
<th>Context</th>
<th>Conditions</th>
<th>Process</th>
<th>Consequences</th>
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</thead>
<tbody>
<tr>
<td>Nurse managers ensuring quality of care on the unit</td>
<td>Units within the organization</td>
<td>The complexity of medical, personal care, and overall well-being needs on the unit</td>
<td>Managing relationships and solving problems</td>
<td>Reinforcing PSW focus on tasks</td>
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**Context: Units Within the Organization.** Nurse managers have the pivotal role of ensuring quality of care and coordinating all aspects of care provided on their unit, including coordinating maintenance efforts, ensuring medication is distributed, assessing changes in the health status of residents, supervising the care provided by PSWs, and liaising with families. This is how one nurse manager described it:

Really, I guess it’s just to organize everything to also try and help people be as healthy as possible, to sort of give them their medications, try and keep an eye on how they are feeling, if they’re sick or not sick, and communicate between other teams like the doctor
or the dietician, like sort of everything funnels through the nurse. Even if like the toilet is broken, that’s my issue. (nurse manager participant)

**Conditions: The Complexity of Medical, Personal Care, and Overall Well-Being**

**Needs on the Unit.** The role of nurse managers is to manage complexity, which requires the integration of residents’ medical care, personal care, and overall well-being needs. They are part of the initial and annual resident care conferences, and they liaise with physicians—for all 32 residents on the floor. Nurse managers have relationships with residents and their families, PSWs, physicians, social workers, and senior leadership. They must also deal with the complexity of changing resident needs, acuity of medical problems, and any staffing changes on the floor. Furthermore, they are called upon to problem-solve by families, residents, and PSWs. When asked who they go to when there is an issue with a PSW, one family member participant responded: “I speak to the nurse.” PSWs, in turn, rely on nurse managers to optimize teamwork:

But before you go to the DOC [Director of Care] you might want to go to the nurse first and see if you can deal with it, you know, if the nurse can deal with it first and then for me I always said if you can’t deal with it then you have to take it a step further, you know, if the nurse can’t deal with it which sometimes they can because like I said some people are really difficult to get along with, they are and they don’t always want to work as a team. So, you know, when you run into those folks then you just kind of have to take it a step further, you don’t even want to get the nurse involved sometimes, you just kind of nip it in the bud and go straight to the top where you might be able to get some—some answers, you know, and get some changes. (PSW participant)

The nurse manager is in charge of dispensing medication, and even this task requires communication with other staff and with residents. When there are 32 residents on the unit, this
requires quality communication. With so many moving parts, conflicts can arise, particularly when the timing of tasks collides. One PSWs described balancing the resident’s wishes to go to bed with the nurse’s need to carry out medication distribution:

And oftentimes they say, “I want to go to bed,” and then when you put them to bed you get into trouble from the nurses because they say, “oh, it’s difficult to give them medications,” but in my scenario, I fight back. I always feel that I have to advocate for this resident because if nobody else, it has to be me. I will start it. I will start to be the advocates of these elderly. So, I would really stand up for my team leader and I would say, “It’s their likes not yours and not mine, and the person is tired, I’m sorry.” (PSW participant)

**Process: Managing Relationships and Solving Problems.** Nurse managers are frequently called upon to manage relationships and solve problems. In this study, residents, families, and PSWs reported that it is the nurse manager who often interacts on behalf of PSWs to solve problems. The example below illustrates how nurses translate residents’ dietary preferences to food services as observed by one PSW:

So, we tell the nurse that this is their preferences and this is how they like it. Basically, say snack time particularly because their diet is already done when they enter the facility but their snacks are not, they like cheese, they like muffin, or they like yoghurt, certain things like that or all of a sudden it changes. “Oh, I don’t like peanut butter now, I prefer just yoghurt.” Those things, we have to say that to the team leader, so the team leader can call the dietician or the food service to say this resident needed this and that, there’re some changes with their diet. So, that’s how we communicate. It’s always to the team leader. (PSW participant)
This means that the nurse manager is directly aware of and involved in issues to be managed but leaves PSWs out of direct decision-making. On the one hand, this speeds up problem-solving, but it also leaves PSWs one step removed from the decision-making process.

Consequences: Reinforcing PSW Focus on Tasks. The consequences of the nurse manager’s problem-solving role of in all aspects of care is that PSWs become even more focused on tasks. LTC home systems and processes already contribute to PSWs feeling pressured by time and focused on tasks, which leaves them with less time for problem-solving with families. The added social process of nurse managers managing relationships and solving problems on behalf of PSWs only reinforces this task-oriented focus, thereby silencing the voices and visibility of PSWs within the organization. One program staff member offered her observations on what PSWs experience:

Being overworked and there’s not enough of them and I think problem is filtered down to that level that are addressed in other areas and I don’t see PSWs getting enough support because I think their job is probably the most important job here. (PSW participant)

In this study, PSWs indicated that what they really want is to be seen and valued, and for senior and middle management to motivate and support them. They expressed that they want senior leadership to “see that you are doing it from your heart” and to know that somebody is backing them so they can do the work even when they are tired: “I wish they would see the good work that we are doing. I wish they would see all the good work that we are doing” (PSW participant).
Primary Dimension 4: Translating Vision Into Programs and Policies (Senior Leadership Team)

In this LTC home, the senior leadership team translates the organizational vision into programs and policies (see Table 4.5). This close-knit group holds a common vision for care provision, is supported, and feels motivated and valued. This is in stark contrast to those providing direct care, who are not involved in creating direct input processes into decision-making on programs and policies, and feel unappreciated, unheard, and unsupported.

Table 4.5

Senior Leadership Team: Translating Vision Into Programs and Policies

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<thead>
<tr>
<th>Dimension</th>
<th>Context</th>
<th>Conditions</th>
<th>Process</th>
<th>Consequences</th>
</tr>
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<tbody>
<tr>
<td>Senior leadership team</td>
<td>Organization</td>
<td>Closely-knit team, agreement on</td>
<td>Neglecting PSW voice in staffing, program, and</td>
<td>Senior leadership group feeling motivated and</td>
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<tr>
<td>team members translate</td>
<td></td>
<td>vision, and feeling supported</td>
<td>policy decisions</td>
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<td>vision into program and</td>
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<td>Point-of-care group feeling unappreciated,</td>
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<td>policies</td>
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<td>unheard, and unsupported</td>
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Context: Organization. Working closely with the ED, the role of the eight members of the senior leadership team is to translate the strategic vision of the organization into programs and policies. The senior leadership team is guided by the strategic plan within the context of providing care for 254 residents on eight different floors, and with input from family and resident councils. The team is responsible for integrating the perspectives of quality of care, human resources, finances, resident services, food services, volunteer services, environmental services, and community programming. This takes place in an environment where residents’ needs are becoming more complex, as described by one senior leader:
And so, my role really is to ensure that we are following our mission, value, and vision here, that we are challenging ourselves to come up with different ideas that are going to meet the needs of residents where they are now and over the last number of years.

There’s challenges for sure because people come in, they’re frailer and frailer. (senior leadership team participant 9)

**Conditions: Closely-Knit Team, Agreement on Vision, and Feeling Supported.** The senior leadership team in my study reports directly to the ED and has the opportunity to identify areas for growth, implement ideas, and feels supported in their work. Each member of this close-knit team is valued by the ED and is involved in decision-making. They are on the same page when it comes to implementing person- and family-centered care. One of the senior leaders explained the context in which their role is situated as a standalone organization without a large corporate structure behind them. Policies are developed by the home, in accordance with the Long-Term Care Homes Act (2007), and include areas such as resident care, infection control, medication management, and risk management. One senior leader described their role as follows: “You really have to identify the high-risk areas and make sure that they have the tools they need and the knowledge they need and then you have to follow-up and make sure it’s happening” (senior leadership team participant).

**Process: Neglecting PSW Voice in Staffing, Program, and Policy Decisions.** Whereas a member of the senior leadership team has a seat on the family and resident councils, there are no processes where direct input is sought from PSWs. Much needs to be coordinated for care to come together in service to the residents, including residents’ preferences, music interests, spiritual needs, physical needs, medical needs, and social needs. Initial referral to services is
coordinated at intake by the social worker and ongoing referrals are made by program or nursing staff.

In this LTC home, there are no formal mechanisms by which PSWs can exchange ideas or provide input into the decision-making process around policies, programs, or staffing. PSWs’ needs are interpreted through the intermediary role of nurse managers and information is shared with them in large town hall meetings.

Like I have to say it all depends on your management, like some management are very understanding, they’re very aware of what’s going on, they’re not—like, if they say okay, you can sneak around for a shower, that’s fine, like some people aren’t as worried about that, some are very strict and schedule oriented, and task oriented. It is like not really being allowed to kind of do what you think is best because they’re like, no, the rule is this, the rule is this, the rule is this, that’s—that’s the big issue. (nurse manager participant)

**Consequences: Senior Leadership Group Feeling Motivated and Valued.** One of the consequences of the senior leadership team’s role is that this group feels valued, supported, and motivated in their work. For example, one senior leader shared her appreciation for her job: “Well, I’m in a supervisory position. I’m in a leadership position here. I have a great job” (senior leadership team participant). She also discussed the opportunities provided by her role to put new programs in place and to be creative:

And that’s a really, really a big part of my role and I think for me because I’m interested in so many different things I’ve been able to bring a lot to our home in terms of some of the innovation and some of the technology and different programming ideas and so on and so forth. So, so I’ve been lucky because I have had my own supervisor who is very
supportive of that, of okay let’s try this, let’s try that sort of thing. So, we have a good home from that perspective. (senior leadership team participant)

**Consequences: Point of Care Group Feeling Unappreciated, Unheard, and Unsupported.** The other consequence of the senior leadership team’s role is that it compounds the disconnect at the PSW level, leaving those who provide direct care feeling undervalued, unseen, misunderstood, and unheard. As one PSW expressed: “I don’t know if our management team sees that what we are doing is hard” (PSW participant).

The senior leadership group sets the tone and develops the policies and programs that form the scaffolding of organizational culture. The organizational rules and their interpretation by nurse managers and subsequently by PSWs influence the pressure and the degree of empowerment experienced by the latter group.

**Primary Dimension 5: Advocating Strategically (ED)**

The ED fulfills the outward-facing strategic advocacy role of this primary dimension. This role takes place within the context of provincial health care decision-making tables and potential donors and requires raising the LTC home’s external visibility by promoting its accomplishments and focus on high quality person- and family-centered care (see Table 4.6). The time and effort that go into these external efforts simultaneously decrease internal visibility, leading to feelings of being misunderstood and undervalued and surfacing resentment on the part of those who provide direct care to residents.
Table 4.6

*Executive Director: Advocating Strategically*

<table>
<thead>
<tr>
<th>Dimension</th>
<th>Context</th>
<th>Conditions</th>
<th>Process</th>
<th>Consequences</th>
</tr>
</thead>
<tbody>
<tr>
<td>ED advocates strategically</td>
<td>Provincial health care decision-making tables and potential donors</td>
<td>Lack of funding requires external fundraising</td>
<td>Raising external visibility</td>
<td>Decreased internal presence and staff feeling misunderstood, undervalued, and unheard Surfacing of resentment</td>
</tr>
</tbody>
</table>

**Context: Provincial Health Care Decision-Making Tables and Potential Donors.** The Ontario health care system is currently undergoing transformational change that will result in the organization of care and financing of the health system being integrated across the continuum of care, including hospital, community, and primary care. Although the LTC sector is not included at this time, these health system changes could affect how residents apply for rooms in LTC, workforce planning in health care, the availability of PSWs, and the ability of citizens to stay in their homes as long as possible. In addition to monitoring these changes, the ED’s role at the provincial decision-making table is to advocate for funding and policies that support the quality of care in the LTC sector, and in this home in particular. Furthermore, in a system that is underfunded and in which funding only covers essential care (Conference Board of Canada, 2011), securing additional financial support from donors is necessary to implement and maintain innovative programs.

**Conditions: Lack of Funding Requires External Fundraising.** The need to raise the home’s visibility externally in order to secure additional funding is a key part of the ED’s role. Investing time in relationship-building—with a newly elected provincial government or with
private donors—is essential to the long-term well-being of the organization. For example, increased visibility has led to donations that have supported several innovative projects that would not have been possible otherwise. These programs have benefited residents directly and have made it easier for the home to keep its focus on care that puts residents at its center.

And if we can bring out quality of life in someone that’s inflicted [sic] with dementia to me it’s a wonderful thing. And I get a lot of joy out of some of the programs. This is not new because that’s why we bought the jDome BikeAround. That’s why I bought the Motiview. That’s why we have the mechanical pets. That’s why we have virtual reality because all of those things are tools that we can use in order to just bring out the best that residents can give us. (ED participant)

**Process: Raising External Visibility.** Increasing external visibility at provincial policy tables to ensure that the needs of the home and the LTC sector are better understood requires the ED to have an external work focus and to work directly with provincial decision-makers. In addition, because this particular home is a not-for-profit organization, being in touch with potential donors and optimizing the use of media is an essential part of the ED’s role. This externally facing focus is unique to the ED role.

**Consequences: Decreased Internal Presence and Staff Feeling Misunderstood, Undervalued, and Unheard; Surfacing of Resentment.** As a consequence of the ED role’s focus on being externally visible, it is simultaneously less internally visible. Internal visibility increases at certain times, such as when external funding efforts are successful and when donors and the media are invited to celebrate funding received. The purpose of these celebratory events is to increase external visibility of success and to generate enthusiasm and connect staff to the possibilities that the newly acquired funds can bring. The events serve the need to be valued and
understood both externally and internally. However, since not all staff can attend—and many do not see or understand the externally facing efforts—these events can lead to feelings of not being understood or valued by those who provide direct care and are the least connected to the ED.

You’re not here and then when you are here, when he is here it feels like he’s only here for the good stuff. For the new living place or we’re going to do this new Butterfly thing and all of a sudden now you see him. (PSW participant)

The ED’s external success in garnering support for innovative programs and services for residents was not visible to the PSWs who provided direct care. When combined with the lack of input into program and policy decisions previously noted, the consequences led to PSWs feeling misunderstood, underappreciated, and undervalued, and their resentment for programs began to emerge. For example, sometimes the implementation of changes was taken personally, as described below:

And just be appreciative. They don’t really—there are so many staff here who’ve been here longer than me and I just feel we’re so dedicated to this place and I feel this is how you—you treat us, like they took the break room away, anything that has to do with money that they can make money with. Downstairs used to be a bistro for the residents and for us. Now because they’re getting money from our government. No, oh my God, no! And the way they post, they put up memos and stuff. Oh, well, they had the audacity to ask us if we had any furniture to bring in like patio furniture or anything so we could set up little nooks everywhere. So, we’re valued so much that we can go sit in the corner or we can go sit in the closet, that’s how they wanted our break room, they don’t care. They don’t care. (PSW participant)
The outward-facing role of the ED is seen by donors and the board of directors and is heard at the provincial level. This has proven successful in securing additional funding for projects that make a difference for residents. However, the increased workload and time pressure experienced by those providing direct care mean that these efforts are not valued by everyone in the organization.

**Summary: Dimensional Analysis**

In this study, each of the perspectives I investigated in this LTC facility shared the same intention to care for residents in a way that centered on the needs of residents and put them first. I described the lived experience of the five major roles I identified through the primary dimensions discussed in this chapter: to seek social connection and meaningful stimulation, to care for residents’ daily needs, to ensure quality of care on the unit, to translate vision into programs and policies, and to advocate strategically. Each of these roles was centered on the intention to improve care for residents. Each perspective sought to be heard, valued, and understood by others, but the mechanisms to integrate perspectives were lacking. Furthermore, each perspective interacted within the meso and macro contexts, which affect them differently. It is this complexity that makes the integration of perspectives challenging. Chapter V will examine these complexities through a situational analysis lens.
Chapter V: Findings of the Study—Situational Analysis

In Chapter IV, I presented a dimensional analysis of the data from the grounded theory methodology. The findings discussed in this chapter highlight the elements that influenced the social processes discussed in Chapter IV in a systematic way. Human and nonhuman elements influence each other, and it is the complexity of the interaction of these elements that I explore using situational analysis in this single, exploratory case study (Clarke, 2005).

It was evident in the interview analysis that elements at both the organizational (meso) and health system (macro) levels influenced the experience of giving or receiving person- and family-centered care. The review of external and internal documents, in addition to on-site observations on all floors of the LTC facility, expanded and enlightened my understanding of the connections across meso and macro level social arenas. The documents I reviewed included provincial health system documents related to overall health care system changes in general and the LTC sector specifically, and organizational policies and strategic plans.

In the following sections, I present three analytic maps that were derived from the situational analysis: (a) a messy situational map, (b) an ordered situational map, and (c) a social world/arena map. The maps depict the complexity of the health system that gave rise to the conditions of care in the LTC home of this case study. To protect the anonymity of the home, its staff, and its residents, home-specific documents are not referenced here but they are integrated into my understanding and analysis of the situation.

Situational Analysis

Situational analysis uses mapping to capture and provoke discussion of the many relationships among elements that contribute the complexity of a situation (Clarke, 2005). The health care system is a complex adaptive system (Plsek & Greenhalgh, 2001). Care that is
provided in LTC homes is influenced at the organizational level and the health system level. The health care system exerts a powerful influence not only on the LTC sector but also on other parts of the system that influence the ability of those with care needs to be independent and make choices about their needs.

**Situational Analysis Maps**

Situational maps allow for the articulation of elements that influence a situation and provide a methodology for examining the relationships among the different elements (Clarke, 2003, 2005). In this study, I used two types of maps: situational analysis and social arenas. Both are explained below and form the foundation of this chapter.

Throughout the research process, I created messy maps as contextual elements surfaced from data collected during the interviews. I placed all elements on these maps without assigning weight to any item, which allowed me to look at the data in different ways and consider who and what formed part of the broader situation. All of the contextual elements that emerged during the interviews are depicted in Figure 5.1, including health care system elements, such as provincial oversight, the Long-Term Care Homes Act, and the mobility of PSWs in the health system; organizational elements, such as staff satisfaction surveys and the internal electronic charting system; and interpersonal elements, such as input into decision-making and not wanting to be a burden (residents and families).
Next, I took the messy map elements and clustered them around descriptive categories using headings suggested by Clarke (2005, p. 90), which I then organized into the ordered situational map shown in Table 5.1. The ordered map shows the density and complexity of the
structural and system elements that influence the social process of providing person- and family-centered care in the LTC home setting. The ordered map also emphasizes the multitude of human and nonhuman elements at play and provides a framework to highlight the silent and implicated actors, in this case the PSWs, residents, and families.

**Table 5.1**

*Ordered Situational Map: Contextual Elements From the Interview Data*

<table>
<thead>
<tr>
<th>Individual human elements or actors</th>
<th>Nonhuman elements or actants</th>
</tr>
</thead>
<tbody>
<tr>
<td>Residents</td>
<td>Long-Term Care Homes Act</td>
</tr>
<tr>
<td>Family members and caregivers</td>
<td>Organizational strategic plan and policies</td>
</tr>
<tr>
<td>Executive Director</td>
<td>Ministry of Health and Long-Term Care</td>
</tr>
<tr>
<td>PSWs</td>
<td>Provincial guidelines for care and staffing</td>
</tr>
<tr>
<td>Nurse managers</td>
<td>Provincial data collection</td>
</tr>
<tr>
<td>Senior leaders</td>
<td>Supply of PSWs</td>
</tr>
<tr>
<td>Program staff</td>
<td>Mobility of PSWs in the system</td>
</tr>
<tr>
<td>Volunteers</td>
<td>Pay for PSWs</td>
</tr>
<tr>
<td>Physicians</td>
<td>Payment structure and funding for LTC</td>
</tr>
<tr>
<td></td>
<td>Innovative programs</td>
</tr>
<tr>
<td></td>
<td>Butterfly Project</td>
</tr>
<tr>
<td></td>
<td>Accreditation</td>
</tr>
<tr>
<td></td>
<td>Volunteer recruitment</td>
</tr>
<tr>
<td></td>
<td>Internal electronic charting system</td>
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<tr>
<td></td>
<td>Staffing on floors</td>
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<tr>
<td></td>
<td>LHINs and CCACs</td>
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<tr>
<td></td>
<td>LTC inspections</td>
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<tr>
<td></td>
<td>Resident satisfaction surveys</td>
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<tr>
<td></td>
<td>Staff satisfaction surveys</td>
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<tr>
<td></td>
<td>LTC home complaint process (internally)</td>
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<tr>
<td></td>
<td>Provincial LTC complaint process</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Collective human elements or actors</th>
<th>Implicated and silent actors or actants</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unions</td>
<td>Residents</td>
</tr>
<tr>
<td>Donors</td>
<td>Family members and caregivers</td>
</tr>
<tr>
<td>Media</td>
<td>PSWs</td>
</tr>
<tr>
<td>Mandatory resident councils</td>
<td></td>
</tr>
<tr>
<td>Mandatory family councils</td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Discursive constructions of individual and collective human elements</th>
<th>Discursive construction of nonhuman actants</th>
</tr>
</thead>
<tbody>
<tr>
<td>PSW focus on task and timelines</td>
<td>Fear of going into LTC</td>
</tr>
</tbody>
</table>
Not being seen, valued, and understood | Lack of choice of facility
---|---
No input into decision-making | Pressure to find additional funding
Gratitude for care | PSW ability to find job elsewhere
Management does not understand our work | 
Need for stimulation and social connection | 
Not wanting to be a burden | 
Admission to LTC comes with little choice and with significant loss | 

**Political and economic elements**
- Organization of Ontario health care system
- Ontario Health Teams
- Underfunded LTC system
- Wait list for LTC
- New Ontario government
- Increased complexity of needs of residents
- Pay difference for PSWs within different parts of the system
- Immigration and refugee policies
- Placement requirements for students in different programs
- Education for PSWs

**Sociocultural and symbolic elements**
- Low public opinion of quality of care in LTC
- Public expectations

**Temporal elements**
- Not enough time to get all the work done (PSW)
- Ministry guidelines for mealtimes

**Spatial elements**
- Location of LTC in city
- Parking
- Furniture in rooms
- Community center next door

**Major issues and debates (usually contested)**
- Safety of LTC
- LTC as an underfunded system
- Quality of long-term care
- Lack of standardized education for PSWs

**Related discourse (historical narrative or visual)**
- Underfunded LTC health system

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I will not discuss the ordered map in detail here, but I will discuss its elements in relation to the social arenas map and its domains, which were extrapolated from the ordered map. The purpose of a social arenas map is to “lay out all of the collective actors and the arenas of commitment within which they are engaged in ongoing discourse and negotiation” (Clarke et al., 2015, p. 14). In other words, a social arenas map provides the analytic framework at the meso
(organizational) and macro (health system) levels. For the purposes of this study, it is a map of
the social words and patterns of collective commitment that represent the different perspectives
that influence the care provided in an LTC home, including human and nonhuman actants. The
social arenas map is a tool that allows for multiple segments, positions, discourses, and
commitments to surface (Clarke, 2005). In addition, it allows for contested positions and
paradoxes to surface, which can also be surfaced in positional maps. I did not create positional
maps for this study, as contested positions emerged in the discussion of the social arenas map
and are more specifically articulated in the discussion of the visual theoretical model in Chapter
VI. Figure 5.2 depicts the social arenas map for this study.
Each element of the social arenas map represents a different “universe of discourse” (Clarke, 2005, p. 46). These social arenas take place at the meso level (within the LTC home) and at the macro (municipality and health system) level. In Figure 5.2, elements are positioned on the map within three concentric circles: the outer provincial health system, the municipality,
and the LTC home. Most elements cross multiple circles, underscoring the complex interaction of multiple elements. Element overlap denotes influence. For example, PSWs, who are found within the LTC home, are influenced by or are part of the social arenas of PSW collective groups, home care services, retirement homes, availability of volunteers, PSW supply and demand, recruitment and retention, as well as unions. The size of the circles indicates the frequency with which these elements were noted in the data.

Elements influence or play a role in influencing the perspectives of adjacent social areas. For example, public discourse on LTC takes place at the provincial health system level, but also contributes to and changes at the municipal and LTC home levels. The discourse is influenced and contextualized differently at each of these levels and provides insight into the complexity of this topic and the interaction of the various elements.

The actions and interactions that were part of the experience of those roles of the ED, senior leadership team, nurse managers, PSWs, and residents and families were the primary dimensions identified in Chapter IV. Rather than mapping the actions and interactions, the roles represent the arenas of discourse on the social arenas map. They are mapped in color for ease of identification.

**Domains of the Situational Analysis**

To create a greater level of understanding of the complexities of the interaction between social arena elements, I clustered the elements in domains that capture the larger context of interaction. These domains allow me to describe the elements within the overarching contexts that tie the social arena elements together both relationally and systematically.

Three domains surfaced in the situational analysis: (a) LTC organization and regulation, (b) the invisible and undervalued workforce and the residents they care for, and (c) social and
professional relationships. The remainder of this chapter will focus on these three domains, which are depicted in Figure 5.3. Specifically, I will share examples of the social processes and conditions that participants identified and integrate the further exploration of relevant sources at the meso and macro levels that make up the findings of the situational analysis.

**Figure 5.3**

*Three Domains of the Situational Analysis*

Each of the domains identified in Figure 5.3 is connected with and influences the others, as experienced by the participants in this study. The first domain, LTC organization and regulation, represents the broader health care system context in which LTC homes exist and compete for funding and resources, the guidelines for quality care set forth by the provincial
ministry, and the needs of the population. The second domain, the invisible and undervalued workforce and the residents they care for, examines the gendered role of health care workers and LTC residents and the macro level influences that affect PSW supply, demand, recruitment, and retention. The third domain focuses on the social and professional relationship influences at the macro and meso levels and includes public discourse on LTC, empowerment of PSWs, and relationships across professions and levels in LTC.

**Domain 1: LTC Organization and Regulation**

This domain describes the provincial health care system in which the LTC sector resides, the rules and regulations that guide the care provided in homes, and the needs of the population that LTC serves: the frail elderly. The discussion that follows provides a brief overview of the current provincial health care system, guideline development by LTC homes, the demographics and trends that drive demand, and the health system policy shift toward community-based care (see Figure 5.3).

**The Health System and LTC Guideline Interpretation.** Presently, the Ontario health care system is undergoing significant change. In 2019, the provincial government launched an open invitation to providers from across the continuum of care to become Ontario Health Teams, “groups of providers and organizations that are clinically and fiscally accountable for delivering a full and coordinated continuum of care to a defined geographic population” (Ontario Ministry of Health and Long-Term Care, 2019, p. 2). The intent behind creating Ontario Health Teams is “to alleviate constraints and allow providers to deliver better, faster, more coordinated and patient-centred care” (Ontario Ministry of Health and Long-Term Care, 2019, p. 4). According to the provincial government, the first Ontario Health Teams they create will demonstrate the impact of this new model and provide critical lessons for implementing the model across the rest
of the province. It is unclear how the LTC sector will be integrated into the Ontario Health Teams, especially given that some homes are privately operated, some operate under a not-for-profit model, and others are municipally operated. However, the PSW workforce is currently distributed across several health care sectors, including home care, community care, hospital care, and private care, so I will discuss the potential impacts of the Ontario Health Teams model on the supply of PSWs in a later section.

As described in Chapter I, all LTC homes are governed by the provincial Long-Term Care Homes Act (2007). Homes receive per diem, activity-based subsidies from the provincial government, which uses a case-mix formula based on data collected for each resident (Gibbard, 2017). The act outlines the standards for care and staffing, which are interpreted by LTC facilities into organizational policies and guidelines and inform staffing levels and job descriptions. All LTC homes abide by the same guidelines, but the resources available to dedicate to the interpretation of the guidelines can vary from one home to another. In Ontario, more than 60% of homes are owned or managed by commercial chain conglomerates (Daly, 2015), which facilitates the sharing of resources among multiple homes. However, the home in this study is a not-for-profit home that developed its own policies.

You have to create the policies because we’re a standalone, we don’t have a corporation behind us. So, the policies are done by us and you have to see the need for it. So, we are guided by Long-Term Care Homes Act. There’s resident care, there is infection control, there is medication management and all of it’s really important and some of it’s at higher risk. So, you really have to identify the high-risk areas and make sure that they have the tools they need and the knowledge they need and then you have to follow-up and make sure it’s happening. (senior leader participant)
Regulation is described as interrelated policy approaches that control quality, guard against abuse, define practice standards, and allow for performance-based measurement (Murakami & Colombo, 2013). Regulation in Canada is described as hierarchal, top down, and within a deterrent or rules compliance paradigm (Daly et al., 2016). In Ontario, quality of care is ensured through a set of regulatory standards and guidelines, which have been labeled as prescriptive compared to other jurisdictions in Canada and in other countries such as Norway and Germany (Daly et al., 2016). The prescriptive nature of Ontario’s guidelines fail to recognize that LTC provision takes place within the complex, adaptive environment that is health care (Plsek & Greenhalgh, 2001) and leave homes with little flexibility in interpretation.

As Daly & Szebehely (2012) pointed out, this lack of flexibility minimizes the voices of those providing direct care and fails to create the environment required to provide care that meets the complex needs of residents in a particular home on a particular day. The minimizing of PSWs’ voices compounds the consequences that surfaced in my dimensional analysis in Chapter IV, where the external role of the ED, the faulty decision-making process set up by senior leaders in developing policies, the problem-solving role of nurse managers, and the heavy burden of caring for the daily needs of residents led to PSWs feeling task-oriented, rushed, undervalued, and misunderstood.

A large research study carried out in six different settings confirmed the tensions that exist in the provision of LTC (Armstrong & Lowndes, 2018). Furthermore, it suggested that medicalized models of care, such as the one found in Ontario, created tensions, including inflexible routines, lack of worker and resident decision-making autonomy, and an emphasis on physical care, which in turn reduced the amount of time available for relational care. This lack of time to focus on relationships with residents was confirmed in another comparative study (Daly
& Szebehely, 2012). These tensions also surfaced during my dimensional analysis, highlighting the interplay between macro elements, such as the rules and regulations set forth by the provincial ministry, and the work pressure that PSWs experience within the organization.

**Population Demographics.** The demand for LTC is high (Ontario Long Term Care Association, 2019a) and is influenced by the health needs of an aging population and by how well other parts of the system work together to allow individuals with care needs to stay at home as long as possible. The reforms currently underway in Ontario seek to integrate hospital, primary, and home care services and may not directly involve LTC homes. However, the quality of care provided outside the LTC sector and the ability for residents to receive care in the community will influence the acuity of residents’ needs. The increased care needs of residents were already being felt within the LTC home in my study, as one senior leader described: “There’s challenges for sure because people come in, they’re frailer and frailer. We have people that are, you know, sometimes at the end stage of dementia.”

By 2036, a quarter of Canada’s population will be 65 years of age or older (Canadian Institute for Health Information, 2011, p. ix). As of February 2019, close to 35,000 individuals are on the waiting list for LTC in Ontario (Ontario Long Term Care Association, 2019a). The wait time for placement averages 150 days, but actual wait time varies by health care region and where the resident is being placed from. For the home in my study, the wait time was almost a year and a half (528 days) for those waiting in the community and over five months (166 days) for those waiting in hospital (Health Quality Ontario, 2019). In 2019, the provincial government promised to create 30,000 new LTC spaces, with 15,000 of those completed over the subsequent five years. However, the number of people living with Alzheimer’s disease or related dementia
in Canada is expected to rise from 480,600 in 2008 to over 1,125,200 by 2038 (Smetanin et al., 2009). The planned new LTC spaces won’t come close to meeting anticipated demands.

Under Ontario’s current LTC system, individuals wait for care either at home with a caregiver who can no longer meet their needs, in retirement homes, or in hospitals, where patients are assigned to alternative level of care beds (Gibbard, 2017). Not only may hospital floors not be equipped to provide the type of support required but it also costs more to operate a bed in a hospital than one in an LTC facility.

In all, this paints a picture of a health care system that already struggles to care for its elderly and is facing increased needs for LTC in the future. This is the environment in which the ED of the home in my study seeks to be heard, valued, and understood as they perform their role of strengthening the LTC voice at the provincial policy-making table and cultivating relationships with potential donors who can alleviate the financial burden.

**Summary of Domain 1: LTC Organization and Regulation.** The health care landscape in which LTC is situated is one of great change and overwhelming demand that is only expected to rise over the next 20 years. The system is underfunded and is providing care with a workforce that is undervalued and in short supply, which I will discuss in the next section.

**Domain 2: The Invisible and Undervalued Workforce and the Residents They Care For**

The gendered role of caregiving and the predominantly female, vulnerable population of LTC residents, make for a workforce and care recipients that are often undervalued, unseen, and not taken into consideration. Elements that make up this domain include the PSWs and the invisibility of this gendered workforce, their supply and demand central elements (see Figure 5.3), recruitment and retention factors, education, collective PSW groups, and relationships with the ED and senior leadership through the LTC home policies and procedures. The PSWs’ role is
central to the provision of person- and family-centered care to a population that is invisible and fragile itself.

**The Gendered Role of Health Care Workers and LTC Residents.** Care work has often been described as women’s work, and in LTC, it carries the expectation that it is an extension of feminized care, which is characterized as self-sacrificing for the benefit of others (Daly, 2015). Most health care in Canada is carried out by women; one in five women in the labor force work in health care and women make up 80% of the total health care and social services workforce (Armstrong et al., 2008). A recent survey indicated that 96% of the PSW workforce in Canada is female (North Simcoe Muskoka LHIN, 2017). The proportion of care provided in LTC is disproportionally filled by immigrants and people from racial minority groups (Armstrong et al., 2008). Much of the PSWs’ work and their working conditions, the authors argue, are invisible and undervalued. Language difficulties influence residents’ perceptions of immigrant providers’ ability to offer adequate care, which in turn influences the relationship between these PSWs and residents (Bourgeault et al., 2010). Furthermore, there is a social belief that women intrinsically know how to do caregiving work (Fletcher, 1999). This belief devalues the work done by women and ethnic minorities and leads to tension between the skills that are recognized and those that remain invisible. At times, PSWs don’t feel seen by visiting families:

Like a lot of times the family come in and they don’t even talk to us. Some of them they don’t even look our way. So, it’s kind of hard to provide, you know, a certain level of care—well, yeah, because everybody wants to feel like what they do is important, right? (PSW participant)
Caregiving is deeply relational, and caregivers must be flexible and adaptable to the needs of those in their care (Abel & Nelson, 1990). However, flexibility and adaptability are stifled in hierarchical, highly regulated bureaucracies such as the Ontario LTC sector (Daly et al., 2016). The highly prescriptive nature of Ontario’s guidelines leaves homes with little choice regarding the flexibility of interpretation. Consequently, PSWs find workarounds to complete their tasks and work under continuous time pressures, which can sometimes affect quality of care. Workarounds and breaking rules have been found to be coping mechanisms for frontline workers providing care for those with dementia (Kontos et al., 2010), which underscores the discordance between regulatory guidelines and PSWs’ decision-making for the best care of residents. Because of their low level of authority in the organization, PSWs acting on their own accord can lead to reprimands from those higher up. In this study, the forms of resistance to the work were not highly visible, but instead tended to be voiced quietly and under the cloak of confidentiality. This type of quiet resistance was also remarked on in the literature (Baines & Daly, 2015). The PSWs in this study identified resistance as “sneaking around,” which I expanded on in my dimensional analysis of the role of PSWs, where managing as best they can includes working around the rules to provide for what they know the residents wants. This is how one PSW explained the breaking of rules:

Well, they sort of like, the best examples is this bath example, like we’re kind of sneaking this in because if they find out that we’ve done this bath before everyone had breakfast they’re going to come and get mad, right? Like, that’s what's happening, right?

(PSW participant)

In LTC homes, PSWs have little opportunity to make autonomous decisions, little latitude on how they spend their time, and little opportunity to center their work on individual
needs. The work has become routinized and the workload has increased (Baines et al., 2012). However, because caring drives the work of PSWs, some take on unpaid tasks in order to optimize care for residents (Baines & Armstrong, 2019). Baines and Armstrong also found that PSWs want to care more for residents, want greater autonomy, and want to participate in management decision-making in order to provide care more effectively (Baines & Armstrong, 2019). This was something I also found during the dimensional analysis part of this study.

The systemic elements that render this overwhelmingly female workforce invisible and undervalued are further added to by the invisibility of the residents they care for. Over 70% of residents suffer from dementia (Ontario Long Term Care Association, 2019a), have no or little voice, and are considered among the most vulnerable members of Canadian society.

**PSW Supply, Demand, Recruitment, and Retention.** There are approximately 90,000 individuals working as PSWs in Ontario, with many working on a contract, part-time, or on-call basis (Kelly & Bourgeault, 2015). The PSW profession is unregulated and there is no standardized way to track their numbers within the Canadian health care system. Canadian survey results (Canadian Institute for Health Information, 2007) found that 96% of PSWs were female, 74% were 40 years of age or older, and just under 45% were 50 years of age or older. Broadly speaking, PSWs reflected the ethnic and racial diversity of Ontario (Bourgeault et al., 2010). However, visible minorities were over-represented, making up 42% of the labor force compared to only 23% of Ontario’s total population. Five percent of PSWs self-identified as Aboriginal (Bourgeault et al., 2010). In 2017, the Ministry of Health and Long-Term Care mandated the Michener Institute of Education to develop a Personal Support Worker Registry of PSWs who have been “verified to meet the Registry’s qualifications to provide safe and competent health care services to the people of Ontario” (Personal Support Worker Registry of
Ontario, n.d.). The registry was completed at the end of 2019 and captures PSWs who are currently employed by a registered employer (those who have entered into an agreement with the registry) and have successfully completed a PSW program at a public or private college or school board. This registry does not capture all PSWs in the province.

Regional demand for PSWs is shared among the LTC, home care, community support services, and retirement home sectors. Providers work in a variety of for-profit and not-for-profit settings, and data collection limitations in these settings make precise estimating of PSW supply and demand challenging (North Simcoe Muskoka LHIN, 2017). For example, in one region, the division of demand was 50% of workers in the LTC sector, 23% in-home care, 15% in retirement homes, and 11% in community support services. This demand is expected to increase by 15% over the next five years. In the same region, demand for personal support services is projected to grow nine times faster than the workforce by 2021–2022 compared to 2015–2016, and by 2035–2036, demand is projected to grow twenty times faster than the workforce, signaling a significant shortage in care workers.

A recent survey by the Ontario Long Term Care Association indicated that 80% of LTC homes had difficulty filling shifts and 90% were unable to fulfill staffing positions (Ontario Health Coalition, 2019). The most challenging position to fill was that of PSW, followed closely by the registered nurse position. With mandated nursing staffing levels, this puts some LTC homes at risk of being non-compliant with the Long-Term Care Homes Act. Despite these shortages, the workforce keeps homes open and continues to provide care for residents, but according to interviews with program staff, the shortages were felt and they were linked to system issues:
Well, I think that again a systemic issue and I think PSWs do get a lot of criticism about how they work, but I think that they’re set up for that or our system sets them up for that. They’re overworked and there’s not enough of them. (program staff participant)

One factor that influences the supply of PSWs is the education stream that feeds it. There is no single, standardized curriculum for PSW education in Ontario (North Simcoe Muskoka LHIN, 2017) The former provincial government’s Ministry of Advanced Education and Skills Development established vocational learning objectives that were incorporated into programs by schools. Unlike community care and home care, PSWs working in LTC have to have graduated from a recognized PSW education program (North Simcoe Muskoka LHIN, 2017). However, new graduates do not feel prepared for the demands placed on them in LTC, where they are responsible for up to eight residents on a day shift and up to 32 residents on a night shift. Researchers have raised the issue of variability in PSW training as quality of care concern for frail, older residents with highly complex care and dependency needs (Estabrooks et al., 2015).

Once in the workforce, the working conditions for PSWs are challenging, which makes retention problematic (Faul et al., 2010). Although the intrinsic motivation is high in this group, it also makes them vulnerable to enduring less than ideal working conditions. Almost half of the PSW workforce in Canada experience violence on a daily or almost daily basis (Zeller et al., 2009).

Wages for PSWs vary across the province, from $16.50 per hour for contracted home care services to $24.00 per hour in some acute care hospitals (North Simcoe Muskoka LHIN, 2017). Reasons for pay discrepancies in Ontario include “legislation privileging the hospital over the home as a care setting; higher rates of unionization among hospital-based workers; devaluing of personal support; and the interest of other health professionals in maintaining the
medical-social division between settings” (Keefe et al., 2011). A study carried out in the Canadian prairie provinces also found that PSWs had a high sense of meaningfullness in their work, and that also carried the threat of burnout, affecting workforce retention in those provinces (Estabrooks et al., 2015).

Understaffing, heavy workload, increased acuity of residents, not enough time to complete tasks, and fear of reporting unsafe practices are factors that affect the well-being of PSWs and, by extension, the quality of care that residents receive. (Armstrong & Daly, 2004). In addition, lack of autonomy in decision-making, not being listened to, and the toll of working in a high stress environment were also identified, as expressed by one PSW:

We carry the weight of this place on our backs. We deal with these—if it wasn’t for us who would look after them? Like we do all the care, we do everything, we get paid the lowest, we’re thought of the lowest, we’re never asked about our opinions on anything, we’re just barked orders. There’s never anything positive said to us like it’s always what we’re doing wrong, what we need to do more. (PSW participant)

Summary of Domain 2: The Invisible and Undervalued Workforce and the Residents They Care For. The complexity of the macro and meso level elements that render the work of PSWs invisible and undervalued is amplified by the invisibility and silence of the residents they care for. A mostly female workforce carries out deeply relational work in a highly regulated, inflexible environment that forces PSWs to focus on tasks leaves them feeling undervalued and invisible. In a health system with increasing demands for the work that PSWs do, where the imbalance of supply and demand leads to chronic understaffing, PSWs manage as best as they can under a heavy and ever-increasing workload. Paid low wages, and having little
autonomy and input into decision-making, this workforce is often discounted as providing skilled and valuable work.

**Domain 3: Social and Professional Relationships**

The provision of care in LTC facilities is inherently relational, as noted in the previous section. The relationships that influence the provision of care in this setting go beyond caregivers and residents. Public discourse about LTC influences how residents and families view a transfer to LTC and influences their interactions with the staff in an LTC home. Social and professional relationships within organizations also influence PSW empowerment and engagement. As depicted in Figure 5.3, in addition to public discourse, the major interactions in this domain include the influence of the actions of the ED, the senior leadership team, and nurse managers, as well as that of residents and caregivers.

**The Public Discourse of LTC.** In Canada, living in LTC is seen as cold, regimented, with little choice, and is viewed by most people with disabilities and by most caregivers as a last resort (Guberman, 2004). The government’s shift in ideology, that care responsibilities should be shared by stakeholders, including family, emerged in the 1980s and was driven by cuts to social and health care spending. Due to the strict access criteria and lack of available beds, LTC often becomes the only available choice. Most people do not have the financial means to choose an option where they maintain independence and buy services, or privately hire people to meet their needs. The alternative to LTC is home care or care in the community. However, most people with disabilities do not want to be a burden to their families (Shanas, 1979). Care provided at home is typically provided by family and friends, with little support from the community, and sometimes not by choice. This unpaid care is mostly provided by close female relatives and there
is an assumption that this is the better or preferred option for both caregivers and those needing care (Guberman, 2004).

In recent years, safety concerns about LTC have surfaced, particularly following the conviction of Elizabeth Wettlaufer on eight counts of first degree murder, four counts of attempted murder, and two counts of aggravated assault; offenses she committed while working as a registered nurse in several LTC facilities in Ontario. A report on the subsequent public inquiry regarding the safety of LTC underlined the increased acuity of residents, rising demands, and increasing workloads for those providing care (Gillese, 2019). The Wettlaufer case shook the public’s trust in the LTC system and created shame for those working in LTC because they were unable to prevent these tragedies. Findings from the public inquiry pointed at a system failure and called for improved collaboration, cooperation, and communication throughout the LTC system. The report called for support of the LTC sector to achieve regulatory compliance, creation of opportunities for advancement for those working in LTC, and encouragement of innovation and the use of new technologies in LTC. The second recommendation links directly to the issue of supply, demand, and retention of PSWs. The report also recommended strengthening education and limiting agency staff.

Empowerment of PSWs and Relationships Across Roles and Levels Within the Organization. The notion that staff well-being is important in providing quality care has surfaced in the literature (Armstrong et al., 2008). In Chapter IV, I described in detail PSWs’ need to be understood and valued. Other researchers have shown that being empowered plays an important part in the ability to provide high quality care (Caspar & O’Rourke, 2008). The lack of formal input into decision-making that surfaced during my interviews influences feelings of empowerment for PSWs. Tellis-Nayak (2007) demonstrated that management approach and
supervisory relationships also play a large role in staff feeling empowered to deliver person-centered care. One program staff member expressed it as follows:

I think management is a big driver for like the tasks and getting things done and making sure that we’re compliant with all the legislation as they should be but I think we miss the person piece a lot, and yeah, I think they could do more to talk about that. (program staff participant)

Canadian researchers showed that organizational factors contribute to PSW empowerment and job satisfaction, including support from supervisors and decision-making autonomy (Chamberlain et al., 2016). The other factor that was identified was slack time in the schedule, which is in short supply for many PSWs. As one of PSWs in my study described it:

Especially if you start at 7:00 but even so, even if you start at 7:00 it’s still like an hour and a half, two hours to get them up and they want everybody to be there at 8:30, umm, I don't know how much, you know, like how much you care, what level of care you can provide within that time for like eight, six, seven residents. I start at 7:30, sometimes I would be lucky if I’m out at 8:30 with three residents especially if you’re going to provide, you know, any kind of, well, maybe not even exceptional but if you’re going to provide good care for them, you know, and try to do things the way they would like to have it done or try to at least get as close as possible to what they would. It’s just really hard, it’s just really hard to work with the time. (PSW participant)

Professional efficacy, feelings of personal achievement or accomplishment have also been shown to contribute to satisfaction and overall work engagement (Fiabane et al., 2013).

The importance of teamwork to get the work done was another factor that surfaced during the dimensional analysis of the role of PSWs in Chapter IV. In the words of one PSW:
Oh, like if I’m going to give shower, I let my team, she knows and then she knows she has to come and help. And like giving shower you need two persons, she has to be there to help and when you’re finished you ring the bell or you do this and that person is right there. So, it’s communication. We do share work. (PSW participant)

Integration across roles in LTC homes is lacking, even though senior leaders admitted that having PSWs attend resident care conferences would be beneficial but added that time does not permit PSWs to be there. One report suggested that this lack of integration might stem from a reliance on hierarchical structures, professional rivalry, lack of training in effective communication, and lack of methods for joint decision-making (Nichols, 2016).

Launched in 2013, the National Standard of Canada for Psychological Health and Safety in the Workplace is a set of voluntary guidelines, tools, and resources intended to help employers promote mental health and prevent psychological harm at work (Dickson, 2018; Mental Health Commission of Canada, 2013). According to the scientific literature that went into the development of the standard, five factors that influence psychological safety were identified as common from both legal and scientific perspectives: (a) job demands and requirements of effort, (b) job control or influence, (c) reward, (d) fairness, and (e) support (Shain et al., 2012). All of these elements are at play in the provision of care in LTC, and the risk to the mental health of PSWs cannot be ignored (Armstrong & Braedley, 2013).

**Summary of Domain 3: Social and Professional Relationships.** The conversations and relationships that take place in the public domain, across professions, and within the organization interact to influence the working conditions for PSWs within LTC and the public expectations and fears of residents and caregivers. Residents come to LTC as a last resort, when being cared for in the community is no longer available or possible, and under the shadow of public concerns
about safety in LTC. The care load for many of these residents is heavy and the demands for daily care fall on the shoulders of PSWs, who manage as best as they can to provide care that is meets the rigorous and time-sensitive standards set by the province and imposed through organizational policies and staffing decisions. Chronically understaffed, PSWs work together to provide care, but find it difficult to provide quality, person-centered care.

**Summary: Situational Analysis**

The situational analysis conducted in this chapter, when combined with the dimensional analysis in Chapter IV, constructs a picture of the different elements at the individual (micro), organizational (meso), and system (macro) levels that influence how person- and family-centered care is perceived and delivered within an LTC organization. The result is a vivid picture of the complexity of all the factors that interact in the reality that is LTC. The analysis surfaced elements in three domains: (a) LTC organization and regulation, (b) the invisible and undervalued workforce and the residents they care for, and (c) social and professional relationships. The Ontario health care system, currently undergoing a time of considerable change, is highly structured and hierarchical, which creates working conditions within the organization that leave little room for autonomy and choice for PSWs. The work of caring is often undervalued and invisible, even though care demands are increasing and the supply of PSWs cannot meet the demand. The public discourse and system forces mean that LTC is seen as a last resort for those requiring care, while the lack of integration across professions and lack of meaningful decision-making input turn LTC homes into workplaces that challenge the psychological health and safety of PSWs.

PSWs are essential to the provision of person- and family-centered care in LTC homes. This predominantly female workforce, which is in short supply, is also undervalued and mostly
invisible in the health care system as they tend to the daily needs of residents under challenging conditions, displaying deep caring for the vulnerable population that they work with. PSWs play the crucial connecting role of translating health system standards and regulations into daily one-on-one care of residents. It is with PSWs that residents have the most contact and with whom they spend the most time in a day. This centrality of the PSW in both the dimensional and situational analyses provided the groundwork for placing PSWs in the center of the theoretical model I will present in Chapter VI.
Chapter VI: Discussion and Conclusions

In this study, I set out to understand what shapes person- and family-centered care in one LTC home in Ontario by exploring how complexities of the social processes among staff and residents (micro), organizational context (meso), and system elements (macro) interact to create a culture of person- and family-centered care in the organization. Chapter IV presented the first part of my findings: the dimensions of the social processes. Chapter V presented the second part of my findings: the contextual domains of organization and health care system elements. In this chapter, I introduce a theoretical model that integrates the two methods of analysis, dimensional and situational, with a particular focus on the critical role of personal support workers (PSWs) in the provision of care in an LTC home setting. I also discuss the theoretical propositions that emerge from the model with reference to relevant, extant literature, and leadership practice in person- and family-centered LTC. Finally, I examine the limitations of this exploratory single case study and offer some suggestions for future research directions.

Theoretical Model

This section explains the construction of the theoretical model, which I developed from the analysis of the participant data that informed the dimensions and the contextual elements of the situational analysis. Visual representation of the data allows researchers to gain analytical distance and provides a graphical display of what the researcher knows and what the researcher does not know (Lempert, 2007). In this study, repeated memo-writing and visual representations allowed for deepening analysis and understanding of the complexity that surfaced from the data. In turn, what emerged is a dynamic, interactive theoretical model that integrates the complexities of system and organizational influences on the PSW workforce that is currently rendered invisible, undervalued, and misunderstood as they play a pivotal role in the provision of
person- and family-centered care. It is the complexity of the interaction of these influences that contributes to the person- and family-centered organizational culture as interpreted through the lens of PSWs. As discussed in chapters IV and V, and evident in Figure 6.1, PSWs play a pivotal role in providing for the daily care needs of the residents in the LTC home. The complexity of interactions of the theoretical model described in this chapter is dynamic and is therefore best visualized as a three-dimensional (3D) model in motion (see Figure 6.9 at the end of this section for the complete 3D animated model). However, to improve understanding, I will present each of the elements that contribute to the dynamic visual model first.

**Pivotal Role of PSWs in Providing Person- and Family-Centered Care**

PSWs are at the heart of LTC provision. They make up the largest staffing complement in the organization I selected for this study. In Figure 6.1, PSWs are depicted as the largest sphere in the middle; the four other spheres depict the other key roles identified in Chapter IV: the executive director (ED), the senior leadership team, the nurse managers, and the residents and families. Each of the roles represents the primary dimensions identified in the dimensional analysis. The domains of the situational analysis are also represented in the figure. The two outer circles represent the domain of LTC organization and regulation, and the inner circle connecting each of the roles represents the domain of social processes and relationships.
PSWs and Their Central Role in LTC Care Provision

During the day, PSWs care for up to eight residents on their unit; at night, this increases to up to 32 residents. They are involved in all aspects of care, are frequently understaffed, and feel rushed as they work under organizational rules and guidelines to provide care for residents with varying cognitive and physical abilities. The amount of personal contact PSWs have with residents and the number of residents they engage with become the critical processes of person- and family-centered care. In this study, I investigated the nature of care and the characteristics of delivery mediums that create or inhibit such care.

Motivated by deep caring, the core dimension identified in Chapter IV, PSWs attend to all aspects of care for residents, and because they have the most physical contact with residents, PSWs are pivotal to the provision of person-and family-centered care. However, despite the
centrality of their role, this is a workforce that is rendered invisible and feels undervalued. Externally, there are health care system influences that contribute to this; internally, social and professional relationships unwittingly do so as well. Both types of influences are explained in this model.

**Complex Adaptive Systems and the Unintended Consequences That Render the Workforce Invisible and Undervalued**

Health care systems are becoming increasingly complex (Chappell & Penning, 2009). Just as health care systems are complex and adaptive, so are LTC and nursing homes (Anderson et al., 2003). Complex adaptive systems are “composed of a diversity of agents that interact with each other, mutually affect each other, and in so doing generate novel behavior for the system as a whole” (Regine & Lewin, 2000, p. 6). In such systems, self-organizing is the process by which people mutually adjust their behaviors to cope with internal and external demands (Cilliers, 1998). However, these well-intentioned behavioral adjustments can have unintended consequences as they are interpreted by those who see the system from a different perspective and with a different lived experience (Senge, 2006). In complex adaptive systems like the LTC home in this study, the unintended consequences of the broader health care system interact with the social and professional relationships within the home, all of which has an effect on the PSW workforce. The unintended consequences of these interactions are described in the following section.

The provision of work in LTC is gendered and power relations shape the gendered division of labor and work provision. This is built on the assumption that care provided by women is natural and instinctual—and therefore of low value—rather than skilled work (Armstrong, 2013). Moreover, residents living in LTC are also predominantly female. Women
live longer than men, are less likely to have a spouse who is able to care for them, and are less able to afford private care (Rodrigues et al., 2012). PSWs are often not included as health care workers and their skills, efforts, and responsibilities are not valued or recognized (Armstrong et al., 2008). Consequently, little attention is paid to their relationships with other health care workers or to their health and working conditions. As depicted in Figure 6.2, this renders PSWs and their work invisible. However, the limited supply of PSWs in the health care system leaves LTC homes scrambling for staff, which leads to high turnover rates, staff shortages, fewer opportunities for relationship-building, increased focus on tasks, and a negative impact on PSW well-being. This is how one PSW described the impact:

Even if your workload was relatively manageable, you’ve been doing it for so many years and you just keep feeling sad that you might eventually start to be closed off to feeling sad because it’s really hard to do that. I’ve felt that in myself sometimes when you’re just like . . . this is a lot.
Within the LTC home, individuals in each of the roles (PSWs, ED, senior leadership team, nurse manager, and residents and families) are motivated by and contribute to high quality, safe person- and family-centered care. Furthermore, each role is driven by deep caring and the need to be heard, valued, and understood, but the roles’ actions have unintended consequences that have a negative influence on the role, value, visibility, and well-being experienced by PSWs.

As discussed in the dimensional analysis in Chapter IV, the primary role of the ED is to advocate strategically. Because the health care system is underfunded and in need of change, the ED must be externally focused in order to achieve the positive consequence of increasing external visibility of the LTC home to the provincial government and to potential donors. As the ED expressed:

Note. PSW = personal support worker.
It’s a difficult time because with the government, I mean we’re looking at decreases in funding. I lost money this year and so it—but I did manage to get a donation from a supporter. You really need to become politically active because if you’re supporting long-term care where we need the support is to bring radical change to the industry.

The ED’s external focus has the unintended effect of decreasing internal visibility to staff, which in turn makes PSWs feel unheard and leads to feelings of resentment toward the innovations in the organization that are often announced with much media attention and little perceived awareness of the impact these innovations may have on PSWs’ working conditions. According to one PSW:

They feel that things are being taken away—a lot of the staff feel things have been done [to them]. I myself at times feel, it feels like everything some days, they come up with some new idea which is nice but then they have to take from somewhere and it always feels like it’s being taken from us.

In Figure 6.3, the intended and unintended consequences of the ED’s external advocacy role are depicted. The diagram on the left illustrates the LTC home’s external visibility to the province and potential funders, with the large sphere of the ED visible from the outside. The diagram on the right depicts the unintended decreased internal visibility, which surfaces resentment and leaves PSWs feeling misunderstood and undervalued.
The role of the senior leadership team is to translate the provincial health ministry’s strict regulations into policies and programs that promote safe person- and family-centered care. One member of the senior leadership team described it as follows:

My role really is to ensure that we are following our mission, value and vision here, that we are challenging ourselves to come up with different ideas that are going to meet the needs of residents where they are now and over the last number of years.

As discussed in the dimensional analysis, the senior leadership team possesses a good understanding of the vision for the organization and has the full support of the ED, making this team feel valued and united in their vision for care. However, as surfaced in the dimensional analysis, because the senior leadership team interprets the health care system standards and guidelines in a manner that leaves PSWs with little autonomy, feeling rushed, excluded from care planning, and without mechanisms to provide input and feedback, it leaves PSWs feeling unappreciated, unheard, and unsupported. One PSW shared the following example:
The residents are not—I mean and—if this is confidential the residents aren’t getting their care, no, I don’t have the time to even just to wash their face and hands and do the little things. No, they just want them in the chair down in the dining room and then it just doesn’t stop all day. Like this was not—I don’t think going from five to four [PSW staff on the floor] was—it was not beneficial for the residents.

Figure 6.4 depicts the intended and unintended consequences of the senior leadership team’s role, which works to provide policies and programming for safe, person-centered care. The diagram on the left illustrates a senior leadership team that is supported, while the diagram on the right shows the PSW role spinning rapidly around its axis to represent feeling rushed.

**Figure 6.4**

*Intended and Unintended Consequences: Senior Leadership Team’s Role*

![Diagram](image)

Intended consequence: members of the senior leadership team feel valued and united in their vision for person-centered care. Unintended consequence: PSWs feel rushed.

*Note. ED = executive director; PSW = personal support worker.*

Nurse managers are responsible for the overall quality of care on the units, as discussed in the dimensional analysis, which means they oversee operational needs as well as the medical needs of all residents on their unit. Much of a nurse manager’s role entails managing relationships and solving problems to ensure the well-being of residents, a process identified in
the dimensional analysis. As one nurse manager summed it up, “everything funnels through the nurse.” However, as nurse managers meet with residents, decide on care plans, and problem-solve, the PSWs’ focus on tasks increases and is reinforced. This pressure is acutely felt by PSWs:

So, there’s a lot of pressure around, you know, especially when you go to certain floors because like I said all residents are not the same, right?

Figure 6.5 depicts the intended and unintended consequences of the nurse manager’s role to ensure quality of care on the unit. The diagram on the left depicts nurse managers playing a large role in solving problems to ensure safe care. The diagram on the right shows the increased pressure that PSWs feel.

**Figure 6.5**

*Intended and Unintended Consequences: Nurse Manager’s Role*

![Diagram showing intended and unintended consequences of the nurse manager's role.](image)

Intended consequence: nurse managers solve problems and manage relationships to ensure the well-being of residents.

Unintended consequence: PSWs feel increased pressure.

*Note. PSW = personal support worker.*

As discussed in the dimensional analysis, residents and their family members seek social connection and meaningful stimulation and they also want to lighten the burden for PSWs, so
they will solve problems directly with the nurse managers or other senior leaders. For example, one family member shared: “And if I see something, I raise it immediately and get it corrected. I know most big players in here.” When residents and families fail to include PSWs in problem-solving, they are unintentionally neglecting the PSWs’ perspective on care, which includes the most intimate understanding of a resident’s daily needs.

Figure 6.6 shows that residents and families want to lighten the load for PSWs (diagram on the left). The diagram on the right depicts how, as residents and families solve problems with nurse managers, the PSWs’ important care perspective is missed.

**Figure 6.6**

*Intended and Unintended Consequences: Residents and Family Members’ Role*

![Intended and Unintended Consequences Diagram](image)

*Note. PSW = personal support worker.*

**Systemic Blind Spot and Its Reinforcement by Limited Social Connections and Narrow Relationships**

When there is little opportunity for triangulation of perspectives within an organization, the unintended consequences of the interactions of different roles may be invisible to the individuals in each of the roles (Senge et al., 1999). I refer to this invisibility as a systemic blind spot. In this study, some people within the LTC home have made this connection, which is
expressed by a member of the program staff, which is not one of the five roles described in the model:

I mean there’s lots of important jobs in long-term care but without personnel support that’s really really the most important thing. So, I’d like to see us elevate them a little bit more and get to know them a little bit more and have them be able to talk about their roles and talk about caregiver burnout and caregiving fatigue, things that I think are really really important to acknowledge and I think that if any of us were working against that type of time pressure it’s then—it is really hard of course to then sit with that person a little bit longer and then maybe not seeing that person as a person makes it easier to walk away when it would just maybe break your heart to do it if you were a little bit more tuned in emotionally.

The blind spot in this case refers to the inability of individuals in each role to see and understand the cumulative effect of system and organizational elements on PSWs and on their pivotal role in the provision of person- and family-centered care. Although the PSWs do not see each of the other roles either, they are depicted in the center of this blind spot in Figure 6.7, since it is the cumulative effect on their experience that is described.
Complex organizations require the ability to think about situations in more than one way (Bolman & Deal, 2013). In complex adaptive systems, the humans in the system discover and make meaning of their environment using behavioral scripts that are expressed as mental models or evaluative rules, and which influence their behavior (Stacey, 1996). Each individual in the system is influenced by their own mental models and evaluative rules as well as by the shared organizational rules, policies, and cultural rules. When there is limited interaction between roles, as described by participants in this study, there is no opportunity for understanding different perspectives or for system learning. In environments such as this, a mental model shift toward system thinking, where all perspectives are valued, is important for better decision-making (Senge, 2006), as depicted in Figure 6.8.
In the LTC home environment described by the participants in this study, there are no mechanisms for true dialogue or forums for collective meaning making, making the already difficult task of integrating different perspectives nearly unattainable (Kegan, 1994). The limited interaction and social connection reinforce the silos and prevent system thinking and insight.

**Summary of Theoretical Model**

The picture that has emerged is one of nested complex adaptive systems. Figure 6.9 presents the animated, dynamic model of the interaction of system and organizational influences on the PSW workforce in the provision of person- and family-centered care in an LTC home setting.
Within an LTC system that undervalues the caring work carried out by PSWs, the ED, senior leadership team, nurse managers, as well as residents and families work to optimize quality care that is centered on the residents and families. The unintended consequences of each of these roles renders the PSW workforce invisible and undervalued while they manage as best as they can to provide resident- and family-centered care. These interactive systems are invisible to the ensemble of players whose views of the system are limited by restricted interactions and narrow relationships. This fundamental blind spot regarding the impact of well-intentioned actions on those who provide the majority of the daily care for residents is part of the mental models and beliefs of those working in the organization. If culture is the accumulated shared learning and system of beliefs, values, and behaviors that may drop out of awareness (Schein,
2017), then understanding and unpacking this systemic blind spot and focusing on the role of PSWs is crucial in fostering a person- and family-centered culture.

**Theoretical Propositions**

The purpose of this study was to gain a deeper and more detailed understanding of the interconnecting complexities of human and nonhuman elements—personal, organizational, and system—that contribute to a person- and family-centered culture in an LTC home. Findings from the data and the development of the theoretical model led to the generation of theoretical propositions. In this section, I describe these theoretical propositions and expand upon the relevant conceptual and empirical literature.

**Theoretical Proposition 1: Provincial LTC Rules and Regulation Combined With Organization-Level Interpretation Diminishes the Role of PSWs**

The LTC model has been conceptualized in two ways: as a social model of care (the family model) and as a medical model of care (Day, 2013). The social model of care has been conceptualized around a “family” model that considers care provided in the home to be the best care possible, which is entrenched in the notion of love and security (Dalley, 1996). The necessity for governments to cut rising health care costs has pushed most of the caring to community and families (Aronson & Neysmith, 1997). The family model of care has gendered implications, as it is typically women who provide the caring for vulnerable adults and children in the home (Armstrong & Kits, 2001). In addition, this social model of care is heteronormative, where men are the breadwinners and women take on caring roles (Tronto, 2010). Furthermore, the model situates the care recipient as dependent on care providers and the care provider as independent and not in need of care, implying a one-way direction of care.
In contrast, the medical model of care separates the relational aspect of care from the physical “bodywork” of care, where the hands-on physical work has been delegated to PSWs, who are paid less and are not considered health care professionals (Twigg, 2002). Caring is seen as a relational activity (Koggel, 1998) built on the interdependence of human beings. However, in Canada, the term personal support worker implies a focus on the physical support function only, but the term nursing care aide (often used in the United States) retains its relation to caring. If the relationship between nurses and patients are therapeutic interactions and the basis for professional decision-making, including how to best care for patients and make them comfortable (Weinberg, 2006), then not recognizing the same for PSWs implies that PSWs have no role in decision-making in the care of residents, which diminishes their role. PSWs are the lowest paid health care workforce (Tellis-Nayak & Tellis-Nayak, 1989) and are perceived to be low-skilled workers (Armstrong, 2013).

This perspective is amplified within LTC organizations, where the workload, emphasis on tasks, and lack of input into decision-making disempowers PSWs, who carry a great responsibility for care but have little authority (Aroskar et al., 1990). They often feel unrecognized for their efforts and powerless to make changes to resident care (Cox & Parsons, 1994). The highly regulated LTC setting emphasizes a focus on tasks and leaves little room for autonomy (Daly et al., 2016; Daly & Szebehely, 2012), further diminishing the value of the PSW role.

**Theoretical Proposition 2: Lack of Mutuality in Relationships Across and Within All Roles Hinders Organizational Learning, Creativity, and Adaptability**

As previously mentioned, health care and LTC are complex adaptive systems (Plsek & Greenhalgh, 2001). Complexity theory is a useful framework to shape the understanding of
person- and family-centered culture (Sterns et al., 2010). Complex adaptive systems are “composed of a diversity of agents that interact with each other, mutually affect each other, and in so doing generate novel behavior for the system as a whole” (Regine & Lewin, 2000, p. 6). However, these systems pose adaptive leadership challenges.

Adaptive challenges are those challenges that have no obvious, single solution, are more difficult to identify and describe, and require revising norms and belief sets. As these challenges cannot be addressed with a new rule or policy, novel solutions must be allowed to emerge from the interactions of people in the organization who face the challenges, referred to as adaptive work. Fundamentally, culture change requires the transformation of an organization to develop new, normative values and behaviors congruent with person-directed care. (Corazzini et al., 2014, p. 617)

A “leadership disconnect” has been identified in the literature, as decision-makers become increasingly disconnected from the people who are affected by their decisions, resulting in those people feeling disempowered (Scharmer & Kaufer, 2013). In this study, I found a similar type of disconnect, as each dimensional role was unaware of the impact of its actions on the PSWs’ feelings of disempowerment. The limited interaction across all roles was a factor in this disconnect. In successful complex organizations, the primary enabling influence comes from the ability to see actions arise from the emerging whole in an environment where players from all levels of the organization come together for decision-making (Scharmer & Kaufer, 2013). This takes deliberate awareness and commitment from senior leadership as well as the ability to foster an environment of trust throughout the organization. In the LTC setting, it also requires an environment that empowers workers, provides point-of-care workers with leadership
opportunities, encourages decentralized decision-making, and allows point-of-care staff to make
decisions about resident care (Doty et al., 2008).

In a complex adaptive environment, a mental model shift toward systems thinking that
takes the bigger picture into consideration and values all perspectives is important for optimal
decision-making (Senge, 2006). Organizations guided by the principles of complexity science
are organizationally flat and promote diversity as well as open and frequent communication. In
relationships that possess mutuality—that is, mutual respect and mutual impact and influence on
each other—a non-linear, interconnected dynamic web is created that fosters creativity and
adaptability (Regine & Lewin, 2000). Trust in relationships, respectful interaction, and rich
communication have all been shown to increase quality of care (Lanham et al., 2009).

Leading in these adaptive environments requires adaptive leadership practices among all
levels of staff and the creation of new normative values and novel solutions with the
participation of all perspectives (Corazzini et al., 2014). Reflections on actions by different team
members can improve practice outcomes as well as relationships. Joint sensemaking and learning
in organizations are important to make sense of the ambiguity that is present in all adaptive
systems. This sensemaking is both an individual and a social activity (Weick, 1995), as is
learning (March et al., 1991), and organizations must make room for individual and collective
meaning making.

Research has shown that practices that increase connections and interactions among
people result in better outcomes for residents (Anderson et al., 2003). In LTC nurses, decreased
reliance on rules, creation of environments of communication without fear (Anderson et al.,
2003), increased participation in decision-making (Anderson & McDaniel, 1998), increased
interaction in formal and informal decision-making (Anderson & McDaniel, 1999), and
formulation of clear expectations and appropriate rewards (Anderson et al., 2004) have all been shown to lead to better resident outcomes, decreased turnover, and improved perception of involvement. Furthermore, homes with a reward climate, where rewards are merit-based, goals are clear, and relationships and employee welfare are important had fewer care deficiencies than those with a laissez-faire climate, where management was disorganized, rewards were status-based, and conflict went unresolved (Sheridan et al., 1992).

In adaptive environments, instead of increasing control, the management focus is on increasing feedback loops across a variety of perspectives, allowing for adaptation in local settings (Senge, 2006, Senge et al., 1999). In organizations, this requires increasing the learning capacity, which requires a personal and collective mental model shift toward systems thinking and a shared vision (Senge, 2006). To create this type of shift requires an openness to developing structures and processes for input into decision-making from all parts of the system and opportunities for real dialogue that consider all parties to be equal partners (Wheatley, 2009). Moreover, it requires fostering an awareness of the leadership capacity in those who would have previously been invisible, which includes the understanding that each person has experience leading change, that open and trusting communication is important and possible, and that the creation of enriched connections between all roles will lead to change in oneself and in others (Quinn, 2004).

Although the structural interventions are important to implementing person-centered care (Hoff, 2013), it is the relational component, along with making time for sensemaking and reflection (Flieger, 2017) that shifts organizational culture. Participative leadership that supports the person- and family-centered values of respect, enhanced relationships, and quality of work
life can successfully address staff morale and facilitate culture change (Scalzi et al., 2006; Luxford et al., 2011).

**Theoretical Proposition 3: Recognizing the Relational Aspect of Caring is Essential to Creating a Person- and Family-Centered Culture**

Person-centered care is built on the assumption that autonomy, individualism, and choice are key aspects of well-being for the elderly, but it ignores the relational aspect of caring (Nolan et al., 2004). Although attention to individual needs is essential to person-centered care, so is respect for personhood (Kitwood, 1997; McCormack, 2004). Kitwood (1997) defined personhood as “standing or status bestowed upon one human being by others in the context of a relationship” (p. 8). Human beings belong to a network of social relationships within which they are deeply interconnected and interdependent (MacDonald, 2002). This also holds true for caring, where reciprocal relationships allow both parties to grow and where all voices in the caregiving relationship are essential (Clark, 2002; Pryor, 2000). In LTC homes, the voices of PSWs are often absent, even though they have the most intimate, consistent, ongoing relationships with residents.

Daly (2013) posited that there is an opportunity to shift from an ethics of care approach, which assumes that caring is about an individual with a set of principles, to an ethos of care approach, which takes into consideration the medical and social aspects of caring and “assumes the interdependence of residents, workers and other citizens” (p. 45). The “Senses Framework” captures the subjective and perceptual dimensions of a caring relationship that must be experienced by all in the caring relationship, including security (feeling safe within relationships), belonging (feeling part of things), continuity (experiencing links and consistency), purpose (having personally valuable goals), achievement (making progress toward desired
goals), and significance (feeling that you matter; Nolan et al., 2001). For optimal caring in the LTC setting, attention must be paid to these concepts of relational care for all caregivers, including PSWs, whose experience of these six senses is often diminished by the unintentional consequences of the current context of the LTC system.

Providing care in the LTC context is to provide care within a social relationship that not only requires visible and invisible skills but also requires a context in which it can flourish and grow (Armstrong, 2013). The enhancement of relationships and community has been identified as a factor that facilitates person- and family-centered care (Scalzi et al., 2006). However, the development of these relationships and familiarity with residents is dependent on adequate staffing levels (Bowers et al., 2000). Having to perform their work while short staffed has a negative effect on the PSW–resident relationship, impacting quality of care, surfacing feelings of being rushed, and leading to staff turnover and the physical and psychological exhaustion of care workers. In a Swedish study, LTC residents and their families identified the importance of social relations and indicated that the lack of intimacy in daily living affected their perception of quality care (Mattiasson & Andersson, 1997).

Organizational care outcomes do not take the quality of relationships into consideration, whereas quality relationships are central to person-centered quality of care for PSWs (Bowers et al., 2000). Measures of quality such as trust, dignity, and resident and family perceptions of quality of relationships are often not measured. In Ontario, what is measured are wait times, use of anti-psychotic medication, physical functioning, depression, behavioral symptoms, avoidable visits to the emergency department, loss of staff time due to injuries on the job, and measures of pain, falls, pressure ulcers, and use of restraints (Health Quality Ontario, 2015). While these indicators are important, most focus on the physical components of care and none focus on the
relational aspect of care or on satisfaction with care. The absence of relational care in measuring health outcomes diminishes the perception of its importance.

A second perspective important to recognizing the relational aspect of caring is the theory of relational leadership and its importance in organizational culture (Uhl-Bien, 2006), which is based on the premise that organizational phenomena exist in interdependent relationships and that meaning making is relational (Dachler & Hosking, 1995). Relational leadership recognizes the importance of leadership beyond hierarchical positions and views leadership as happening in relational dynamics throughout the organization (Uhl-Bien, 2006). Complexity science and complexity leadership also recognize the importance of fostering interconnectedness and understand that nurturing bottom-up dynamics promotes innovation (Marion & Uhl-Bien, 2001). The uptake of innovation in health care is promoted by inclusivity and a shared understanding of the reasons for and value of innovation, which requires enhanced interconnectedness across all roles within an organization as well as connectedness between policy makers and those delivering care (Côté-Boileau et al., 2019).

**Theoretical Proposition 4: Fostering an Environment That Empowers PSWs is Key to Quality Person- and Family-Centered Care**

Feeling undervalued, both professionally and personally, has been shown to contribute to turnover of certified nursing assistants in LTC facilities in the U.S. (Bowers et al., 2006), and feeling undervalued and underappreciated by supervisors in particular—feelings that also surfaced in this study. Previous research has also shown that staff empowerment is important in fostering a person-centered approach (Engle et al., 2017; Killett et al., 2016). An organizational management style that is centralized, with little room for care workers to make care suggestions (Waxman et al., 1984), and with restricted chances for enhancement, lack of opportunities to
contribute to care planning, and lack of or reward for good work (Banaszak-Holl & Hines, 1996; Blair & Glaister, 2005) also contribute to feelings of not being valued and appreciated. Furthermore, interpretation of guidelines and feedback from supervisors have been identified as dismissive, failing to recognize PSWs’ skills and expertise, individual integrity, intelligence, and commitment (Bowers et al., 2003).

Workers who feel empowered have greater commitment to their workplace (Kanter, 1979). Kanter posited that employee effectiveness and commitment to work are influenced by complex interactions between power and opportunities. According to Kanter, power sources included the formal power that resides in a worker’s job title and responsibilities and informal power, such as relationships and alliances with others in the work setting and access to information, support, and resources. Opportunities included possibilities to advance, learn, and be rewarded and recognized for skills. These factors have also been found to be important in LTC (Beaulieu et al., 1997). Nursing aides identified appreciation and trust to be the most important components of empowerment (Campbell, 2003). Educational opportunities, better feedback and appreciation methods from nurse managers, opportunities to discuss quality improvement with peers, and engagement in continuous quality improvement issues are all key to PSW empowerment.

Factors that contribute to feelings of disempowerment include lack of job visibility, centrality, and flexibility; lack of trust and supportive relationships; lack of access to things needed to carry out the work; and limited opportunities to grow and develop both professionally and individually (Kanter, 1979). The highly regulated LTC setting, with little room for autonomy and its focus on rules, renders PSWs disempowered and task focused (Daly et al., 2016; Daly & Szebehely, 2012). Ongoing positive communication between PSWs and residents were found to
be important to empowerment and quality of care (Deutschman, 2001). In addition, recognition of a job well done and access to educational opportunities were shown to be important in the ability of LTC care aides to provide individualized care (Caspar & O’Rourke, 2008).

Access to informal power, formal power, information, support, resources, and opportunities are facilitated through immediate supervisors (Caspar & O’Rourke, 2008; Kanter, 1979). Improved quality of life for staff has been associated with residents’ quality of life (Tellis-Nayak, 2007), therefore it follows that empowering PSWs in the LTC setting is key to the provision of quality person- and family-centered care. Fostering empowerment practices for PSWs at all levels of the organization is important and takes deliberate commitment from leaders within the organization, which requires systems thinking and social interaction practices that foster mutuality, organizational learning, and collective methods for meaning making that include PSWs. In the section on practice implications, I will discuss some potential approaches for fostering such an environment.

**Limitations of the Study**

The limitations of this study are described in terms of research design, facility choice, participants, and data analysis methods. As previously mentioned, this study uses an exemplar case study design. The methods I used to identify the exemplar facility relied on expert input and opinion. No externally validated method of identifying exemplar LTC facilities with a person- and family-centered culture currently exists. Care was taken to interview experts in the area of LTC with knowledge of research methods, the movement toward person- and family-centered care, and a cross-provincial view of LTC facilities. Nevertheless, the facility I selected is but one example of an organization that is deliberate about implementing a
person- and family-centered care approach, rather than an exemplar case. A different setting might have revealed a different lived experience.

Although a case study design allows for in-depth exploration and understanding of the experience of a person- and family-centered care approach and culture, it also limits the generalizability of the study. Therefore, the results of this study are not generalizable, but the identified theoretical propositions should be transferable to other LTC settings within the province of Ontario. Organizational culture is contextual to the organizational setting and the health care system it operates in. This study focused on the context of one LTC facility within the province of Ontario at this particular moment in time. As such, it is important to be careful about extrapolating results in care settings with different health system relationships, policies, and standards.

Resident voice is essential to understanding the person- and family-centered care experience. However, since many of the LTC residents in the facility I selected have cognitive difficulties, it was impossible to include a diverse sample of residents in this study. Instead, only those with adequate cognitive abilities were included. However, I also included family members for the group of residents who were not able to participate themselves.

In addition, I brought my own experience, bias, and understanding to the data analysis for the grounded theory and situational analysis, which will have undoubtedly affected the lens through which I interpreted the findings. Having a coding team allowed me to be more aware of this bias. My coding and mapping choices influenced the conclusions I drew from this study. One of the criticisms of grounded research is the lack of perceived rigor and the subjectivity in this process. The use of memo-writing, documenting analytical decisions, returning to the data until saturation, and theoretical coding assisted me in meeting the criteria of trustworthiness,
including credibility, confirmability, dependability, and transferability (Holloway & Schwartz, 2018).

**Implications of Theoretical Propositions for Leadership Practice and Future Research**

The implications for leadership practice from this study can be found at the health care system (macro), organizational (meso), and interpersonal (micro) levels. In this section, I discuss the implications for practice in all three areas and identify areas to explore in future research.

**Health System Implications**

The provincial health care system desires a person-centered approach to LTC yet outlines strict requirements for adherence to regulations that do not allow for care worker interpretation or modification. This, combined with inadequate staffing standards, lack of recognition of support workers as health professionals, and low payment of PSWs, contributes to the invisibility of these workers in the system, high turnover, low recognition, and staffing shortages. This system paradox needs to be addressed in LTC policy design.

Developing guidelines for interpreting the provincial regulations that recognize the autonomy of PSWs and the skill required to adapt care to the individual needs of residents under their care will facilitate a person-centered approach. In addition, developing staffing standards that are in line with the increased workload that has occurred in LTC settings in recent years would help to alleviate the workload pressure on PSWs and lighten the burden of working short-staffed shifts. Finally, developing educational standards for PSW education, articulating PSW competencies that recognize their unique role in LTC, and recognizing PSWs as health care professionals will give PSWs a system voice and solidify their role as important members of the health care team.
**Organizational Practice Implications**

The implications of this study for organizations revolve around developing practices that augment PSW autonomy, that include them in decision-making and care planning, that provide them with meaningful feedback from nurse managers, and that foster spaces for joint reflection and meaning making that consider PSWs as equal and valid partners at the table. Nurse managers also need to be empowered, as shown in other research that found a need to involve nurse managers in decision-making and highlighted their shared frustration with the difficulty in providing quality of care when recruitment and retention of PSWs is challenging (Campbell, 2003). Senior leaders within the organization are key to empowering nurses, who in turn, are key to empowering PSWs (Beaulieu et al., 1997). Equal attention must be paid to supporting nurse managers and PSWs in LTC facilities.

In order to foster an environment that empowers PSWs and nurse managers, LTC homes must develop safe spaces for organizational dialogue that protect all players, especially those who have been silenced by systemic blind spots, and processes for joint decision-making that create space for team sensemaking and learning. Rather than increasing the focus on compliance with rules, organizations should foster discussions about the complexity of care and recognize the importance of the role of relationships in solving complex care issues. Developing a coaching culture could contribute to personal and organizational learning that values the perspectives of all and considers systems thinking (Luxford et al., 2011; Riddle et al., 2015).

However, simply introducing new methods of person-centered care delivery will not shift organizational culture. This type of change requires a commitment to building a culture that values the well-being of its employees, fosters healthy relationships within the organization, and is committed to modeling these values in practice (Banaszak-Holl et al., 2013).
Involving PSWs in decision-making is likely to have an impact on the operations of the entire organization and is also likely to be contentious, and may result in increased disagreements between PSWs and other staff members (Sterns et al., 2010). This will require increased relationship-building on the part of all staff, as well as the ability to manage conflict and to examine underlying assumptions. These steps require time, training, and incorporation into daily decision-making. Particular attention must be paid to equipping PSWs so they have the skills to assume more of a leadership role in their teams and within the organization.

**Interpersonal Practice Implications**

In this study, each of the roles in the organization unintentionally contributes to the systemic blind spot described in the theoretical model section of this chapter. These unintentional contributions highlight the need for each role to make a practice change. This requires a three-pronged approach that includes changes at the senior, middle, and point of care levels.

While it is important for the ED to continue their strategic, externally focused work, it is equally important for the ED to create forums to understand the practical implications of new ideas from diverse perspectives and to discuss ideas openly and honestly. The senior leadership team, in its development of policies, must create new ways of working with and seeking input from all levels of staffing that are safe and meaningful. New methods to include PSWs in care planning and family meetings must be developed. Nurse managers should develop new approaches for providing input and feedback that ensure PSWs are heard, valued, and understood. Frequent feedforward performance conversations that allow for mutuality should also be incorporated, which will require a shift for all roles. The inclusion of PSWs in care discussions will increase their visibility and their contribution to care, and will allow residents and families to include
PSWs in problem-solving more often. Finally, PSWs will need to find their voices and be willing to take a more active role in decision-making and problem-solving.

A second implication for leadership is a shift toward the integration of relational care concepts to complement the person- and family-centered approach, which would entail a shift from the notion of “support workers” to one of “personal care specialists” at the direct care level, and would integrate the importance of the relational aspects of care in practice at all roles. This shift would not only focus on the direct relational care that staff provide but it would also require a shift outside the organization’s walls, as the importance of the relational aspect of care is recognized within the health care system.

Organizational culture is influenced primarily by what leaders pay attention to, measure, and control on a regular basis, how leaders model, teach, and coach, and how they allocate reward and status (Schein, 2017). To foster a culture shift toward a culture that is more inclusive of PSWs and their contributions to person- and family-centered care, leaders at all levels of the organization must make the inclusion of PSWs in decision-making part of their performance expectations and integrate this into daily practice. Furthermore, they must model respect in daily interactions and adopt coaching and feedback mechanisms that invite and value PSW perspectives.

**Future Research**

This case study explored the perspectives of those working and living in one LTC home in Ontario. Studies of other homes, including those of different sizes and with different types of governance, will provide more insight as to whether the systemic blindness to the diminished role of PSWs that I discovered in this home is experienced similarly across different settings.
Further research is needed to understand which methods of empowerment are most meaningful and effective for PSWs in the Canadian context. The workforce in this particular LTC home is made up of a largely immigrant workforce, and while my study did not uncover issues of racism, with a culturally diverse workforce such as this, it is important to understand how issues such as gender, race, and immigration patterns influence PSW empowerment.

Working in LTC requires the ability to navigate the complexities of complex adaptive systems. What are the competencies required in the ED, senior leadership, nurse manager, and PSW roles to see different system perspectives and foster interconnectedness among roles? Further research is needed to explore how leaders at each of these levels learn and develop competencies to recognize the interdependence of their roles and to work in partnership with one another.

If part of the solution to optimizing person- and family-centered care is the integration of relational practice and leadership, then research is needed to identify the criteria for relational practice and leadership in LTC and to evaluate how the adoption of these criteria can be promoted in the sector.

Finally, additional research is needed in the area of organizational design that investigates which models of decision-making, motivation, information-sharing, norms, structure, networks, and mindsets foster a person- and family-centered culture that values the role of PSWs.

**Conclusion**

Culture change takes time, is complex, creative, organic, influenced by all players in the organization as well as by organizational policy and procedures, and requires personal and organizational learning (Chapin, 2008; Schein, 2017). The gendered, predominantly immigrant PSW workforce in the LTC sector plays a pivotal role in the provision of person- and
family-centered care. They provide care that is assumed to be natural, of low value, and instinctual. The roles of the ED, senior leadership, nurse managers, and residents and families each focus on enhancing care for residents, but unwittingly undermine the important role of PSWs. This systemic blind spot is maintained by limited interaction between roles and continued siloed work (Scharmer & Kaufer, 2013). The high rules environment of LTC leaves PSWs with little autonomy, making them feel rushed and focused on tasks, which prevents them from building the relationships with resident that are important for quality of care (Daly et al., 2016).

In complex adaptive systems like LTC, optimal decision-making requires systems thinking where all perspectives are deemed important (Senge, 2006). However, in this study, I found that the PSW perspective is often missed, particularly in decision-making, as decisions are often made for this group rather than with them. The lack of mutuality in relationships, meaning mutual respect and mutual impact and influence on each other, hinders organizational learning, creativity, and adaptability (Regine & Lewin, 2000). Recognizing this systemic blind spot and empowering the PSW workforce is pivotal in improving care quality and requires building meaningful resident relationships, participation in decision-making, respectful feedback, safe environments to question authority, and creating room for dialogue, meaning making, and reflection that considers PSWs as equal and valued partners at the table.
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Appendix
Appendix A: Glossary

Family

A person’s family includes all those whom the person identifies as significant in his or her life (e.g., parents, caregivers, friends, substitute decision-makers, groups, communities, and populations; Registered Nurses’ Association of Ontario, 2015).

Long-Term Care Homes (Ontario)

LTC homes are places where adults can live and receive help with most or all daily activities and have access to 24-hour nursing and personal care. Those deemed eligible for placement in an LTC home have care needs which cannot be safely met in the community through publicly funded community-based services and other caregiving support. LTC in the province of Ontario is funded and regulated by the province with strict guidelines on how homes are funded, how much can be charged to the residents, who is to be admitted, what the requirements for care are, and how performance is measured.

Person- and Family-Centered Care

Person- and family-centered care in LTC is organized around the resident, values residents as individuals, treats them with dignity and respect, builds on a person’s strength, respects a person’s values, preferences and expressed needs, is integrated throughout the care journey, includes a person’s physical, medical, social, emotional and spiritual needs, and is provided in partnership with the resident and family as desired (Brooker, 2003; CMA, 2010; Frampton et al., 2008; Kitwood, 1988; Lines et al., 2015). The term family refers to individuals who are related (biologically, emotionally, or legally) to and/or have close bonds (friendships, commitments, shared households and child rearing responsibilities, and romantic attachments) with the person receiving health care.
Organizational Culture

The accumulated shared learning of that group as it solves its problem or external adaptation and internal integration; which has worked well enough to be considered valid and, therefore, to be taught to new members as the correct way to perceive, think, feel, and behave in relation to those problems. This accumulated learning is a “pattern or system of beliefs, values and behaviors that come to be taken for granted as basic assumptions and eventually drop out of awareness” (Schein, 2017, p. 6).
Appendix B: Informed Consent Form and Interview Questions

This informed consent form is for employees of [insert chosen LTC facility] who we are inviting to participate in a research project titled “Understanding the interactions that shape person-and-family-centered care in a long-term care setting”.

Name of Principle Investigator: Ellen Melis  
Name of Organization: Antioch University, PhD in Leadership and Change Program  
Name of Project: Understanding the interactions that shape person-and-family-centered care in a long-term care setting

You will be given a copy of the full Informed Consent Form

Introduction
I am Ellen Melis, a PhD candidate for Leadership and Change at Antioch University. As part of this degree, I am completing a project to understand what contributes to implementing a person-and-family-centered care approach in LTC. I am going to give you information about the study and invite you to be part of this research. You may talk to anyone you feel comfortable talking with about the research, and take time to reflect on whether you want to participate or not. You may ask questions at any time.

Purpose of the Research
The purpose of this project is to understand what helps or hinders the provision of care that is person-and-family-centered. We understand that many factors contribute to the ability to do so and we are interested in what happens between people that helps or hinders this, but also what other factors influence this. This information will may help us to better understand the bigger picture of what influences patient-centered care. Every organization is unique, but we hope that themes identified in this study might help other organizations understand this bigger picture and learn from it to provide more person-and-family-centered care.

Type of Research Intervention
This research will involve your participation in a one-on-one interview with me that will last approximately an hour, where I will ask you about your personal experience with what helped or hindered the provision of person-and-family-centered care in your organization. Each of these interviews will be recorded solely for research purposes, but all of the participants’ contributions will be de-identified prior to publication or the sharing of the research results. These recordings, and any other information that may connect you to the study, will be kept in a locked, secure location.

Participant Selection
You are being invited to take part in this research because you work at [insert chosen organization] and bring a unique perspective. We are looking to capture perspective of those in different parts of the organization – those in an administrative function, provide direct care, or provide support services.

Voluntary Participation
Your participation in this study is completely voluntary. You may choose not to participate. You will not be penalized for your decision not to participate or for any of your contributions during the study. Your position in the [insert name or org] will not be affected by this decision or your participation.
You may withdraw from this study at any time. If an interview has already taken place, the information you provided will not be used in the research study.

**Risks**
No study is completely risk free. However, I do not anticipate that you will be harmed or distressed during this study. You may stop being in the study at any time if you become uncomfortable. If you experience any discomfort as a result of your participation, employee assistance counselors will be available to you as a resource.

**Benefits**
There will be no direct benefit to you, but your participation may help others in the future.

**Reimbursements**
You will not be provided any monetary incentive to take part in this research project.

**Confidentiality**
All information will be de-identified, so that it cannot be connected back to you. Your real name will be replaced with a pseudonym in the write-up of this project, and only the primary researcher will have access to the list connecting your name to the pseudonym. This list, along with recordings of the discussion sessions, will be kept in a secure, locked location.

**Limits of Privacy Confidentiality**
Generally speaking, I can assure you that I will keep everything you tell me or do for the study private. Yet there are times where I cannot keep things private (confidential). The researcher cannot keep things private (confidential) when:
- The researcher finds out that a child or vulnerable adult has been abused,
- The researcher finds out that a person plans to hurt him or herself, such as commit suicide,
- The researcher finds out that a person plans to hurt someone else.

There are laws that require many professionals to take action if they think a person is at risk for self-harm or are self-harming, harming another or if a child or adult is being abused. In addition, there are guidelines that researchers must follow to make sure all people are treated with respect and kept safe. In most states, there is a government agency that must be told if someone is being abused or plans to self-harm or harm another person. Please ask any questions you may have about this issue before agreeing to be in the study. It is important that you do not feel betrayed if it turns out that the researcher cannot keep some things private.

**Future Publication**
The primary researcher, Ellen Melis, reserves the right to include any results of this study in future scholarly presentations and/or publications. All information will be de-identified prior to publication.

**Right to Refuse or Withdraw**
You do not have to take part in this research if you do not wish to do so, and you may withdraw from the study at any time without your job being affected.
Who to Contact
If you have any questions, you may ask them now or later. If you have questions later, you may contact Ellen Melis at XXX.

If you have any ethical concerns about this study, contact Lisa Kreeger, Chair, Institutional Review Board, Antioch University Ph.D. in Leadership and Change, Email: XXX.

This proposal has been reviewed and approved by the Antioch International Review Board (IRB), which is a committee whose task it is to make sure that research participants are protected. If you wish to find out more about the IRB, contact Dr. Lisa Kreeger.

DO YOU WISH TO BE IN THIS STUDY?
I have read the foregoing information, or it has been read to me. I have had the opportunity to ask questions about it and any questions I have been asked have been answered to my satisfaction. I consent voluntarily to be a participant in this study.

Print Name of Participant ____________________________

Signature of Participant ____________________________

Date ____________________________

Day/month/year

DO YOU WISH TO BE AUDIOTAPED IN THIS STUDY?
I voluntarily agree to let the researcher audiotape me for this study. I agree to allow the use of my recordings as described in this form.

Print Name of Participant ____________________________

Signature of Participant ____________________________

Date ____________________________

Day/month/year

To be filled out by the researcher or the person taking consent:

I confirm that the participant was given an opportunity to ask questions about the study, and all the questions asked by the participant have been answered correctly and to the best of my ability.
I confirm that the individual has not been coerced into giving consent, and the consent has been given freely and voluntarily.

A copy of this Informed Consent Form has been provided to the participant.

Print Name of Researcher/person taking the consent_______________________________

Signature of Researcher /person taking the consent_______________________________

Date ___________________________
    Day/month/year
Template of Interview Questions

I am interested in learning more about what it is like to provide/receive person-and-family-centered care.

Major question that will serve as a starting point:
- From your perspective, how would you describe person-and-family-centered care?

Follow up question could include the following
- How would you describe it here, at this organization?
- How do you see your role in this?
- What difference does it make?
  - For you? For the residents? For the family? For the Organization?
- What has allowed you to provide this type of care?
- What in particular has made a difference for you?
- What has been tricky?
- What has been in the way?
  - Explore what has hindered further

We know that this type if care is influenced by people as well as plans, guidelines, rules or even physical things. I would like to know more about all these elements.

People
- If you think about the team you work in, how has your team helped or hindered this approach?
- What about people in other parts of the organization?
- Did anyone stand out? Why?

Plans, guidelines or rule
- What plans, guidelines or rules play a role in person-and-family-centered care
- How do they help you?
- How do they hinder you?

Physical Things
Sometimes there is something physical – a layout of the location of something that makes a difference in person-and-family-centered care.
- When you think about that, what comes to mind?

For residents and family members:
- What about the care would you describe as person-and-family-centered?
- What difference does it make for you?
- What has helped this type of care approach?
- What do you feel hinders it?
Appendix C: Copyright Permissions

Introduction to all copyright requests:

I am a student completing her doctoral thesis at Antioch University in the US. I am requesting permission to use a table found in your publication as part of my doctoral thesis. The request is for a license without a time limit.

My dissertation is entitled: Understanding the Context and Social Processes that Shape Person- and Family-Centered Culture in Long-Term Care: The Pivotal Role of Personal Support Workers

It will appear in the following places:

1. Proquest Dissertations and Theses Database and that Proquest is a Print on Demand Publisher [http://www.proquest.com/products-services/pqdt.html](http://www.proquest.com/products-services/pqdt.html)

2. Ohiolink Electronic Theses and Dissertations Center and that Ohiolink ETD Center is an open access archive [https://etd.ohiolink.edu](https://etd.ohiolink.edu)

3. AURA: Antioch University Repository and Archive and that AURA is an open access archive. [http://aura.antioch.edu/](http://aura.antioch.edu/)

For Table 2.2:

Request to National Research Corporation Canada
I have attached the table as I would like to include it in my dissertation.

The content for the table can be found in the following publication:

Toronto, ON: National Research Corporation Canada.

No changes have been made to the wording in the document

I am looking forward to your permission for this request.

Sincerely,

Ellen Melis

Response received on April 3, 2020
Hello Ellen,

Regarding your Copyright request we discussed earlier, please properly credit NRC Health in the citation. You are not allowed to use our logo, but otherwise can reference data.

Please let us know if you have any further questions.
For Table 2.3:
Request to Canadian Medical Association:

I have attached the table as I would like to include it in my dissertation.

The content for the table can be found in the following publication:


The table in my dissertation includes the exact text from the Charter for patient-centred care on pages 8 and 9 of your document. No changes have been made to the wording in the document (for convenience, your document has also been attached).

I am looking forward to your permission for this request.

Sincerely,

Ellen Melis

Response received March 30, 2020:
Hello Ellen,

You have our permission to use this table.

For Figure 4.2

Request to participating organization:

I would like to include the attached figure as part of my thesis. It is a sample activity schedule that I have adapted to ensure facility and staff anonymity. I require your organization’s permission to use it in my dissertation.

Response received March 30, 2020:

That is fine with me