



Negotiating Tensions in Long-Term Residential Care

Ideas Worth Sharing

Edited by Pat Armstrong and Ruth Lowndes

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in Long-Term
Residential Care:**
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Pat Armstrong and Ruth Lowndes

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INTRODUCTION

Pat Armstrong

This book is about the tensions in long-term residential care. By tensions, we mean ideas, approaches, practices, programs, interests and communities that have conflicting demands and/or consequences. There is often, for example, a tension between the need to give priority to the increasingly complex medical needs of residents and the plan to provide the kind of support that emphasizes social care and interpersonal relationships. Such tensions can mean significant trade-offs or even negative consequences, as for instance when residents are put in wheelchairs to avoid falls but end up unable to walk as a result. For analytic purposes, we set out some of these tensions as if they represent simple alternatives and our ideas worth sharing sometimes suggest a simple alternative. But in practice alternatives overlap, and there are often benefits as well as negative consequences to each of them.

As we explain in the next section, our research team studied long-term care homes in six different countries. In our observations and interviews, we became increasingly aware of tensions that often sparked debates among our team members. At the same time, we began to recognize both that many of these tensions could not be eliminated and that there is seldom a single alternative that works for everyone. Moreover, we saw strategies designed to address one problem end up creating others. For example, the Eden Alternative model was intended to emphasize flexibility and responsiveness but its very success has standardized the model in ways that can reduce flexibility and responsiveness. Our understanding that tensions need to

be understood and balanced contrasts with approaches that search for single best practices, single models, or one, right way.

This bookette explores some of the tensions we encountered and debated together as a research team that shared the experience of conducting 27 rapid site-switching ethnographies. We identify promising practices for negotiating and addressing these tensions in ways that can work for both those who need and those who provide care, while recognizing that tensions will remain. We heard, for instance, about families or residents objecting to intimate care for a woman by a man. While perhaps understandable in terms of personal history or culture, the objections can mean extra work for the female care providers and undermine a man's right to equal work. One home handled this tension by getting the man to work in a team with a woman until the residents became accustomed to his presence, but this approach does not always overcome family objections. By making such tensions more visible, we seek to promote conversations about strategies for change that address and balance them.

Our evidence

Our research project on *Reimagining Long-Term Residential Care: An International Study of Promising Practices* is searching for ideas worth sharing. We focus on promising practices because what works well for some people in one place at one time may not work for everyone, even in that place and time. In other words, the context matters. We can nevertheless learn from those practices and investigate whether these or similar ideas work effectively for others in other places and times. Our purpose is to promote change that treats both those who provide and those who need care with dignity and respect, and that brings joy. In the process of doing our research we have encountered some tensions that are integral to long-term residential care, tensions that can at least benefit from their identification and from open debate about how to handle them.

Established eight years ago, our project brings together researchers from Norway, Sweden, Germany, the UK, the US and Canada. The five major unions in the Canadian health care sector are partners, along

with an employer association and a senior's organization.¹ These partners keep us connected to those who work and live in residential care, provide advice on where we should look for ideas worth sharing, and help keep our publications grounded in their experience.

We have used two basic strategies to gather evidence. The first, ongoing approach involves producing analyses of funding, payment and ownership; staffing and work organization; approaches to care; and means of ensuring accountability, such as reporting on injuries. Our scholarly and popular work on these areas can be found on our website, Reimagining Long-Term Residential Care, at <http://reltc.apps01.yorku.ca/>.

This research provides the background for our second strategy, the one that is the primary basis for this small book. Called rapid, site-switching ethnography, our method involves taking a team of 12 to 14 researchers into a long-term care home to observe and interview. We have conducted ethnographic research in 27 different sites, with at least two studies in each jurisdiction involved in the project. The homes ranged significantly in size, location, age and ownership, although most were non-profit. They also varied in terms of the models of care, with the Eden Alternative, Dementia Care Matters, and the Gentle Persuasive Approach just some of the examples of models we saw in practice.

To identify homes to study, we interviewed union representatives, community groups and government officials to ask where they would go to find promising practices and why they would select that particular home. While issues such as ownership, staffing and overall approaches to care were high on the list of factors contributing to the suggestions for homes to visit, most of those interviewed also identified physical environment issues such as location in relation to the community, floor plans, outside spaces, home-like atmosphere, and staff input on design as promising practices.

Based on these recommendations, we approached homes to ask if they were willing to have us look for promising practices in their places. This most commonly involved providing us with background information on such matters as floor plans, staffing and ownership and allowing us to observe and interview over a week. We also conducted shorter

“flash” ethnographies at another home in the same jurisdictions. These involved the entire team entering the home for a full day of observation and interviewing, and was conducted after we had begun the longer study in the same jurisdiction.

The teams that went in to study these long-term residential care homes were both interdisciplinary and international. Although each team was different, they all involved researchers from multiple countries and multiple educational backgrounds. They worked in pairs over three shifts, with the first shift starting at 7 a.m. and the last ending at midnight or later. We also made sure we included weekdays and weekends in our stay, based on the assumption that the involvement of families and volunteers would vary over this time period.

This approach allowed researchers from different countries and different perspectives to observe and talk with the same people in the long-term care home and to constantly compare how they understood what they saw and heard. So, for example, in one a Canadian physician and former medical director of a nursing home was paired with a Swedish woman just finishing her doctorate in social work; in another a nurse was paired with a political scientist. The physician and nurse were much more likely than the social worker or the economist to notice how medications were stored and delivered while the social worker and political scientist paid particular attention to the places where staff could rest and how staff organized their time.

Each night, team members who were not on shift met to discuss the day and the entire team met midweek and at the end of the week to discuss what we saw. These meetings allowed us all to reflect on what we thought we saw and heard and to compare what we learned, adding more voices and more perspectives to the research. It also allowed us to identify discrepancies, issues worth pursuing, and missing information we needed to seek out. For example, during one study, a researcher reported to the group that they were told that the blue section on the linoleum floor confused a resident who thought it was water and tried to dive into it. We followed up on the story to ensure it was not simply apocryphal. This led us to ask questions in each site not only about dementia and floor coverings but about colours.

These reflections taught us how much we have been trained to look for negative practices rather than for good ideas worth sharing. It is often much easier to notice a resident yelling than it is to recognize the calm that results from a worker handling a situation effectively. It is easier to see a worker sitting recording liquid intake in a dining room than to see the absence of recording and a worker offering a resident a drink as she walks down the hall. To counter this tendency, we daily reminded ourselves to look for ideas worth sharing and at the end of the week we together worked to identify both what we saw as promising practices in that place and what conditions made them promising for whom.²

Comparisons and reflections went further than one site. Carrying out the same kind of research in all six countries allowed us to compare across countries as well as within them. Witnessing staff having a meeting where they discussed how to deal with issues like feeding budgies or how to get a woman to agree to have her hair washed allowed us to ask how decisions about such issues would be made in other jurisdictions. This also demonstrates another important contribution of the comparisons and reflections. They allowed us to see what was missing. We started to notice, for example, when staff could see and respond to incidents in the dining room or that in some care homes the registered nurse(s) never helped with the meals. And we began noticing when a place was quiet or when there were no offensive odors.

Seeing what had negative consequences allowed us to appreciate what did seem promising, for whom it worked and why. These comparisons and reflections allowed us to consider options and their consequences, asking questions and rethinking old assumptions. A Swedish colleague, for instance, started to wonder if the Swedish notion of organizing long-term residential care homes into areas for nine to 11 residents created social spaces that were too small, after she saw larger units in other homes that allowed residents to socialize with a larger and more varied population.

We have well over 500 interviews conducted with the entire range of people involved in long-term care. We have hundreds of documents about the places we studied and a thousand pages of fieldnotes. And we have the notes on our many reflections and our lists of promising

practices. Together they provide a rich source of evidence on ideas worth sharing and worth trying.

Although we were not searching for broad generalizations, we did find some shared lessons and drew some conclusions about the most promising practices. For example, we are convinced on the basis of our research in Canada, Germany, Norway, Sweden, the US and the UK that continuity in staffing and sufficient staffing levels are essential to care. Nonetheless, the composition of the staff and how the staff divide up the work can take multiple forms and still support care that brings joy to residents and is rewarding for those doing the work. Similarly, we gathered enough evidence to show that food is central to well-being in care homes and that recognizing food is critical to care means having meals prepared and served on site by employees of the home who know the residents and take residents' preferences into account. However, various forms of work organization can help ensure meals contribute both to providing nutrition and to promoting care as a relationship.

As we continued our search for promising practices, we concluded not only that there were shared lessons to be learned but also that there were multiple tensions that could not be eliminated but could be addressed by methods worth sharing. These tensions exist on multiple levels and with varying degrees of intensity. In order to be addressed, though, they need to be recognized. Similarly, even the best-intended strategies may end up having negative consequences and it is important to understand how these consequences can be addressed.

Some of the tensions were evident in debates we had in our reflection meetings, as the notes from one such meeting in Norway indicate. The first speaker is a Norwegian architect:

People say long corridors are bad. But I think they are a good thing. They give residents a feeling of variation which is good, despite the corridors being locked up. The new design of eliminating them is wrong.

The second is a Norwegian graduate student in anthropology:

The long corridors allow staff to observe residents to ensure residents don't go in [the] wrong room. Residents like to sit at the end of the corridors to see what's happening on the corridors. That's what they like to look at.

The third is a Canadian doctor:

There is a bit of contradiction between a family-centred place and a home which doesn't have long corridors. Long corridors help with surveillance. But if you want a home-like environment, you should break them up. Put things in the corridors. Stuff. These corridors [are] too bright, shiny, distracting.

This was only one example of team members taking different views. Often it was participants from different countries and from different disciplines, as is the case here, but there was no general pattern. For example, the nursing home that had hardwood floors and was filled with light-coloured Scandinavian furniture felt home-like to many of us, regardless of our country of origin. But others on the team questioned whose home was reflected in the décor and asked whether we were simply responding in terms of our own age and culture.

Sometimes the tension was identified by a team member reflecting on their own country after participating in research in other jurisdictions, as in this example from a Norwegian:

Norway having 96% single rooms is a problem. It means people who want to stay with someone can't any longer. Also, with shared rooms, people get twice the number of visitors. We've swung too far to the other extreme.

And sometimes we addressed tensions that required new imaginings, as in the discussion below taken from meeting minutes:

Isn't there a third way? Something between the binary of home and institution? A model of "communal living." We seem to be trying to recreate individual homes. But we all have different styles of homes. Also, the reason you're in this space is because your home wasn't

working. Why can't we think of a communal space that is different? That is a comfortable space without being dominated by a medical culture? We've heard from nurses in [the] UK, "I'm not going to run around and hug people. I've had clinical training. I want to use it." The structure of their past learning is influencing the attitudes they bring to their work.

Some tensions only became visible to us over time. Memory boxes placed outside residents' rooms provide one example. These cases with pictures and objects that belong to the resident are intended to remind staff that residents have individual histories and identities while also helping residents to find their way home. But we started to see empty boxes, and wondered how these residents felt. And we heard about family quarrels about what should go into the box, prompting us to wonder who was being represented, on what basis in that instance. This led us to question whether the cases were a good idea at all.

These are just some of the examples of our debates about tensions, which ranged from ownership and funding to the size of closets. In the rest of this chapter, we identify some major tensions by drawing heavily on our analytical mapping. The rest of the book relies primarily on our evidence from the ethnographies.

Tensions over profit

At the global level, population aging is creating a growing demand for health services. One result is increased pressure on governments to invest in care for older people. At the same time, proponents of a neo-liberal approach, in particular, pressure governments to keep spending down and reduce the size of governments. With a lot of money to be made in health services, there are those within and outside nations who work to open all services to global investors. Proponents of open markets and international investment argue that for-profit approaches will do more than bring in needed cash; they will also increase efficiency and choice. This side of the tension has enjoyed considerable success. As the research from our project demonstrates, there has been a rapid expansion in for-profit, corporate care homes.³

Yet these powerful forces supporting open markets in care services face significant opposition from within particular countries. Opponents point to the need for democratic control of health services, control that will be lost when private companies insist on secrecy to protect their competitive edge and when global corporations make the rules. Quality has also been an issue, with research by members of our research team demonstrating that there is a clear pattern of lower quality in for-profit homes than in non-profit and government-owned homes.⁴ This is not surprising, given that staffing levels tend to be lower in for-profit homes.⁵ Moreover, the notion of choice based on the individual right to buy private services conflicts with the notion of shared responsibility guaranteeing the right to care through government services. And popular movements have opposed the notion of the individual right to buy private services.

Our team invited a presentation from Linn Herning, an activist in Norway, who described how community organizing successfully worked to reverse some of the for-profit ownership, based on the evidence about both quality and control and on the idea of the right to care. The community activists introduced the notion of “Welfare Profiteers” to draw attention to the ways in which global corporations were exploiting the public funding of care services for their own gain.

In an Ontario home we studied, the board, the resident council and the union united to eject the corporation that had been contracted to provide the food, returning to food production in-house. The corporate food was terrible, we were told.

The challenge to markets in care homes does not mean there is no place for markets anywhere in society but it does imply that markets create major questions about what role if any they should play in care. Some for-profit, corporate-owned homes have ideas worth sharing and it is important to learn from them.

Tensions over regulations

There are of course other global tensions that play out or arise within the different jurisdictions in our study. One of the most prominent

concerns the neo-liberal call for deregulation, for a removal of the red tape that is characterized as stifling the competition that leads to innovation, choice, and thus quality. On the other hand, there are multiple voices calling for greater regulation and more inspections to ensure quality and, in particular, to avoid the problems that the search for profit can bring.

One study conducted by our team looked at the response to scandals involving care homes that were reported in the media. The most common government response was more and more detailed regulation of practices within care homes and more inspections.⁶ Even though such scandals were more common in for-profit homes, none of the new regulations address questions of ownership although some try to limit where the public money goes. Ontario, for example, tries to ensure that profit cannot be made out of essential services by dividing funding into envelopes for specific expenditures, such as nursing staff and raw food, requiring any unspent money to be returned. But companies have managed to work around these restrictions by, for instance, hiring from their own staff agencies and by buying through their own companies. At the same time, though, some of the non-profit organizations see these envelopes as limiting their possibilities for innovation.

The global budgets that are the basis for funding in Norway do allow for more innovation and more local control.⁷ However, there is no public system in Norway for financial reporting, which limits democratic control especially as international corporations enter the sector by preventing public scrutiny. On the other hand, local control of the public system can sometimes serve to undermine equity by creating unequal investments from one local area to another.⁸

Not incidentally, the most detailed, standardized and deterrence-based regulations were found in countries with higher rates of privatization, especially in the United States where corporate ownership is the highest.⁹ Although there is evidence that regulations can help improve care, our comparison of Germany, Canada and Norway indicates that in the more prescriptive environments, workers tend to have less autonomy in responding to individual needs and be more task oriented.¹⁰ For example, in BC, any falls must be recorded and reported,

which has such negative responses from the inspectors that several homes told us they put any resident at any kind of fall risk into a wheelchair. In other words, the regulations can have the contradictory effect of undermining the quality of care.

In Norway, where for-profit ownership is lowest among the six countries, there are more limited regulations and inspections tend to focus on improving care rather than on punishing infractions. In a home we studied there, falls are only reported if they are serious and then the first response is for the care providers to have a discussion within the home about how to avoid such falls in the future. In contrast to detailed regulations on falls that can promote physical and pharmaceutical restraints, training programs have been shown to help reduce the use of restraints among dementia residents.¹¹ However, our research found that even in Norway there is an increase in these kinds of detailed regulations as more for-profit agencies enter the field.¹²

Like other regulations, those regarding minimum staffing levels may have a contradictory impact. The US literature suggests that 4.1 to 4.5 hours per resident of direct care is the minimum amount required and indicates that such a minimum should be legislated.¹³ However, these minimums can become maximums that do not respond to the care needs of those in any particular home. Moreover, they may encourage strategies to work around the minimum rather than to provide care. Direct care hours data too often record only the staff listed on the books and not the number who are actually at work, including among the minimum those nurses who are mainly keeping records rather than providing care, as well as those on sick leave, maternity leave, and vacation. We heard many reports of absent workers not being replaced. Moreover, minimums may be met by redistributing the work. For example, the number of laundry workers may be reduced and part of the laundry job made the responsibility of nursing staff.

Norway and Sweden do not have minimum staffing level regulations but they have significantly higher staffing levels than Canada.¹⁴ More funding, less for-profit ownership, a stronger commitment to services for older people and pro-active inspections all contribute to higher staffing. This is not to suggest that regulations regarding staffing

levels are unnecessary but rather that they are not sufficient and the consequences can be contradictory unless other measures are taken.

While our research leads us to recognize that both regulations and inspections are necessary, our evidence suggests that regulating ownership, providing supportive inspections and building trust through programs focused on education are also necessary.¹⁵

Tensions over global labour markets

The growing demand for long-term residential care also contributes to the growing international demand for people to provide the care. One source of this labour is low-income countries where economic pressure encourages migration for work. At the same time, the low wages or availability of more attractive jobs mean there is a shortage of workers who have been born in the high-income countries we studied. Research in Canada indicates that employers are more likely to hire immigrants as care aides and assistants than as RNs, and some employers indicate that immigrants make up more than half of this workforce.¹⁶ The overwhelming majority of those recruited are female, as is the case for the long-term care labour force in all the countries we studied.¹⁷ Many of those who migrate to do care work are from racialized groups, as was very visible in all but the rural homes we studied.

In our studies of homes, we heard from immigrant workers and from residents' families as well as from residents about tensions related to language and race. Residents and families complained about their difficulty communicating with staff because of language, complaints that often referred directly to race or implied an issue with race. We heard from staff in several of the homes we studied that they faced direct racist comments or non-verbal actions they understood as racist. Although most of the staff were female, we interviewed some males, all of whom were from racialized groups and were immigrants. These men reported that it was common for residents, and more often families, to object to a man providing care and the objections were as much about race as they were about gender.

These tensions are complicated by notions of age and ability. We heard both staff and managers dismiss the racism and language complaints as products of age and/or dementia, although some staff reported that supervisors told them to “suck it up” if they objected to the racism. The preference for female care providers was complicated not only by race but by culture, with some family members arguing that their culture or religion prohibited care by a male.

We also saw various strategies used to address these tensions. In Norway, a special language program involved workers whose first language was Norwegian to teach care-relevant terms to those who had difficulty speaking Norwegian. The program was paid for by the employer. In Ontario, we saw workers taking the initiative to switch residents in order to avoid tensions and a female care aide working with a male aide until the resident became accustomed to his presence. In the UK and in Germany, the manager made it clear to families that racism is not allowed and that a resident would have to leave if the racism continued. The first step was recognizing the tension.

There were also tensions related to the credentials of the migrant labour force. There was an assumption that much of the personal care work involved skills all women have, and thus all women are eligible for some of the jobs in long-term residential care. At the same time, those from other countries with formal credentials, such as a nursing diploma or degree, often have difficulty getting those credentials recognized.

Tensions over responsibility for care

Countries differ in the extent to which they see care as an individual or collective responsibility. The extent to which Norway and Sweden assume a collective responsibility is reflected in their funding for care homes, with these countries spending much more public money than the US and Canada. While Sweden has 66 long-term residential care beds per 1,000 people age 65 and over, Canada has 52 and the US only 37.¹⁸ Yet even in Norway and Sweden there have been tensions over funding and ownership, and thus over who has the responsibility for the care.

However, there is no simple divide between the countries that stress the right to care with services provided through public means and the countries that demand individual or family responsibility. For example, all countries in our study require some form of payment from those living in long-term residential care. The amount of the payment varies widely even within Canada and so does the extent to which income is taken into account.¹⁹ So does the extent to which property and income are considered, although this may be seen as a form of progressive taxation. And Sweden to a greater extent than Norway has been moving away from commitments to the universal access that was central to their welfare states, exposing other tensions within the Nordic countries.²⁰

In Canada, there has been considerable media coverage of poor quality care in care homes and long waiting lists for the homes. Although this coverage has sparked outrage, it has not led to much discussion about how we will pay for better quality care. There is no simple answer to the question of how much collective resources should cover individual care, but there is need for a public debate about shared responsibilities and how these responsibilities will be financially supported.

Tensions over calling these places home

In all the countries in our study, the term “home” is used to describe these places for care. At the same time, in all of these countries, a combination of factors means that more and more of the people entering care homes have complex medical needs and a majority has a form of dementia. The growing number of people over age 65 is one factor and so is the number of beds available not only in long-term residential care but in care alternatives, including home care. The result is a growing tension between medical care and what is often called social care, which emphasizes personal support and care relations. The tension could also be described as that between a hospital and a home. Especially as residents require more medical care, the tension increases and is exacerbated by both low staff-to-resident ratios and an insufficient number of spaces in care homes.

The medical care side of the tension is reinforced in North America by the growing reliance on the Resident Assessment Instrument-Minimum

Data Set (RAI-MDS) system for developing and implementing a care plan.²¹ While defended as a validated plan for assessing medical care needs and ensuring that the care plan is followed, the documentation required often has negative consequences for any notion of home. We witnessed care aides filling out forms while seated with residents at the dining room table and charts on wall tablets with check boxes for everything from the nature of a bowel movement to hours of sleep. For all the care providers, filling out these forms takes time away from care. It also reinforces a rigid hierarchy, because only formally qualified nurses can fill out the final documents. Moreover, the system fails to count quality-of-care issues or home-like aspects such as whether or not residents are required to get up at a particular time. Some monitoring, care planning, and accountability is required but systems such as RAI-MDS can make the counting rather than the care relationships a priority.

The hospital-like side of the tension is further reinforced in some jurisdictions by the division of labour. Especially in North America, nurses have worked hard to have their skills recognized and to ensure that those who practice nursing have the required skills. There are usually three levels of care providers, with care aides who have the least formal credentials providing most of the personal care. The defined scopes of practice are made visible in many homes by the uniforms staff wear and by a strict division of labour. The rigid, hierarchical division designed to protect workers' skills and residents' care too often means care is divided in ways that restrict the development of care relationships and prevent more integrated services. Although Germany, the UK and the Nordic homes we studied did restrict certain tasks to those with the highest qualifications, there was a much more fluid work organization. Those with the most formal credentials also provided hands-on care and consulted in teams that included the full range of staff. The emphasis was on integrated care, rather than on division. But such integration can also lead to work overload and be used as a means of saving money on labour.

Many of the tensions discussed in this book are shaped by and reflect the physical environment. This is particularly the case when it comes to what we mean by home. We had many debates within our team about

what was home-like. It quickly became obvious that what we saw as home-like reflected our culture, our age, our gender and our discipline. We had no single answer but we did become convinced that all homes should debate what home looks like, and for whom, especially as the resident population becomes more diverse in age, gender and culture.

This includes debates about whether or not all rooms should be single rooms. As we began our research most of us assumed that a private room is the appropriate alternative, in part reflecting our own preferences. Private rooms were the rule in the Scandinavian homes we visited and the rest of the countries in our study were moving in that direction. We agreed that crowded rooms for four people in one home we visited had created problems, especially when it became clear that today more and more residents were dying a short time after they arrived. There was no privacy for conversation, TV watching or sexual activities. Roommates were often incompatible, especially if there was a large age or cultural difference.

However, we gradually started to see how private rooms could be isolating. Residents often spent large parts of the day alone in their rooms. They did not share the visits others had from relatives, friends and volunteers, as was the case in rooms with more residents. Other residents were not there to help or to get help. In light of the kinds of tensions, we concluded that the rush to private rooms for everyone needed to be re-thought.

The size of a care home and how it is divided up are also commonly at issue. Based on our observations, our team agreed that units of 35 beds, placed on either side of long corridors with a clear hospital "message" did not feel like anyone's home. Units of this size did not work for the staff either because they had to walk long distances in order to respond to residents' calls. However, such long halls may have good site-lines that allow for better monitoring. Significantly smaller units (i.e., at least half the size) not only created a more home-like setting but allowed both residents and staff to know each other.

Large homes could realize economies of scale and thus save money on such things as purchasing. More services and supports could be

provided for both staff and residents. There were also more options in terms of developing relationships, in contrast to the small family-size units that could create family-like tensions, as we saw in Sweden.

Although our research did not lead to any firm conclusions about ideal size, there is evidence to indicate that relatively small units within bigger facilities can offer some of the benefits we saw in large and small homes.

Tensions over families

Families can help make long-term residential care places more like home. Many of the residents' relatives, and especially the female ones, told us they wanted to help their family member, and both staff and residents often reported appreciating family member assistance. However, there are also multiple tensions created with and by families.

Tensions appear when families are required to help because care is not provided. We heard, for example, from more than one daughter in Ontario and BC who reported that their mother did not get enough help eating if they were not there to assist. Or clothes were destroyed in the laundry unless daughters took the clothes home to wash. Families blamed the staff, who in turn blamed the shortage of workers. When there are "not enough hands," as we heard repeatedly from families, staff may have to rely on the supplementary labour of families but this labour is almost by definition intermittent. Indeed, family participation is usually variable, creating tensions in terms of staff planning for the labour. Higher staffing levels can help reduce this tension, as we saw in Sweden, where staff assumed that they were taking on the work families had done in the past, including such things as shopping for clothes.

At the same time, tensions may arise when families try to provide care that interferes with staff work or involves services such as bathing that could put the resident at risk. Women in particular may have long provided this care at home, before their relative entered the residence. However, there is no guarantee that the care previously provided was safe and effective. The long-term care home also worries about liability, and regulations may prevent anyone but a formally qualified worker

from providing the care. At the same time, family members often criticize the kind of care being provided by staff to their relatives.

In the UK we saw the naming of a “responsible nurse,” a person who would be the liaison with the family about a particular resident. This helped reduce some of the tensions, as did family councils in Canada that provided a place where families could raise their concerns.

In North America, we saw families trying to address the gaps in care by hiring personal companions. While these companions can provide some of the social care missing when staff levels are low, they can create their own tensions. For one thing, staff reported to us that the personal companions could take over the most rewarding parts of care at the same time as they reduced the pressure on governments and employers to provide more permanent and formal staffing. Tensions also erupted over who did what, especially in places that had no rules about what companions could and could not do. At the same time, there was no guarantee that personal companions had the skills required. And some staff thought the personal companions were used by families to spy on the employees of the home.²² A few homes are attempting to address the tensions by introducing policies about what personal companions are allowed to do and what kinds of qualifications they have.

Tensions over culture and communities

We studied homes that were intended for particular communities. There are some clear advantages to homes that are connected to religious organizations or cultural communities. There are often a common language and shared pasts. There are more volunteers, there is more money from donations, and there are often appropriate foods and activities. However, there are also disadvantages. These communities are not uniform and practices and politics are not necessarily shared. For example, the homes we visited that focused on the Jewish community kept kosher but the majority of Jewish residents had not done so at home and didn’t necessarily want to now.

There are also advantages to homes focused on particular health issues such as dementia or hearing impairment. Staff can have special training

and the physical environment can be designed for special needs. But this too can be isolating for residents and staff because they are segregated from other communities.

Another tension arises related to equity in access. All the homes we studied had public funding. In most countries, this means that the home cannot refuse admission to those who are not members of their community on the grounds that there should be equal access to publicly funded facilities. The entry of non-members can help undermine the advantages of the community focus while leaving the non-community residents isolated. In the home that kept kosher, there was a rebellion over the prohibition against any non-kosher food by those who were not Jewish. The workers, too, faced difficulties. In the Jewish home, we were told that most of the workers were not Jewish and one worker had been disciplined for bringing in a non-kosher birthday cake for another worker. The strategy of giving priority to community members can help address some, but not all, of these tensions.

The cultural tensions are not exclusive to homes focused on particular communities or illnesses. In all of the countries we studied, a growing number of staff are from abroad and the resident population is increasingly diverse in terms of culture, religion, national origin, racialization, gender and sexuality.

Tensions over relational care

There is a growing understanding of how important relational care is to the well-being of both residents and staff.²³ However, in many homes we studied, there is an obvious tension between work organization and the potential for building care relationships. Relational care takes time every day as well as over months and years. The low staffing levels, documentation requirements, a strict division of labour, and the growing priority given to medical care all mentioned above influence the extent to which there is time to practice relational care. Managerial practices taken from the corporate sector also mean an emphasis on minimum staff and a focus on getting the task done, contributing to difficulty in relating to the whole person.

Relational care requires continuity in staff that allows those who provide care not only to know residents and their families but also the rest of the staff. Managers require some flexibility in staffing to deal with work absences resulting from leaves of various sorts and thus often need to bring part-time and short-term workers into the home. However, a reliance on agency staff to fill these absences means there is little continuity, generating more tensions. One strategy we saw in Manitoba and the US was for the home to have its own roster of casual employees who knew the home, the staff, and the residents and their families.

In addition, the short time residents live after they enter a home makes it difficult to build care relationships. Moreover, if staff develop a relationship with residents and their families it may make it harder for them to deal with a resident's death.

Telling stories about tensions

This bookette cannot possibly cover all of the tensions among forces, interests, groups and individuals in relation to long-term residential care. The purpose here is to make tensions visible, rather than to provide a compendium. The chapters in this bookette do, however, tell stories and use examples from the 27 homes we studied. They are intended to capture the complexity of the issues while suggesting some ways we saw of addressing them.

NOTES

1. Partners include the Canadian Federation of Nurses Unions, the Canadian Union of Public Employees, the National Union of Public and Government Employees, the Service Employees International Union, Unifor, the Ontario Association of Non-Profit Homes and Services for Seniors and the Council on Aging, Ottawa.
2. For further details on this method, see P. Armstrong and R Lowndes, eds. (2018). *Creative Teamwork: Developing Rapid, Site-Switching Ethnography*. New York: Oxford University Press.
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Chapter 1

TENSIONS BETWEEN RISK AND SAFETY

Hugh Armstrong

When we first walked into a dementia unit in a German nursing home, I immediately saw an elderly woman wielding a sharp knife. It was a startling sight, but I soon realized that she was cutting up onions for dinner. In fact, she was asking the other residents across the island separating the kitchen from the dining and living room area of the “haus” or house where they lived whether they preferred that the slices be thick or thin. She had presumably been slicing onions and other vegetables for 60 or 70 years, and apparently no one thought anything should be any different in her current home.

During our visit, we were constantly reminded that the nursing home is home for her and the other residents. Everything possible was being done to make it home-like in reality, and not simply in rhetoric. Just as risks are to be found in private homes, so they are in this nursing home. Of course, care needs to be taken to avoid cut fingers and infections caused by unhygienic conditions, but fingers do occasionally get cut and infections do occasionally happen in both settings. To rigorously protect against every possible risk is to transform a nursing home into some sort of “total institution,”¹ paradoxically generating the attendant risks of boredom, inactivity and social isolation, risks that are themselves unhealthy. The risks involved in meal preparation need to be weighed against the risks of inactivity. Participation in the life of the nursing home can reduce risk, as it reduces alienation and frustration (and thus knife-wielding violence), including among residents with mild or moderate dementia. Risks can be positive.

This is not the whole story, however. Safety is also a concern. In 2003, Health Canada introduced its Business Transformation Strategy as an element of the government's "smart regulations" strategy. The emphasis shifted from the "precautionary principle" that sternly declared that first you should do no harm, in favour of an emphasis on establishing a business-friendly environment. The government has mixed its responsibilities for the protection of food, drug and medical devices with a commitment to the promotion of economic growth and the reduction of administrative burdens on business. As our research team colleague Joel Lexchin persuasively argues,² Health Canada assigns a higher priority to hastily approving new drugs than to monitoring the safety of drugs already on the market. More emphasis on safety is needed here.

The notions of risk and safety are not dichotomous. This is not an either/or situation, for there exist *degrees* of both risk and safety. A discussion about risk involves questions about how and what should be measured, by whom, and indeed when and where to acknowledge limits on what is measurable. This in turn raises the issue of the relationships between facts (will it happen?) and values (does it matter?). In other words, risk assessment is not a simple and "objective" issue. Nor is safety.

These are not just abstract philosophical issues. They find concrete expression in nursing homes. I cited the example of sharp knives in the hands of residents with dementia during meal preparation. Here is another example we have encountered. Falls can result in broken hips and transfers to hospital, a dangerous destination for frail seniors in particular. Should this mean that residents at risk of falls should be placed in large, motorized, tilt wheelchairs from which they cannot escape without assistance from staff or family? Will this in turn result in these seniors having increased rates of incontinence, resulting in increased rates of urinary infection?

Rates of falls, restraints, incontinence and urinary infection are all subject to measurement. Indeed, each is widely used as an indicator of the level of quality in nursing homes. One problem, however, is that these indicators are not all straightforward to measure. How do

you measure a fall? It may appear simple, but what if a resident is discovered on the floor while looking for something under her bed and lacks the capacity to explain what she is doing? Is a tilt wheelchair from which a resident cannot escape a restraint device even without a seatbelt?

If falls are the most important concern, wheelchairs and guard rails on the beds will likely be promoted. If urinary infections are the major concern, mobility will likely be promoted. Which risks, and which safety concerns, are deemed to be more important, and to whom? To those who transform great mounds of quantitative data into stark indicators of quality? To the facility manager seeking approval from the government funder? To the rushed personal support worker or care aide? To the family member who walked into the nursing home with her mother? To the mother, now resident, herself? To the resident's health insurer? To the home's liability insurer? (One hint we picked up during an Ontario visit is that if the home wishes to light candles for celebrations, remembrances or dark winter days it should seek out the firm that provides fire insurance to the local Catholic church.)

Here is another factor to consider: the time dimension to take into account when assessing the appropriate balance between risk and safety. Most nursing home residents are near the end of life. The choice may be between adding more years of life or adding more life to the remaining years. This is a legitimate question of values, and there is no ready answer in many cases. But consider the nursing home we visited which took soya sauce off the menu because it contains too much unhealthy salt. A majority of this home's residents are of Asian ancestry, and most have enjoyed soya sauce all their long lives. Its denial can only have a negative impact on their appetites. Their care plans should balance the health benefits of enjoyment in life with the medical risks of excessive salt intake.

It is clear from these examples that nursing homes, at least in Canada, should tolerate more risk. How much more risk is not so clear. In the private home, risk is first and foremost a subjective matter, more a question of perception and of moral values than it is a matter of rational choice. The common-sense alternative of conducting some

sort of risk/benefit analysis is misleading because it assumes that risk is necessarily negative. Yet risk can be positive. It can promote mobility and social engagement. It can fight boredom. The enduring tension is how to balance the encouragement of risk with the maintenance and in fact enhancement of safety for nursing home residents.

NOTES

1. The concept of “total institution” was introduced by Erving Goffman. See E. Goffman. (1961). *Asylums: Essays on the Social Situation of Mental Patients and Other Inmates*. New York: Anchor Books.

2. J. Lexchin. (2016). *Private Profits versus Public Policy: The Pharmaceutical Industry and the Canadian State*. Toronto: University of Toronto Press.

Chapter 2

TENSIONS BETWEEN PRINCIPLES AND PRACTICES

Albert Banerjee

I returned to a Canadian nursing home to follow up on some questions I had about care planning. I interviewed nurses, care aides and managers over the course of a day. Everyone's initial response to my questions about care planning was to let me know that it was important. And yet, when I sought to uncover how these plans mattered to the care of residents, I was repeatedly told that a big challenge was that care aides did not look at them. So the [care plans] did not in fact guide the work that aides did.

The Resident Assessment Instrument-Minimum Data Set (MDS-RAI) Coordinator, whose job it was to maintain the care plans, admitted that she continually struggled to develop strategies to encourage aides to read them. She recently made a shorter version of the plan, a "cheat sheet" she called it, and put them in places that aides would be likely to see. For instance, inside the residents' closet in the hope that care aides would glance at them when dressing residents. Yet they still didn't bother to read them! Worse, the MDS-RAI Coordinator now had one more document to keep up-to-date.

~ Albert Banerjee, Reflections on Fieldwork, May 2016

How do we make sense of a situation where the care plan — a document that is supposed to be integral to caring — is ignored in practice? The above example contains a number of tensions that we have encountered in the nursing homes we have visited. Most notably,

there is a tension between the desire to provide attentive, personalized care and its implementation in a manner that ends up being rigid, bureaucratic and ultimately, counterproductive. To put it succinctly, it reflects a tension between principles and practices.

Principles and practices

The concern for care planning described above forms part of a broader attempt to provide what has come to be called “person-centred care” (PCC). This is an approach to care that developed in response to legitimate concerns that nursing homes were overly medicalized and routinized. As the term suggests, PCC aims to treat the resident as a person rather than a patient. The goal is to put the whole person and the diversity of her or his needs at the centre of care, rather than having care be guided primarily by clinical concerns or institutional requirements. This approach suggests principles of care that are both attentive and responsive.

How to do this? One strategy that has been adopted in Ontario and in some of the other jurisdictions we visited was to require homes to create an individually tailored document that specifies the care each resident is to receive. Facilities are required to follow this plan, updating it as necessary. Hence, the import granted the care plan.

Considerable resources are now dedicated to developing the technologies to monitor the care plan — such as the Resident Assessment Instrument-Minimum Data Set (RAI-MDS) — as well as practices such as intake assessments, care conferences, and reporting requirements for staff in order to ensure these plans are kept up to date.

And yet, as our study reveals, the care plan’s role in guiding the work of care aides is minimal at best. This contradiction reflects a tension that we found whereby well-meaning principles became reduced to a set of rigid rules. Person-centred care becomes care planning, in this instance.

On the surface, care planning makes sense. If you want to provide personalized care, it makes sense to get to know the resident as a person, make notes about their needs and preferences, and use these

to direct care. Unfortunately, what we saw was that the care plan took on a life of its own. It was important for care aides to read the plan. It was important to update the plan. Whether and how this plan actually mattered to the care that residents received was lost.

Practices or conditions?

I found there were two key reasons why care plans were not used by aides. Both were relatively straightforward. The aides I spoke to explained that they simply did not have the time to read the care plans. They also observed that the information in them was usually out of date. So they could not trust them. What's more, care aides felt they had more immediate and reliable sources of information, such as the morning shift report or simply asking their colleagues. In fact, as several aides pointed out, they were the ones who provided much of the information found on the care plans in the first place, so they already knew what was in them.

It's worth noting that these findings are not unique to this study. Many studies have found care plans are typically not relied upon by aides, and for similar reasons — either aides don't have enough time or the information is unreliable. One recent British Columbia study¹ found that cheat sheets (or shorter versions of the plan) were made in order to encourage aides to pay attention to the information in care plans, but when the researchers looked at these sheets they found that half the residents listed had already died!

One of the limitations of focusing so narrowly on whether practices such as reading the care plan are being followed is that it misses the broader facility and policy context that set the conditions for care. The fact that aides don't have sufficient time to look at these plans or that they are not kept up to date is related to resources and the way they are allocated.

What's more, in focusing so narrowly on practices like care planning, we have failed to inquire what matters to care aides. They told us face-to-face dialogues were one of the most important methods of knowing what was happening with the residents they were caring for. Residents'

conditions changed fast, and so it was more reliable for aides to come in early and ask workers from the previous shift what had transpired. And yet, as we were told, these practices were not supported. So care aides came in on their own time.

In an interesting twist, the RAI-MDS coordinator I mentioned at the opening of this chapter developed a strategy to keep the plans up to date. She would routinely call a 30-to-40 minute meeting where staff would come together to discuss three or four residents. The staff found this to be very valuable and would even come early for these meetings, eager for them to start. So, time for dialogue could be found and could be paid for. But it was not set up to meet the needs of workers or to meet the needs of residents. It was to keep the care plan up to date! The practice of care planning would seem to have completely overshadowed the principle of providing care that is person-centred.

Protecting the home, not the resident

Despite their irrelevance to the work of care aides, care plans continue to matter in Ontario because they have become documents that are inspected by the Ministry of Health and Long-Term Care, which oversees quality. Indeed, in another twist, rather than protecting the resident, these plans are used to protect the home. “Make sure that is care-planned,” is a comment often heard on the floor. What this means, I was told, is that if aides are going to do anything that contravenes specific ministry regulations they have to make sure it is written down in the care plan — even if this is what the resident wants. Otherwise, the facility risks being cited by inspectors.

When I asked about this practice, it was explained to me that if a resident wanted to sleep in, this violated the rule that residents needed to be eating by 8 a.m. However, if this “preference” was care-planned and an inspector came in and questioned why the resident was still in bed, the staff could point to the care plan and thus avoid citation.

IDEAS WORTH SHARING

What happened to the principle of person-centred care? How did it come to be reduced to a practice that has such little impact on care? How do we better balance the tensions between principles and practice? A few lessons can be gleaned.

First, in order to understand what works when improving care, it is a good idea to speak with those doing the actual caring. This can help ensure that the practices we implement are those that make a difference on the ground. Thus, while care workers do not rely on care plans for up-to-date information, they have developed a number of knowledge-sharing practices that could be better supported. If some aides come early to speak with colleagues, shift overlaps can be intentionally scheduled and paid for. If staff are eager to participate in reflection meetings, these practices too can be supported. These are just some of the knowledge-sharing strategies that workers tell us help them care for residents. Supporting these would also support the principle of personalization.

Second, ensuring adequate time for personalized care matters. Care aides tell us that developing familiarity with residents is how they get to know their preferences. This takes time. Sharing information with colleagues takes time. It also takes time to provide care in a manner that supports relating and not rushing. Ensuring that the conditions are present so that care aides have time to care is another way we can support quality personalized care. This will also prevent practices from becoming counter-productive. Because, without ensuring sufficient time, any new practice will simply take time from another area of care.

None of the above is overly complicated. As our research shows, it is also not impossible to achieve, particularly if we are willing to direct resources appropriately.

NOTE

1. S. Caspar, P. Ratner, A. Phinney, and K. MacKinnon. (2016). The Influence of Organizational Systems on Information Exchange in Long-Term Care Facilities: An Institutional Ethnography. *Qualitative Health Research*, 26(7):951-965.

Chapter 3

TENSIONS OF GENDER, RACE AND CULTURE

Susan Braedley

In an Ontario nursing home located in an urban area, Saafi,¹ a Muslim woman originally from Somalia, has refused to allow men care workers to provide personal care, such as help with bathing, dressing and toileting. The staff assume that she has asked for women care workers due to beliefs about gender emanating from her religion and culture. Despite Saafi's request, one of the men care workers, Andre, has been working hard to gain her trust in the hope that eventually Saafi will allow him to provide personal care.

Andre believes that he works harder than his colleagues who are women, because he continually must overcome a preference for women care workers held by many residents. He knows that he and other male workers are often resented by their women co-workers. The men are seen as not doing their fair share of the work, as a result of residents' preferences for women's care. Andre is a recent immigrant from Haiti. He worries that his accented English, which some residents find hard to understand, together with prejudices against black men may figure in residents' preferences for other workers. He is concerned that all these circumstances are eroding his job security.

These conundrums about gender, race and culture also affect the manager's work in this nursing home. Residents' gendered preferences mean that the manager must ensure there is always a woman worker available to provide care. Staffing is dramatically reduced at night, based on the assumption that residents will sleep. Nevertheless, there

is still care to provide. And given that many men prefer to work nights, the only care aide on shift may be a man. Further, the manager hears complaints from women workers who say the men are not pulling their weight on other shifts. If she were able to schedule a shift with only men working, this would be less of a problem, but because of concerns like the example with Saafi, she cannot.

Saafi is aware that tension exists between her and some of the staff, but all she and her family know is that some staff consider Saafi to be "difficult." Was she being treated this way due to racism or prejudice against refugees? She thinks so.

As researchers hearing these stories, we wonder about another potential factor: the history of violence against women, including mass rape, that was part of the Somali Civil War that brought Saafi and her family to Canada. Whether or not Saafi experienced this violence personally, Somali women and men have been affected by this traumatic history. Saafi and her family members, like others affected by gendered violence, may not be fully conscious of how this history plays out in their everyday interactions with others.

This research story brings up just some of the questions and tensions about gender, race and culture that crop up every day in nursing homes. What is reasonable accommodation in nursing home care?² What are the rights and responsibilities of residents, workers and managers? How should those involved address these tensions? While it is clear that relations of gender, race and culture are woven into the everyday life of nursing homes, when problems occur, the influence of these relations is not always so clear. How should Andre, Saafi and her family, and the manager act in this situation? Is it possible to ensure Saafi's comfort, Andre's job security, the women workers' extra load and the manager's scheduling difficulties? If not, whose concerns get priority?

In our research, we did not find one answer to these questions. In many nursing homes, we discovered that the tensions that the research team perceived as relations of gender, race and culture were perceived as the individual problems of difficult people, which is what Saafi and Andre

both experienced. In other nursing homes, we found different levels of awareness, discussion, policy development and action. We found no quick fixes or one-size-fits-all solutions. However, we did find ways forward and ideas worth sharing.

Acknowledging inequitable gender relations

A first step toward negotiating these tensions is to acknowledge that all care work is gendered. As many feminist scholars have pointed out, women perform most of the unpaid and paid care work in households, families and communities. As a result, many people expect that care work will be done by women, and/or will be done better by women. Despite the huge body of evidence against such ideas, many people still believe that women are “naturally” caring. These beliefs help to assign women to care work while at the same time, their care work remains unskilled and is given low value.

Ideas about men being unsuited to care work are also implicated in the gendered tensions of nursing home care. Concerns about men’s violence, especially toward women, combine with widely held beliefs that men are “naturally” unsuited to care work. Homophobia can also be involved in cases where men residents resist being cared for by men workers. Homophobic and sexist ideas converge in situations where people assume that because a man is a care worker, he must be gay. Thus, men workers report having to negotiate with residents and women co-workers due to beliefs about gender and sexuality. Women co-workers report that they experience sexism from some men co-workers; for example, when men “skim” parts of the job, leaving the more mundane and heavy work of laundry, lifting and toileting to women.

Nursing home residents are mostly women, and this is itself related to inequitable gender relations. Women are more likely than men to live alone in late life, due to both their longer life spans and the fact that men tend to marry younger women. Women are also more likely to have lower incomes, and thus are less able to afford private paid alternatives to nursing home care. It also means that activities and interests more common to men are sometimes neglected in nursing

home programming, that men residents often feel romantically pursued by women residents, and that men residents do not have many other men for company.

Gender relations also shape situations where residents and workers exchange flirtatious, humorous comments that reference sexuality or gendered attractiveness. Our research team frequently witnessed these kinds of exchanges, and this banter was usually enjoyed and well-received by all. But sometimes the comments had sexist overtones. Further, some care workers reported that they experienced significant inappropriate grabbing and touching from residents.

In some nursing homes, residents who expressed overt sexism and racism were tolerated and excused, even by the workers most affected, with the explanation that they were too old or too demented to change. Some staff told us that to challenge this behaviour would be insensitive to residents, as “this is their home.” However, in permitting this behaviour, not only did workers lose the right to a harassment-free work environment, but everyone in the nursing home was forced to tolerate the toxicity of expressed racism and sexism.

Some nursing homes set clear policies to forbid racist and sexist comments and behaviour. Interestingly, these nursing homes reported significant success with these policies, including with very old and demented residents.

Acknowledging that gender relations play out as an everyday part of care relations is a step toward addressing the inequalities and tensions associated with gender. Whether workers and residents are women, men or people whose lives do not conform to this gender binary, our research shows that their relations with one another are affected by their individual gendered positions and experiences as well as by widely held assumptions about gender relations. Rather than ignoring, hiding or missing tensions related to gender, nursing homes can open dialogue as a first step to addressing them.

Acknowledging inequitable race relations

Interwoven with gender relations, race relations permeate care work and care relations. Just as nursing homes as a group could do much better by acknowledging gender relations, they have at least as much work to do to acknowledge race relations. Nursing home care is affected by widely held assumptions about race and care. Histories of colonialization and racial discrimination reverberate in nursing home care, where in the European, Canadian and US contexts included in our research, many care workers were from colonized, racialized and immigrant or refugee groups, while residents were more likely to be members of white, colonizing groups. For example, in urban areas of Canada, many nursing home workers are immigrants from the Philippines. We often heard from these workers and others that the Philippines was a more caring society for older people than Canada, and thus made better care workers. Yet the Philippines, a former Spanish then US colonial territory, has a well-documented care work education industry that produces care workers “for export” to support an economy reliant on the remittances these workers send back home. The discourse of “more caring” serves these interests, while also solidifying racist assumptions about care.

Racism is a regular occurrence for many nursing home workers. This fact was one of the consistent findings in our research across contexts. Further, workers were expected to endure racism and sexism as an inevitable part of their jobs. Racism was experienced through verbal and physical abuse from residents, families and co-workers. It was experienced through work expectations for care as well as rejections of care. It was experienced through silences about racism and expectations that workers put up with racism on the job.

Residents also experienced racism, as in the case of an aboriginal woman in an Ontario nursing home, Joanne, to whom racist remarks were directed regularly by her roommate. Joanne told us that her roommate was too old to realize what she was doing. It was also clear that this aboriginal resident was not too old to identify the racism or feel its sting. There were no plans to move either resident, as no one was complaining about it to staff, although staff overheard the racist

remarks regularly. While Joanne spoke coherently and could advocate for herself in some ways, it seemed that experiencing racism was such an accustomed part of her life that she didn't expect or demand that the nursing home would be different.

Nursing homes can begin to address inequitable race relations by acknowledging that racism is an issue, by working toward a harassment-free environment for everyone, and by challenging notions that people who are old or living with dementia cannot adjust their behaviour toward others.

Acknowledging culture

In a British Columbia nursing home, a resident of Chinese descent was eating poorly and losing weight. Her family reported that when they brought in Chinese food, she ate well. Eventually, the residence staff figured out that it was not so much the Chinese food as the chopsticks the family brought with them that made the difference. The resident was not comfortable eating with European flatware. Once chopsticks were made available, she was able to enjoy meals of all kinds.

Culture is central to caring, and nursing homes can take culture into account in many ways. It may be the music that is played, the food that is served, the way in which bathing or hairdressing is done, or the routines and habits involved in religious observances, holidays and other occasions. It may mean that staff learn some words in different languages or learn about disability cultures and their specificities.

Tensions around culture emerge in the contradiction between providing consistent, equitable care and providing personalized, culturally informed care. Attending to culture is easier, but not always easy, in culturally specific homes, such as the Chinese, Quaker, Jewish and other nursing homes where a large number of residents share a common cultural background. For example, when government funding means that limited spaces are available, and beds cannot remain open for the next Chinese or Jewish senior but must be filled by the next person on the waiting list, there are tensions between ensuring care for all and giving preference to those from particular groups.

Once a culturally specific home begins to serve a more diverse population, clashes can emerge. For example, in homes in both Manitoba and Ontario, concerns over maintaining kosher environments led to controversies about food. Further, global migration means that both residents and staff populations are increasingly diverse. Dealing with the varied cultural needs of a diverse resident population can be perceived as an impossibly complex task. Given that nursing homes experience a relatively high rate of turnover in their residents, it is also a task that is never finished, with novel demands continually emerging.

Like gender and race, acknowledging culture as an everyday aspect of care, instead of as a care problem, is a promising approach.

IDEAS WORTH SHARING

Our research findings included only a few promising practices around gender, race and culture. We have a lot to learn in these areas. However, there were some ideas worth sharing.

1. Nursing home boards of directors, managers, resident and family councils and staff unions and associations can acknowledge that there are tensions regarding inequitable relations of gender, race and culture that affect residents and workers. They can commit to working together to create harassment-free environments for residents and staff.
2. Long-term care educators can develop materials to train all those involved in an intersectional gender+ analysis. This analysis takes into consideration sex and gender, race, class, sexuality, ability, age and more.
3. Cultural competency training is a promising practice.
4. Involving families in the details of care planning, asking informed questions about care preferences, and consulting with residents and families on cultural matters is important.

NOTES

1. All names are pseudonyms for purposes of anonymity.
2. In Canada employers must make every reasonable effort to accommodate an employee who is protected against discrimination in human rights law. Michael Lynk notes that "In most cases, the protected ground requiring an accommodation is a disability, although recent accommodation cases have involved other grounds such as religion, gender, and race." See M. Lynk. (2008). *The Duty to Accommodate in the Canadian Workplace: Leading Principles and Recent Cases*. Sault Ste. Marie, ON: Ontario Federation of Labour.

Chapter 4

SIZE MATTERS: ISSUES OF SCALE IN LONG-TERM RESIDENTIAL CARE

Martha MacDonald

Our site visits exposed us to various approaches to the design and use of space in long-term residential care homes, raising questions in terms of costs, quality of care and organization of work. As a sector, long-term care sits awkwardly between acute care (hospitals, with a highly medicalized “institutional” model) and family/community care (where the ideal is “home”). There are tensions between these two approaches, manifested in debates about the appropriate scale of residence.

Germany and Canada both have a tradition of a hospital model and larger facilities, while Sweden’s tradition is smaller, more intimate homes. There is a trend across countries toward a less medical model, though at the same time the frailty of residents is increasing, and with it their medical needs. Meanwhile, the emphasis on resident-centred care strengthens support for a more “home-like” environment. However, there are tensions about what is the appropriate unit of analysis for a homey setting — is it the unit, or the overall facility?

We have seen various versions of this across our case studies. Some jurisdictions have moved away from large facilities; sometimes facilities have restructured to create smaller living units within a larger institution. In Canada the traditional nursing home was organized around floors, like a hospital, with more than 30 residents spread out along a long hall, with a hospital-like nursing station. Newer models have units of nine to 15 residents. This is closely tied to new models of work organization, with the emphasis being on teamwork and consistent staffing. A key element is how food is organized. While older

homes typically have one large dining room per floor, the newer model has a small dining room for each group of residents.

Our case studies showed several tensions related to size. Are there cost efficiencies attached to either a small or large size of the home or the unit? The focus on small units intersects with other trends in long-term care — for example, the outsourcing of food preparation to centralized, highly institutional kitchens, which runs counter to the more personalized ideal associated with small size. While the smaller units emphasize close staff/resident relationships, the trend towards casualization of work disrupts care relationships. In terms of care, while smaller facilities are more intimate, large facilities can offer more diverse programming and services, and residents or their families may prefer the stimulation of a larger setting. There are also many staffing tensions related to size. This chapter discusses various dilemmas and uses examples from the case studies to show promising practices related to size, taking account of the implications for the quality of the work environment as well as the quality of care.

The first question is what is meant by size. We might count the number of residents or focus on the area and layout of the physical space, including whether rooms are single or shared, or the size, number and location of dining rooms (per unit, per floor, per home). There is the size of units, homes and organizations to consider. In general, there are nested scales to consider. Fundamentally we are interested in how the care model is embedded in physical space, either by design or by accommodation. How does the physical space influence the care model? How does the care model influence the physical space?

Overview of facilities

The facilities we visited cover the spectrum of size, both in terms of number of residents and size of units. Of the 21 nursing homes in which we did a full or flash site visit, seven are on the small side, with fewer than 75 residents. Ten homes are mid-size, with 75 to 149 residents and four have 150 or more residents. Note that two are very small, with fewer than 50 residents, and two are very large, having more than 200 residents.

In terms of unit size, seven have very small units of fewer than 10 residents, while another two have units in the 10 to 16 size range. Six homes have relatively large units of at least 25. The rest have mid-sized units, most commonly about 20 residents per unit. The two homes with the largest units (more than 30 residents) were both in Canada. Sweden, Germany and Norway tended to have smaller units, though the size of the homes varied. Note that some facilities have a mix of unit sizes. For example, there were smaller numbers of residents in palliative care or dementia units. Most homes had one dining room per unit of eight to 36 residents.

We saw various combinations of unit and home sizes. There are units of fewer than 20 residents in each facility size grouping. And there are similar-sized facilities in different countries that have different unit sizes, with smaller units the norm in Norway and Sweden. The majority of the facilities we studied are part of larger organizations that operate multiple homes, or are part of a continuum of care “campus” with buildings or units for different levels of independence, including acute care hospitals. These included not-for-profit, cooperative and non-profit organizations. In one Norwegian case the small nursing home was part of a vibrant cluster of community facilities; in another case in the same country, a small care home “floor” was integrated into — and overwhelmed by — a more acute care medical unit for seniors.

Physical space and models of care

Physical spaces embody the model of care and reflect trends over time. To change the model of care you need to change the building. Newer buildings reflect current thinking, while older buildings may be renovated to keep up with the times. In Nova Scotia, facilities built under a bed expansion and replacement initiative in the first decade of this century had to follow exacting design standards explicitly influenced by the Eden Alternative model of care.¹ Requirements included a small number of residents per unit, single rooms, and a dining room for each unit as well as ground-level access to outside space. The design requirements also favoured small total bed counts for the new homes, though replacement homes were allowed to maintain their existing bed levels. We visited one of the smaller new

homes with small units as well as a larger replacement home with small units. In each case the model of care was person-centred and home-like. In Norway we visited a new small home that was part of a larger integrated complex, reflecting a model that emphasizes community connectedness. Another element of the current model across jurisdictions was the lack of a traditional nursing station per unit. Nursing stations tend to be shared across units or integrated into common resident spaces, or the administrative nursing tasks are relegated to small offices.

One home that was “state of the art” when it was built in 1991 in British Columbia, was relatively large with over 100 residents, but it had relatively small units of 15 residents each. On the other hand, it had one main dining room for all residents except for those in the dementia unit. This home reflects elements of traditional and current models. Another Canadian home had a 2001 building with a common dining room and a 2008 addition with dining rooms on every unit and shared nursing stations.

Most older buildings had been designed with an institutional, hospital-like model of care. Two such buildings had been renovated to create smaller units with individual dining rooms by converting rooms into dining areas. Common spaces had been added to the ends of wings. A general trend in renovating was to remove the central nursing stations. In one facility the nursing station was replaced with a bar, where beer and wine were available, reflecting a model that emphasizes resident freedom of choice.

While the trend is to have dining rooms on each unit, there is variation in whether food is cooked centrally, on the unit, or off site. There is a lot of difference in the scale/functionality of the kitchens in these units — some are just places to make a cup of tea and a snack, while others are fully functional and resemble home kitchens. There are also differences in how the central kitchens relate to the units. In some, food is delivered in large carts ready to serve, while in others, centrally prepared meals are heated in the unit kitchen or servery. We observed smaller kitchens or serveries primarily used for reheating food in Norway and in Canada.

At the same time as the current model of care emphasizes more intimate, home-like units, we noticed large, fancy public spaces in some nursing homes. We saw grand atriums and hotel-like lobby areas, which seemed to be more for the benefit of families and visitors than for residents. One tour guide proudly noted the “wow factor” of the building entry. In another, an impressive ballroom-like staircase seemed to signal the wealthy clientele the home sought to attract. These “wow” factors characterize what some people call a “hotel” or “cruise ship” model of long-term care.

Resident perspective

From the perspective of residents, the mix of public and private space is important, and there is a tension between intimacy and stimulation. Single rooms offer privacy, but may contribute to isolation. In one variation we saw related to this tension, each room had a window onto the public spaces. In theory this allows the resident to connect more with the outer life of the home. However, it also enables staff surveillance and it was unclear who controlled whether the window blinds were open or closed. In general, staff noted that there was less aggression with more personal space and smaller units.

Space is also used as a non-invasive way to handle wandering, as building design can allow residents to move securely around a facility. In one relatively large facility with spread-out small units and lots of corridors where residents were free to roam, we were told that a resident might end up in a different unit and even be given food there, then would be taken back “home.”

While small units offer more intimacy and can foster relationships, they also limit the social options and can contribute to boredom. In both large and small units, residents gravitate to where there is some action or life, whether it is the traditional nursing station, or a chair by the elevator to watch the comings and goings. In general we noticed that cozy sitting areas — part of a home-like space — were not used.

The smaller dining spaces seemed to offer residents a calmer mealtime environment. This was enhanced in facilities where there were more

resident-centred options in terms of the timing of meals and the choice of food, which coincided with maintaining in-house food services.² This was seen most often in terms of breakfast — in some facilities, residents could eat when and what they wanted.

In terms of the scale of the overall facility, smaller facilities sometimes lack the diversity of programming and even the therapy options available in larger ones. We saw that this could be somewhat alleviated if small facilities were part of a larger organization, where specialized staff could be shared among the component facilities. However, this option is more likely to occur in the private for-profit sector.

Staff perspective

There are links between scale and models of work organization. The shift to homier spaces and resident-centred care has meant changes in the division of labour and the organization of staffing. The spatial model of smaller units is closely tied to new models of work organization, with the emphasis being on teamwork and consistent staffing. With teamwork the division of labour becomes more fluid. In smaller units care staff may take on cleaning tasks usually assigned to separate staff, and everyone is encouraged to “pitch in” as needed.

In one case with small units and a functional kitchen in each unit, cleaning staff were given the expanded role of preparing breakfast for residents, enabling the care aides to focus on direct care and the residents to eat when and what they wanted. The cleaning staff were generally positive about this expansion of roles and the relationships it fostered.³ In another new, smaller facility where food was brought in from off site, care aides took turns working in the servery on the unit, heating and serving the food. This increase in scope of practice was viewed in far less positive terms. There is a tension between the possible rewards of teamwork and simply being called on to do more for increasingly frail residents in smaller units with less back-up.

The emphasis on resident-centred, relational care also translates into the need for consistent staffing on units so that staff members get to know the residents and their needs and preferences.⁴ For staff there

may be a tension between this and the variety possible in bigger units or with more rotation. There may also be issues with small units and the ability of particular staff members to work together. Of course work on units can be heavy or light, by reputation or in fact, as a result of the composition of the resident population. And despite the model of “home” and relational care there is often pressure on staffing levels and a trend toward casualization of work. We saw examples of facilities keeping staff at just under full-time hours to avoid paying benefits, which frustrated workers. In other cases staff are pressured to work extra shifts or overtime due to a lack of replacements. These demands on staff work in opposition to the committed relational care that is supposed to be facilitated by smaller units.

We saw some challenges for staff in facilities with spread-out wings and dispersed units that required a lot of walking to get from one to the other. Similarly, facility-wide spaces like activity and therapy rooms may be far from the unit. The units are isolating for staff, especially during the evening and night shifts when there are fewer workers on duty — perhaps only one registered nurse for the whole facility.

The issue of scale can also be applied to management. Has authority become more decentralized, in keeping with the ethos of smaller scale? We did not see much decentralization, and most unit staff felt that more decision-making power should reside at the unit level. There was a tension between having more responsibility but not more authority.

Scale and efficiencies

Are there economies of scale in nursing homes? If so, are they at the scale of the facility or of the organization? We were told by one administrator that the literature says 120 to 150 is an optimal facility size in terms of cost. Stand-alone facilities, unconnected to a larger organization, are the minority across jurisdictions, as noted earlier. To the extent there are economies of scale these may be realized across the organization. There can be cross-efficiencies through sharing “back of the house” services like human resource management or finance, or by sharing specialized personnel like therapists, or even having centralized food preparation. The small stand-alone home does seem to

be at a disadvantage in this regard. In our case studies the two smallest nursing homes are embedded in larger complexes (Norway). Although both for-profit and not-for-profit organizations are using a campus model, there does seem to be a link between scale and privatization. Large private for-profit companies are building smaller homes as part of bigger entities that share services and these companies are better able to compete when governments move to request for proposal models for building new publicly financed facilities. For example, all of the smaller new homes built in Nova Scotia are part of for-profit chains.

The focus on small units intersects with a trend toward more outsourcing in long-term care — for example, outsourcing of food preparation to centralized, highly institutional kitchens, running counter to the more personalized ideal associated with small size. We have seen this result in a “homey” space with airplane-type food.

IDEAS WORTH SHARING

- While there are tensions, the trend toward smaller units and a model of “home” seems to be generally positive. And smaller units can be found across the full range of facility sizes and jurisdictions.
- The potential of small units seems to be best realized where there is in-house food preparation, with resident participation and flexible eating times. This means having functional kitchens on units.
- Consistent staffing and decision-making power at the unit level can contribute to finding new ways of working together without making everyone work harder.
- Embedding smaller units in larger organizations can combine economies of scale with the intimacy of small units. However, an ongoing challenge is to develop ways to counter the current pressure for this “scaling up” to favour the for-profit sector.

NOTES

1. S. Braedley and G. Martel. (2015). Dreaming of Home: Long Term Residential Care and (In)equities by Design. *Studies in Political Economy* 95:59-81.
2. R. Lowndes, T. Daly, and P. Armstrong, (2017). "Leisurely Dining": Exploring How Work Organization, Informal Care and Dining Spaces Shape Residents' Experiences of Eating in Long-Term Residential Care. *Qualitative Health Research*, 28(1):126-144. DOI:10.1177/1049732317737979
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Chapter 5

THE QUALITY CONUNDRUM

Tamara Daly

When it comes to quality, there is a tension between what is measured and what is experienced as quality of care. The example of an excellent music activity highlights this tension.

Our fieldnotes describe how at 1:30 p.m. we accompanied the care aide and a resident downstairs for their weekly live music program in a Nova Scotian nursing home. We entered the multi-purpose space — sometimes it's a chapel, sometimes it's a music room — and the band was getting set up, with guitars, a fiddle and a keyboard.

A steady pace of residents entered the large room, walking on their own, or using their walkers. Some people using wheelchairs were brought into the space by volunteers, care aides and family members. Getting everyone to the space took about half an hour, but no one seemed bothered by the wait; after all, the band members were moving around and there was excited chatter in the room. There were more than 50 residents there, half of the home's population — along with some family and at least four volunteers. As 2 p.m. approached, the flow of residents slowed, but care aides continued to bring residents in well past when the lead singer introduced himself; we began enjoying their lively performance.

It was a delightful and memorable time. As the music played, residents tapped their toes, clapped their hands and swayed their shoulders. The music was upbeat, fun and local. A Rita MacNeil song had most people

singing along. A staff member invited a female resident to dance to “Tom Dooley” in the floor space in front of the band. The resident and care aide had a great time and they danced the whole song away. The staff member then danced with a male resident. He kept the beat but she adapted her steps to take the lead when he hesitated. It worked wonderfully. His grin was broad and genuine.

Reflecting on that warm May afternoon evokes pleasurable memories because of the moments of joy reflected on the faces and in the body language of the residents, staff, volunteers and families. However, translating that joy into language that a policy-maker would recognize stops us cold. Our decision-makers don’t use the kinds of metrics that measure joy or pleasure experienced in the everyday life of residents in long-term care. The only word that even comes close is quality. How is “quality” currently defined when we think of living life in long-term care? How should it be defined?

Donabedian argues that quality is defined by assessing the “structures” available to provide for the care, the “processes” or actions undertaken to care, and its “outcomes” or results.¹ Researchers in our project team have observed many unremarkable music activities accompanied by a ghetto blaster, song sheets and an activity director. The activity sometimes proceeds on schedule, despite the clear lack of resident engagement. We’ve been in other homes, for example in Germany, where spontaneous music was a part of the day and where music, dancing and rum punch were also part of the fun.

A holistic approach to quality that takes structures, processes and outcomes into account would acknowledge how a ghetto blaster and a live band are qualitatively different, or how dancing to music can produce positive health outcomes. As well, having staff available to assist with activities is a structural indicator of quality care. We don’t get anywhere close to a holistic approach with what we currently measure, and even less so with what quality indicators are publicly reported. In jurisdictions that use the Resident Assessment Instrument-Minimum Data Set (RAI-MDS) 2.0 tool, we measure whether a resident participated in an activity, looking back to just the previous seven days, not over time. The indicators do not measure whether residents liked

the Rita MacNeil music or whether they would have preferred Mozart instead. Was it too loud for some to participate? Was the time of day a good one? Or did the stimulation of the live music encourage some of the challenging behaviours associated with dementias that descend late in the afternoon?

By focusing on measuring whether the resident participated or not, but not on the actual quality of the activity or the extent to which the activity engaged the resident, we miss the whole point of having activities, and of measuring quality, for that matter. Activities should not simply be an entry on the calendar to fulfill the regulations. They should be meaningful to the residents and meet them where they are at — in pace, structure, timing and content. In the worst examples of activity, residents in their wheelchairs are lined up in front of a TV — whether in their own rooms or in the common spaces — with little capability to determine what to listen to or to watch. In the best ones, the activity evokes the senses and brings smiles and happiness to the faces of residents and staff, family members and volunteers.

Quality indicators that are publicly reported by the Canadian Institute for Health Information (CIHI) on the website www.yourhealthsystem.ca, are not measures of the quality of residents' experiences or engagement; these indicators measure select health outcomes and medical complexity. The "quality indicators" reported by CIHI focus on safety (falls in the last 30 days and worsened pressure ulcers); appropriateness and effectiveness (inappropriate use of anti-psychotics, restraint use); and health status (improved physical functioning, worsened physical functioning, worsened depressive mood, experiencing pain, and experiencing worsened pain).

A quality agenda focused on health outcomes alone may unduly measure how long-term residential care contributes to or alleviates shifts to more costly acute care, or substitutes for it. What is measured currently may contribute to nursing home funding, as residents' medical complexity is rewarded with additional funding, but such things as residents' need for slowness and to take care, and their challenging behaviours, are not. Process quality indicators are missing from our current assessments of quality and therefore from funding.

Like the missing process indicators, structural indicators of quality, such as those which measure appropriate staffing levels, are also missing. As a result, what we measure may do very little to improve real experiences of quality. For instance, the “falls” quality indicator, which measures the proportion of people who fell, is considered integral likely because falls can lead to poor health outcomes (e.g., broken hips, wrists and ribs as well as concussions) that are also costly for the system. Falls are also a key example of the delta between what we say is quality and what is experienced as quality. For instance, some homes have the approach that the best way to avoid a fall is to limit residents’ mobility and in the worst homes, to get people into wheelchairs as quickly as possible. With this reduction of mobility comes increased medical complexity and increased workload as every movement requires two people, and the resident requires a mechanical lift to be moved so as to — quite rightly — protect the bodies of care staff. The time it takes to move people from bed to wheelchair and from wheelchair to bath is time-consuming but can mostly be done at predictable times (morning or afternoon). The time it takes to aid someone to walk to lunch or an activity if they are a bit unsteady is more time-consuming, though may ultimately be better for the resident. In places that encourage mobility, a wheelchair is used judiciously, when the need arises, but residents are still encouraged to ambulate. In places where preventing falls at all costs is prescribed, or where understaffing does not permit slowness, wheelchairs are more readily used as a stand-in for staff. Similarly, incontinence products are used to extend staffing levels. In some places, residents who call for toileting are told to urinate in their “product” as there is no time for the staff to come on demand.

By measuring falls, are we signalling a concern for safety, or a concern for additional costs to the health care systems? What could be gained if instead we measured and rewarded efforts to sustain and encourage mobility? How would we measure it in ways that take account of the qualitative aspects of quality? For instance, the fact that there were so many people in the Nova Scotia home who were aged over 100 and who walked down to enjoy the afternoon music program was a signal of quality on many fronts. Like many of the European homes we studied, there were fewer wheelchairs in general in this home. This was

in stark contrast to some homes in Ontario, where people are more readily placed in wheelchairs.

IDEAS WORTH SHARING

Can residents' and care workers' joy be elevated to a level where policy-makers can see it reflected in the indicators and reports and factored into assessments of performance?

Policy-makers like to say if you can't measure it, it can't be counted. But if we are to use a robust approach to quality, we can't simply count what is easy to count or leave out what cannot be counted. We also can't simply count indicators that are likely to point to costly health outcomes without considering the costly outcomes to quality of life.

The enjoyment of the high-quality music in the Nova Scotia home was clear. But how do we capture that aspect of quality? If what we measure is simply that someone attended an activity or did not have a fall, we miss the process indicators — such as creating meaningful activity and maintaining residents' own capacities and mobilities to the end. We also miss the measurement of structural indicators — including staffing levels, appropriate spaces and an approach to understanding quality that respects dignity in older age and the care providers who work in long-term residential care — that turn the quality review back on the policy-makers.

NOTE

1. A. Donabedian. (1988). Quality Assessment and Assurance: Unity of Purpose, Diversity of Means. *Inquiry, The Challenge of Quality*, 25(1):173-192.

Chapter 6

A DAY IN THE LIFE: COMPARISONS OF SOCIAL AND MEDICAL CARE MODELS IN GERMANY AND ONTARIO, CANADA

Ruth Lowndes and Jim Struthers

7:40 a.m. For the past 10 minutes the RPN (registered practical nurse) has been alone with... five residents, mixing and giving them morning meds, and keeping track of... Tyler who keeps attempting to get out of his wheelchair and is at risk of falling, while the PSWs (personal support workers, or care aides) are off in the rooms busy getting residents up, cleaned, dressed and ready for breakfast.

8:05 a.m. Gloria has arrived in her wheelchair.... She then walks into the dining room by herself and sits down.... The RPN gets her back into her wheelchair and pushes her into a line of four, back in the lounge area. [Clearly, she doesn't want residents in the dining room by themselves, until some PSWs are available to help out and keep an eye on them. Falls prevention is always job one.]

8:40 a.m. Breakfast is being served table by table. The residents are very quiet, while they wait for their food. Quite unlike dinner, there is no conversation among them. Perhaps they are still sleepy...

8:55 a.m. Everyone [23 residents] now has their breakfast.... There are 4 PSWs, 1 RPN, and the one dietary services woman doing the breakfast.... They are working very smoothly and efficiently to get everyone fed.... The housekeeper [who has been dusting] is now vacuuming the lounge area.

9:50 a.m. [After breakfast] The familiar wheelchair line-up is now back

in formation.... The RPN is giving Ming his liquid medications. "Don't punch," she tells him.

10:20 a.m. It's now very quiet in the lounge area. A PSW tells the RPN, "They've got to change the breakfast. Every day it's eggs and bread. Eggs and bread. Why don't they have pancakes for a change?" [She] agrees emphatically.... Alarm klaxons ring. Tyler has tried to escape by pushing the code buttons on the exit. The RPN moans, "I'm so far behind..." PSWs are now entering data on charts at the nurses' station.... The RPN says, "All done. Now I have to start again (referring to dispensing meds), and complaining to the PSW, "Yesterday I was here until 4 o'clock finishing my paperwork. What a day. It's always something." Indeed, she's now back at her table preparing the next round of meds.

10:25 a.m. The recreation therapist [RT] has turned off the TV and the stereo and started a two-balloon "play therapy" session with the 18 residents now lined up in the lounge [by the PSWs], half in wheelchairs and half in lounge chairs facing each other. She bounces a green balloon toward the face of a seated resident, and they are supposed to punch it back to her. She approaches one woman resident who is asleep in her wheelchair. "Wakey, wakey," she says.... Only Ming seems interested in the balloon game.

10:50 a.m. One PSW is charting. The RPN is preparing meds. The balloon game continues.... The RPN now tries to calm down Janet who's been sitting next to Gloria and is getting quite agitated. She says to the RT, "You're scaring her. Keep away the balloons." The RT checks her watch and says to the group, "This balloon game is good for you. Gets your blood moving. But some of you don't like it. It's not a good day. So we'll leave." (Fieldnote, Ontario)

There is an obvious tension between dealing with the medical and physical needs of residents and their social need for human support and interaction. The tensions become more visible as residents who live in long-term residential care (LTRC) have increasingly complex medical needs. However, we saw in Germany and elsewhere more of a balance, with more emphasis on social needs than in Canada, where time

pressures are made worse by the need for recording, aligning with regulations, and low staffing, all of which increase the emphasis on the medical.

In a medical care model, biological data such as hygiene, medication administration, and the measurement of physiological evidence of health are prioritized over the more social or relational aspects of care.¹ Work is organized in a task-oriented manner, decision-making tends to be hierarchical, divisions of labour are strict, and routines are often fixed and rigid.² For instance, nutritional content and amount of food intake take precedence over the pleasurable aspects of eating. In this medicalized model, social activities are less important than physiological tasks such as bathing. This approach to care, driven by detailed government regulations that require daily, quantifiable data entry,³ determines the workers' day, directing the type and amount of care that can be provided.

As the above fieldnote capturing a Saturday morning in an Ontario care home reveals, this approach also creates tensions. Work was task-oriented, organized to meet physical care needs, with a strong division of labour between different jobs. Care aides started their shift by getting residents out of bed, dressed, and into the dining room in a timely fashion. The RPN began her shift administering medications, a task which took up a large portion of her day. Personal care and dietary staff then orchestrated the serving, feeding and cleaning up of the breakfast meal to accommodate the restricted dining time of one hour. Bathing and bed-making took up care aides' time after breakfast and all staff spent a considerable amount of time keeping records. The RPN reluctantly stayed late to complete her paperwork.

Documenting dietary intake was one of the required time-sensitive tasks that had to be completed right after the meal was finished. Measuring the intake of food and fluids conflicted with the pleasurable experience of dining. For instance, in order to get residents into the dining room on time, the staff had to get them up early, which did not allow any choice for residents who wanted to sleep in. This unit had 36 residents, 23 of whom were in the dining room on this particular morning, many requiring varying degrees of assistance. Some residents

waited for almost two hours for breakfast and because the dining time was restricted to one hour, had to eat and leave the dining room quickly. Because meals were prepared in the care home's main kitchen located away from the resident living areas, there were no pleasant food aromas and little choice or variety in the food. Staff commented on the lack of variety in the breakfast menu and sympathized with the residents.

In this example of a medical model of care, reinforced by regulations, activities were also medicalized: trained "recreation therapists"⁴ provided simulated life skills programs and measured outcomes. The only scheduled activity on this Saturday was the balloon toss organized by the recreation therapists, which had to be cut short because it heightened the distress of residents and care staff. Many activities were scheduled in a central location at this site and, due to low staffing levels, residents in the secure unit could not attend because staff could not accompany them. This organization of care, although meant to keep residents safe, creates tensions: residents end up sitting in chairs for extended periods with little stimulation or meaningful activities to occupy their time and become agitated.

This over-emphasis on the physiological aspects of care left staff little scope to engage in emotional care. Whatever time they had outside of their mandated tasks was spent trying to calm and distract residents. Ironically, many residents are in distress precisely because the medical model, reinforced by detailed regulations, provides them with little emotional and social support, let alone quick responses to their calls for help related to biological issues.

In contrast, in Germany we saw a social care model embedded in practice that attempted to manage these tensions. The division of labour was blurred and there was a less hierarchical, more flattened work organization. For example, qualified care workers (RN equivalents in North America) got residents up in the morning, prepared meals, and engaged in social activities with them, together with other care workers. There was also an apprenticeship program for students, essentially doubling the staffing ratio. In contrast to the Ontario site, where cleaning staff were encouraged not to engage with residents and to stick to physical tasks such as vacuuming and dusting,

housekeepers in Germany were observed regularly engaging in relational care:

A housekeeper comes in. She interacts with one of the women who wants to hold her hand and bring it to her cheek.... She spends time with the resident who holds her hand close to her cheeks. She then rubs the ladies' backs... for a couple of minutes. All of the women are responding to the touch. She talks to all of the residents [and] they respond. (Fieldnote, Germany)

Breakfast was not rushed because there was a full open kitchen in each of the five common living areas, which each accommodated a maximum of 12 residents (in contrast to the Ontario site, which housed 36 residents in one living area). Food was prepared and cooked by care staff and residents without time restrictions, which positively influenced how the morning unfolded:

It is 8:50 and slowly the residents are being brought into the dining room.... There are the smells of food cooking and hot scrambled eggs are served to residents.... One of the women who last night could not sit down to eat as she kept getting up is now finished breakfast. It is [now] 9:20 and she sits in a cozy chair with the newspaper.... The breakfast is bread with eggs on top and pieces of ham on top. It is attractively displayed in squares and it is fed slowly. The food is alternated between food that requires chewing and smoothies or tea.... At 9:46 one woman gets up and leaves. The [care worker] helps another woman to rise to her feet and get her walker. She moves to a comfortable chair by the window. She puts up her legs and gets comfy with a blanket over her legs.... It is 10:10 and the breakfast is completed. (Fieldnote, Germany)

There were no locked doors or dedicated secure units in this home. Residents were encouraged to use their skills to the best of their ability by engaging in everyday activities of daily living such as preparing food and cleaning, as they would do at home. In order to make the place feel even more home-like, residents were free to wander wherever they desired and so could participate in a meaningful way in the everyday social life of the home. We observed residents using knives to peel

potatoes. There was also a less strict attitude towards dispensing medications, which often sat on the countertop, were placed beside residents as they ate, and were not double-checked. Residents were also not awakened at night to take sleeping pills, a counterproductive practice we observed in other sites.

Social care was prioritized and staff were consistently engaged in conversation and activities with residents both during and outside of mealtimes. Staff were often observed sitting with residents, conversing and singing with them, touching, holding hands, and engaging in various games and craft activities.

After breakfast it is time for spending time together. The [care worker] sits down and plays a memory game where she starts the sentence and they finish the phrase. After she plays that as a group and as individuals, they all sing songs together. [At]10:50 a banana is peeled and shared. Also an apple is cut and shared. The workers don't pause to make it clinical. They use their hands and provide the snack casually. It does not come up from the kitchen. It is done in situ. (Fieldnote, Germany)

IDEAS WORTH SHARING

- Strict divisions of labour and a task-based work organization, often found in a medicalized model of care, create tensions such as inflexible routines, lack of worker and resident decision-making autonomy, and an emphasis on physical over relational care needs. In a social care model, these tensions are lessened by ensuring a more team-based approach through blurred divisions of labour, allowing residents and workers to choose, for example, what to cook for breakfast and when to get up, and prioritizing meaningful social participation over “getting the task done.”
- As the nursing home population increasingly becomes older and frailer, greater attention to the medical aspects of resident care is, to some extent, inevitable. Over-emphasizing physical,

measurable aspects of care, however, reduces the amount of time available for relational care, including engaging in conversation with residents during and outside of meals. In a social care model, in contrast, stress is placed on relational aspects of care, for example, ensuring a pleasurable dining experience (cooking smells, quality food, and a non-rushed atmosphere) rather than on the medicalized measurement and documentation of residents' intake.

- The social care model also places more emphasis on residents' freedom of movement and their ability to socialize and engage in meaningful activities as they would if they were at home.

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Chapter 7

TENSIONS FOR REGISTERED NURSES IN LONG-TERM RESIDENTIAL CARE

Jacqueline Choiniere and Ruth Lowndes

As Pat Armstrong writes in the Introduction, the tensions we explore in this bookette include approaches and practices that have conflicting demands and consequences. In this chapter, we focus on the tensions experienced by Registered Nurses (RNs) who practice in Long-Term Residential Care (LTRC).

Intensification of care demands

One of the primary tensions facing RNs is the intensification of care demands in environments that provide only minimum levels of staffing and place considerable reliance on casual, part-time nurses and other care providers. We witnessed this in many locations, in spite of considerable research supporting the link between staffing levels, staffing continuity and quality of care in this sector.¹ Here's an example from Ontario:

The RN working tonight was from another area in the hospital, and had to look after a sick resident on a unit he is unfamiliar with, while also being in charge of two floors (71 residents in total). This is a lot of responsibility for one person. He looked extremely tired by the time his shift was over. (Fieldnote, Ontario)

RNs who work in LTRC are often responsible for overseeing a large number of residents on numerous units. On night shift, it is not uncommon to see one or two RNs responsible for the entire care home,

something we observed across countries. In another Ontario site, a fieldnote captures that an RN “tells us that it is very busy, and explains that she must cover three floors on nights.” Consistently working short-staffed and having heavy workloads creates tensions — including exhaustion and burnout — as these individuals strive to ensure quality care.

Selective regulatory approach

Another tension we observed with implications for RNs is the selective way in which certain aspects of care are regulated in some settings, and the particular implications for staffing levels, staff-mix and division of labour within these environments. For example, Ontario LTRC homes are mandated, through the Ontario Long-Term Care Homes Act (2007) to have an RN on duty at all times. In this province as well, complex assessment, recording and reporting of clinically focused aspects of care are mandated.² Yet in this same jurisdiction, there is no regulation for staffing levels — or for staff mix — other than one RN on site at all times. In fact, a prior regulation identifying minimum staffing levels was removed. In our observation, this selective regulatory approach has contributed to a strict division of labour, with RNs primarily responsible for carrying out administrative functions, along with extensive reporting. They are removed from direct resident care, and often invisible on the units, aside from times when they are needed to provide clinical treatments that are considered outside the scope of the registered/licensed practical nurse (RPN/LPN), and/or are required to assess and respond to acute clinical needs. In this case a regulation designed to protect care serves to undermine it.

In Ontario, care aides are responsible for most of the direct body care. RPN/LPNs are responsible for some (decreasing amounts) of body care, administering medications and performing clinical tasks such as dressing changes that are within their scope of practice. In this model of care, RNs have little time available to spend with residents to gain tacit knowledge, to engage in emotional care, or to strengthen their relationships with residents and families. Instead, they necessarily are focused on administrative issues, reporting, connecting with medical and other providers, transcribing orders, ensuring that these orders

are carried out, and that the appropriate reports are completed and submitted. The following fieldnotes capture this absence:

The RN was rarely seen engaging with residents — other than to give certain medications. The RPN was mostly engaged in distributing meds — but would also assist during mealtimes. The RN did not participate during mealtimes. (Fieldnote, Ontario)

And from the same home:

A few comments were heard from staff — indicating that management/administration is “never around”; the new Director of Care (who used to be the night nurse), was specifically identified as someone who does not visit the floor. (Fieldnote, Ontario)

The channelling of RNs into overseeing the increasingly complex clinical needs of residents, in an environment in which there are no other staffing level regulations, means that they have little time to engage with residents’ social and relational needs. It also has implications for the quality of working relationships among and between other providers, who, as our fieldnotes suggest, resent this lack of support.

Collaborative approaches

Yet our research also illustrates that other jurisdictions have taken a different direction in terms of the role of the RN, and in the process have eased some of the tensions we raised. For example, we observed RNs working in a more collaborative manner in some of our 27 site visits in various jurisdictions. This excerpt from a translated interview with a Qualified Care Worker (QCW) in Germany (equivalent to the RN in North America) illustrates the extent to which nurses are involved in direct resident care:

So between seven o’clock and nine o’clock it’s early morning care. We’re taking care of the individual residents... nine o’clock is a joint breakfast, which we prepare together with the residents... that lasts until approximately 9:30. Then we clear up the groups.... I work

on the computer. I have to organize the medical visits and various coordination duties which I carry out on the computer....[There are] [t]welve residents in the group and we split that to five and six each.... I myself look after five to six people.... If there are more of us then I only have to coordinate and monitor the other people.... It's designed to be like a reference person so that they know us and we know them. It's more a family type atmosphere. (Interview with QCW, Germany)

The next fieldnote, one of many instances captured by researchers in this particular care home, illustrates how this more integrated approach to care made a positive difference:

There are five staff members coming in and out of the room.... Residents are coming into the room for "coffee" time (around 2:30). Two residents sit at a second dining table and one begins chatting to the other — seems to be sharing a long and complex story. One resident seems to be quite concerned about the lack of fresh-air... and another resident doesn't want the window open (she is cold).... Staff members seem to work through the "disagreement"... There is a lot of chatter between/among residents and also with staff. It is a very friendly, open and easy feeling in the room. Quite a bit of laughter, quite a lot of touching of residents by staff: stroking a hand, touching someone's cheek, putting an arm around residents, holding onto residents' hands. (Fieldnote, Germany)

A little later, our fieldnote describes the hands-on involvement of the QCW in meal preparation:

[T]he qualified elder care provider is the responsible or reference provider for the unit. She is working on the pizza dough but at the same time, very aware of what each resident is doing. (Fieldnote, Germany)

The nurses in this setting were very visible and present, involved in all aspects of the residents' care, engaging with and working alongside other care providers. In this model, we see a "blurring," or less entrenched, division of labour, with the QCW engaged more often in actual body care, in addition to overseeing the more clinical aspects

of care. We also noted that there was not the same level of complex recording and reporting, perhaps in part because the nurse is engaged more closely with residents and other care workers.

Some Canadian LTRC homes also reflected a more collective, collaborative approach to care. In one Manitoba home, teamwork was identified as a key aspect of the care philosophy of putting the resident first. Here, RNs actively participated at mealtimes, for instance, and knew all the residents' and family members' particularities. Documentation of the inter-professional progress notes was by exception only, so although RNs still spent time on charting, it was less onerous. As one RN reported, "[At this home]... I think I have enough time to really converse with the residents. We're not too busy here to do like one on one. We can really talk to them and look after their needs."

In this setting, there was also care continuity: a low turnover rate, little reliance on casual staff (there were no casual positions, only full-time and regular part-time permanent positions), and it was policy that every staff member, regardless of designation, make contact with residents on a daily basis. RNs, along with other staff, were given both the autonomy to work to the limits of their scope of practice and decision-making authority. The focus on relational care and the less precise division of labour meant that care quality was heightened in this home — even though RN and other care worker staffing ratios were no higher than in other LTRC homes.

Mentoring and training

Another tension for RNs in LTRC is their level of involvement in training and their ability to mentor others about approaches to care, given the reality of residents with complex care needs. Indeed, an important reason why an RN presence is mandated in some jurisdictions is to take advantage of their knowledge and expertise in overseeing the mentoring and training of other care workers. Yet in homes with a strict division of labour and a priority focus on clinical indicators and extensive documentation demands, RNs are so far removed from resident care that their involvement in this type of training is not feasible and not facilitated. Training is often provided via solo, online

options, rather than interactive, hands-on or team-based learning. We also witnessed a devaluing of training of providers to build care relationships in homes that place a priority on clinical, measurable aspects of care (e.g., falls prevention and wound care). These contrast sharply with the German and some Canadian care homes we visited, where training was a more collective, and we would argue, a more effective approach.

One German jurisdiction addressed the staffing level problems by instituting a large apprenticeship program for QCWs, offering hands-on training and mentorship opportunities in addition to classroom education. In one home we visited, there were 110 apprentices in addition to the 167 employees for 90 residents — with apprentices essentially doubling the staffing ratio. We observed that the QCWs on staff were actively involved in student mentoring in all aspects of care, including direct body work, medication administration, and meeting diverse, relational care needs. The importance of care relationships was prioritized in this facility, with all staff spending the majority of their workday with residents, communicating, engaging them in meaningful activities, encouraging them to use their skills and abilities to the greatest extent possible, while creating a home-like, traditional atmosphere. Hands-on, in-the-moment training and mentoring was tailored to unique, individual resident needs and was integrated into everyday practice as a team effort. This was in contrast to being offered as, for example, a mandated computer course fit into the care worker's already busy schedule or worse yet, a course required to be completed without pay, outside work hours.

The apprenticeship model, while increasing staffing levels and providing hands-on training, is not without tensions. Regular staff members are called on to organize, teach and supervise apprentices, while also ensuring safe care is being provided. There may also be tensions arising from challenges to the continuity of care as apprentices move back and forth from the classroom component of their training.³

In the Manitoba example discussed earlier, the home opened with a vision, which transpired into an embedded approach and philosophy, which the manager described as follows:

The philosophy that we wanted was very, very simple and that was the resident would always come first. Regardless of what we were doing, the resident would always come first. And so during the orientation I did some fairly interesting things. People got to have baths and they got to be in the ceiling lift. They got to play in the equipment that we were going to put the residents in so that when we got the residents there was some knowledge of what it's like to dangle in because we have these ceiling lifts and you literally dangle from a thread ... in the air with nothing else. Well that can be scary. So we put [staff] in there. We also pushed them on the rod so they could feel the sensation of basically flying through the air with nobody to stop you. [Staff] had baths. We did lots of stuff where, you know, they rode on the trolleys, they rode on the chairs so that when we finally got the residents, you know, the staff had got a really good idea of what it felt like to be in this equipment which is a start because, you know, you don't. You put these people in and you don't really think about what it feels like when someone just hoists you off the bed and you're in the air. I think the orientation period was probably a good two years. I spent almost all my time on the floor teaching. (Interview with Manager, Manitoba)

This form of training facilitates the building of experiential insight and empathy for the residents and their positions as care recipients. In addition to this unique approach to orientation, staff members were encouraged to work closely with care aide, LPN, and RN students during their school placements, offering hands-on training opportunities. During hiring processes, staff input was encouraged to ensure appropriate "fit" with the home's philosophy.

IDEAS WORTH SHARING

LTRC homes are generally understaffed, including in terms of RNs. As noted, in at least one jurisdiction, the minimum standard of one RN per facility 24/7 is often the maximum. These low RN staffing ratios create tensions, given the burden of administrative responsibilities in overseeing care. An alternative to the minimum staffing rule is required, along with the hiring of sufficient numbers of RNs so they can play an integral role in quality care provision.

In many LTRC sites, the strict division of labour, in addition to low staffing levels and documentation requirements, have served to remove the RN from the resident's care and from other care workers. In settings where we observed a more collective, collaborative approach to care, the RN is included in the everyday life of the residents through team-based work organization. This approach to care is less hierarchical and aligns with both resident and worker desires to engage in more relational/social care, which is imperative for overall quality of care and life.

There are similar issues when it comes to the RN's involvement in training and mentoring. Training that is increasingly provided to individuals one-at-a-time, through online platforms, instead of a hands-on, interactive, team-based approach, misses an important engagement opportunity for staff and residents alike and raises another tension. Although the organization is saving money by workers doing training on their own time, we need to consider the costs of this approach, including the lost benefits to staff and residents from the social interactions, learning/teaching in the moment, and exchanging of knowledge and skills pertinent to individual needs.

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Chapter 8

OWNERSHIP TENSIONS

Margaret McGregor and Pat Armstrong

Historically, long-term residential care (LTRC) homes that received government funding were owned by municipalities, by non-profit organizations such as churches and cultural groups, or by private individuals and families, many of whom were nurses or other kinds of health care providers. All or almost all of those who worked in them were employees. More recently, and often with the support of governments, large for-profit companies have moved into the long-term care sector. In addition, some non-profit homes have contracted out some services — such as cleaning, food services, direct nursing care, and management — to for-profit firms.

Ownership of LTRC homes by for-profit corporations can and does create fundamental tensions.

On the one hand, most of the funding comes from the public purse and governments seek to hold the companies responsible for ensuring that appropriate services are provided. On the other hand, corporations are responsible to shareholders and investors, who expect to make money on their investment and who want to have some control over their investment. Corporations make some of this money through economies of scale and managerial strategies taken from the for-profit sector. Their size and experience with markets help give them the edge in the competitive bidding processes that have been introduced in some jurisdictions. However, because the biggest cost in LTRC is staff, the biggest savings come from paying less for qualified staff by

reducing their wages and benefits, hiring more people with limited formal training, and reducing the number of staff. Research has shown that all of these strategies have been associated with lower quality care.¹ This creates a basic tension between providing quality care through investing in staff and generating profit. And where, through increasing corporatization of the sector, pressure to make a profit is strong, quality is sacrificed.

As our team has shown, scandals bring attention to the negative consequences of for-profit managerial practices.² The primary response to these scandals is more, and more detailed, regulation. But new tensions are created by the use of regulations to manage the tension between money going to profit and money going to care. This leads us to ask, does regulation work, and if so, what type of regulation works?

One of the most widely supported and least implemented regulations is a mandated minimum number of staffing hours per resident, and US research indicates this type of regulation can help improve the quality of care.³ However, this type of regulation does not exist anywhere in Canada. Ontario once had minimum staffing regulations but these were eliminated by the Harper Government in the name of removing red tape. Instead, facilities are faced with the numerous, meticulous regulatory standards that have become increasingly common as for-profit ownership becomes increasingly common. Regulation has moved away from a system of trust and mentoring to one that assumes most facilities value revenue generation over care. However, the detailed regulations and documentation required to ensure they are followed are often very destructive to care relationships and take time away from care.

Regulatory processes are also costly. As reported in the US in 2000, regulatory processes cost a minimum of \$22,000 per facility annually⁴ and this number has likely doubled since then. With increasing for-profit ownership, more regulation is required because profit-making rather than care may become a driving interest. The cycle spirals; with increasing regulation comes less trust, and more need for reporting, inspection and regulation.⁵ A massive infrastructure must be developed to ensure the for-profit industry is not doing wrong

by the residents, staff and families. Moreover, it is difficult to develop regulations to cover all contingencies. Take, for example, the case of the giant corporation Carillion. Based in the UK, this company has a wide range of public/private partnerships in the Canadian health sector. It has asked for bankruptcy protection and may well leave the Canadian government holding the bag.

What are some other dimensions that influence the tension between profit generation and care provision? One is the larger context in which facilities operate. In jurisdictions where public and non-profit ownership is a predominant model, there is evidence to suggest this context raises the overall standards of care and mitigates the impact of private, for-profit care provision. A strong union environment and good clinical leadership in the facility further counter the impact of private, for-profit care provision. For example, some of the large, privately owned facilities have dynamic clinical nurse leaders who are able to balance this tension. It is also possible that public reporting of nursing home staffing and other data by the state and scandal reporting by the media mitigate some of the negative impacts of private, for-profit provision. Similarly, single, for-profit homes owned by a care provider such as a nurse who takes great pride in her organization represent a vastly different scale of weighing potential trade-offs of revenue generation versus care than large multi-site, shareholder-owned chains where there's a huge push by distant investors to produce 10% to 15% profit.⁶

Professional ownership is no guarantee, however. In a nurse-owned home we visited in the UK, we saw workers balancing heavy trays up steep stairs after manoeuvring around a gate used to prevent residents from falling, and saw residents wearing flimsy blue plastic bibs long after mealtime. For-profit, family-owned homes may also operate on principles different from those found in corporate-owned ones. A home we studied in the US offered calm, pleasant meals in a bright airy room where care assistants sat and chatted with residents while they ate. But the tension here is that the next generation may sell out to a corporate firm or turn into one, as we saw in one Canadian province.

There is, in addition, a tension between public funding, ownership and delivery and private, non-profit ownership. Although public

homes tend to do better on quality indicators and are responsible to government, this does not necessarily mean that all homes need to be publicly owned. Many of the non-profits have a host of supports from the communities with which they are linked. These communities fund-raise, volunteer and provide visitors for the homes. Many are focused in ways that respond to the diverse needs of the cultural and ethnic communities in which they are embedded. This raises a question about whether or not there are other indicators of quality we should be assessing when comparing public and non-profit homes and to what extent non-profits respond to their communities but not to the broader public.

Another tension is related to public and non-profit ownership and the drive for cost savings, irrespective of profit. In Ontario, for example, numerous non-profit facilities contract out services and sometimes the entire management of the place. In BC, many publicly owned and operated facilities have contracted out their food services and housekeeping, and some non-profit facilities have contracted out their nursing care to for-profit companies. When this happens, it is more difficult to compare for-profit and not-for profit consequences because the division becomes very blurred. And official non-profit status no longer implies better quality care. In one Ontario home serving a particular cultural community, for example, we were told that the quality of the food as well as food options declined significantly when a for-profit management firm took over. Worker injuries also increased when the new managers did things like increase the size of the garbage bags.

And finally, there is a tension between summary statistics on the quality of care and each individual facility's own story. We may hear from people working in a for-profit facility that "you know, this place I work in, we don't do that. We're for-profit and we're great." Alternatively, some people have described horrible experiences in non-profit or public sector facilities. In other words, while the overall pattern indicates more verified complaints, more hospitalizations and lower staffing levels in for-profit homes compared to non-profit or government ones, individual homes may break this pattern. We cannot assume that what is the general pattern applies in each individual case.

In sum, although publicly owned and operated homes do better on many quality indicators and money directed at profit does not go to care or care workers, there are multiple tensions to consider in developing strategies for change. This is especially the case in the context of trade agreements that limit our capacity to take over corporate chains. Even if trade rules allow governments to prevent for-profit ownership in LTRC, this does not address the tension between the non-profit and public sector. Nor does it address the question of whether or not small, owner-operated for-profit homes should be supported and what kinds of regulations can ensure quality without creating enormous bureaucracies that limit autonomy and take time away from care.

NOTES

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Chapter 9

ROBOTIZING SOCIAL TIME, A WAY FORWARD?

Monique Lanoix

The Ontario Long-Term Care Homes Act of 2007 is indicative of the mission of many long-term residential care homes, which is to provide total care. It explicitly states that “a long-term care home is primarily the home of its residents” and will be a place where residents can “have their physical, psychological, social, spiritual and cultural needs adequately met.”¹

In this chapter, I examine the manner in which some long-term care homes attempt to fulfill the mandate of providing social care by focusing on a novel approach using robots, and a more traditional one using personnel dedicated to social care. I highlight the tensions and contradictions that result from these proposed responses.

Many long-term care residents have few visitors. Many long-term care homes have social programs and group activities such as bingo or singalongs; however, the programs do not always fill the void of companionship. The short time given to specific activities means that residents must find other ways of occupying themselves, either sitting by themselves clustered around the nursing station or in front of a television set passively watching whatever is on. In addition, the scheduled group activities may not be suitable for individuals with dementia, especially in the later stages of the disease.

One of the therapies used to lessen loneliness is animal-assisted therapy (AAT) and studies have found that even “one session of 30

minutes per week, was effective in reducing loneliness to a statistically significant degree.”² However, animals must be trained and need human supervision. In addition, concerns over allergies and possible bites may prevent some centres from considering animals. This is one of the reasons that robot companions have been introduced in geriatric care. In a study comparing real dogs with a robotic dog, AIBO (Sony), researchers found that “elderly residents living in long-term care facilities who received scheduled AAT with either a living or robotic dog were significantly less lonely than those who did not receive AAT.”³ The authors conclude that robots can be helpful in relieving loneliness.

Various types of robots have been developed as emotional robots and one of these robots, PARO, is quite popular, even if pricey. PARO is a fuzzy robotic seal designed to look like a Canadian Harp seal and is programmed to be interactive. The website for PARO describes the robotic seal as:

an advanced interactive robot developed by AIST [National Institute of Advanced Industrial Science and Technology], a leading Japanese industrial automation pioneer. It allows the documented benefits of animal therapy to be administered to patients in environments such as hospitals and extended care facilities where live animals present treatment or logistical difficulties.⁴

Recent studies have focused on medical indicators such as blood pressure and medication for residents who have had therapy sessions with PARO. The studies conclude that weekly sessions with PARO lower blood pressure and reduce the use of psychotropic medication.⁵ In the sessions, PARO is an assistive device and interaction with PARO is facilitated by nursing staff. The robotic seal has been touted as a way to compensate for the shortage of caregivers and the general isolation residents may experience in long-term care homes. The idea would be to provide residents with their very own PARO; however, the question remains whether this type of intervention would reduce loneliness and isolation.

The relationship between a resident and her robotic seal has been documented on film. In the documentary, *Mechanical Love*,⁶ we follow

Frau Körner, who lives in an assisted living facility in Germany and who has her very own robotic seal. We witness Frau Körner going about her daily life; she is assisted by a caregiver but she walks independently and appears to need only occasional help with physical tasks. She is not confused and she is aware that PARO is a robot and is not a real living animal. Nevertheless, as she enters her room, PARO is interactive and he appears to react when he senses that Frau Körner is close by. She answers him and we can observe the gentle manner in which she interacts with PARO and talks to the robot as she settles into her room.

The caregiver is present in Frau Körner's room to assist her and his tasks are centred on her physical well-being. It is clear that PARO is taking care, either wholly or in part, of the affective dimensions of Frau Körner's life. It is difficult to know if the caregiver would have been more talkative with Frau Körner if PARO were not present, but certainly in this instance she relies on the caregiver only for help with physical tasks.

One evening, Frau Körner decides to bring the robotic seal to a singalong that the assisted living facility has organized for Christmas. Because PARO reacts to voices, he is quite disruptive at the singalong. The other residents are annoyed at Frau Körner and whisper amongst themselves that she is an old fool playing with a doll. Frau Körner reacts, telling PARO not to mind them, and says that she and PARO are just fine together. Although Frau Körner is well enough to engage with others, PARO appears to be her special friend. The risk is that she might actually become more isolated from the other residents because of her attachment to the robot. Although PARO appears to be a steady companion for Frau Körner, the robot does nothing to enhance her interactions with her caregivers or the other residents.

This is one of the adverse effects of using PARO. Although a nursing home might encourage residents to have a companion such as PARO because the robot can be with them at all times and will not seem to lose interest, the consequence might be, as in the case of Frau Körner, that the resident still retreats into her own world, this time in the company of her robot. Although it might appear as if the problem of isolation is dealt with, it may still be present.

As noted earlier, the effects of robots are measured by medical indicators. This further medicalizes social care. Put differently, even if robots are used in social care, they are technological interventions yielding medicalized outcomes. The contradiction here is that the goal of social care, although not directly medical, has its benefits measured and lauded in medical terms, which is a supposedly objective standard. The question remains as to whether the residents feel lonely, which is after all a subjective measure, even if their blood pressure has decreased.

For residents with severe dementia, one of the dangers is withdrawal from the external world. It can be a self-fulfilling prophecy as individuals with dementia have a hard time relating to others, and those others find it too time-consuming to engage with individuals who have dementia. The result is that the person with dementia becomes more withdrawn and this is particularly troubling when the person with dementia reaches the non-verbal stage. Then interaction with others is seriously endangered. Not surprisingly, occupational therapists and those who have the task of caring for persons with dementia have developed strategies to keep such residents engaged. Some of these therapies do not require much in terms of technological apparatus. For example, here is an activity I observed in a long-term care home in Germany:

On this particular afternoon, the residents, all female with middle to advanced dementia, sit around a large table. The room is a bright gathering place and serves as a dining room as well as an activity room. The women are quiet and appear quite passive. In the residence, young people who are apprentices are milling about; they are paid workers who are part of a pilot program sponsored by the German government. Their job is to provide social connection.

At around 4:30 p.m. an apprentice takes out a vivid pink tactile ball and rolls it on the table. Immediately all eyes are on the ball and it gets pushed around the table by the residents. All the women are focused and interested; from being seemingly passive individuals, they suddenly show interest and joy in the ball game. One resident in particular really wants to push the ball around and gets to do so. After a while, the apprentice takes away the ball, but the effect lingers as one resident has become more talkative. Once the game is over, juice

is served and everyone sits around the table as supper will be served shortly.

In this scenario, social time has been incorporated more successfully into regular time. The game takes place on a table that serves as the dining table and the apprentices who participate in the game will be present to help the residents with their meal. The game is a collective activity; however, because this activity takes place in the dining room, it does not give the impression of being a special session. The game is simply part of the day and it is left to the apprentices to figure out what the residents would like to do. In fact, since the apprentices are regular workers, they get to know the residents and use that knowledge to think of fun games.

The scenario with Frau Körner illustrates how a robotic aid can both fill a void and create division between a resident and staff and other residents. When PARO is used in a group setting, the outcomes may be different. In this case, the goal is to use PARO as a device to engage the residents, either to get them to talk, act or engage with others. These sessions are led by a therapist or someone from the nursing staff and take place at set times and at a specific location. This is similar to the group activity with the ball; however, there are notable differences. As is the case with therapy sessions in general, sessions with PARO usually do not take place in a room used for everyday activities, such as meals, and they are not blended into the activities of everyday life. In addition, if the session is overseen by a therapist or someone from the nursing staff, that individual is a specialized worker. Most likely she will not be involved in other care activities, such as help with eating. She is an expert who comes in to supervise an activity. This not only sets her apart from other workers, it also indicates that social time as robot time is a specialized activity that requires a type of professional intervention. Social time as robotized time is a highly structured activity.

There are worries that emotional robots may replace human beings.⁷ Used as an object of affection, PARO is always in the arms of a resident, never bored, never angry. The robot can be a source of comfort and it may look as if it could replace humans. However, as the case of Frau Körner demonstrates, PARO may isolate the resident to an even greater

extent. Why would a resident not prefer a warm fuzzy creature over a caregiver who may be associated with unpleasant tasks, such as having to take a bath? Nevertheless, if PARO cannot replace humans, can the robot be a good therapeutic aid?

In their comparative studies of emotional robotics in Germany and in the UK, Klein and Cook discuss how sessions with the robots and a facilitator increased the interaction between residents and staff and each other.⁸ Overall there are positive results, although the authors caution that the German study included young students “who bring in liveliness in often rather dull days in the nursing home.”⁹ The authors could not disentangle the contribution of the young students from that of the robots. This is an important observation.

IDEAS WORTH SHARING

Even if robotic devices become more affordable in the future, there are tensions that remain. One of them is in the way in which robotic devices are integrated into social care. Therapy with robots is scheduled at specific times and in special locations, just like other occupational therapies. However, that is not the case with the apprentices: the apprentices are present all day long and the interactions they have with the residents take place in the common living areas, not in rooms dedicated to therapy. Although the apprentice program is promising, it is not permanent, and the status of the apprentices is not clearly defined. So even though this is a tangible attempt to address social needs, it remains poorly recognized.

To conclude, the program put forward by the German government is more promising than robotic care. The apprentices are part of the fabric of daily life in the residence: they are present, engaging with residents throughout the day and navigating effortlessly from assisting with the essential activities of daily living, such as providing help with eating, to setting up entertaining activities such as a ball game. The effect is that life in the care home becomes somewhat less structured around a medicalized system with types of care being provided by the clock. It more closely resembles the chaos and liveliness of life.

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Chapter 10

PERSON-CENTRED OR COMMUNITY-CENTRED CARE? WHY DOING IT WRONG IS SOMETIMES RIGHT

Gudmund Ågotnes and Christine Øye

Here's breakfast at a medium sized private, non-profit nursing home in Norway:

During the final preparation for breakfast at approximately 8:15 in one of four units at the nursing home, the unit is uncharacteristically hectic: most residents are "out"; all the available staff members are busy, and things are "happening" at a, for a nursing home, furious pace. The large dining table in the centre of the large common room is all set. It is the only dining table in the room; two coffee tables are placed at the other end, but are currently unoccupied, as is the sofa area in front of the television. The table has enough room for all 12 residents on the unit, of which eight are seated, while another is on her way. The remaining three residents are bedbound and have already received breakfast in their rooms. Compared to the other units at the nursing home (and others), these are "good" numbers; nine out of 12 residents capable and willing to eat in the common room is considered good. ...

Several residents small-talk in various small groups. Two residents talk amongst themselves, but about different topics without the apparent ability of relating to what the other is saying. They continue like this for a while, not bothered about what appears as a nonsensical conversation for the outsider. Others talk about the meal and the seating arrangement, asking about the whereabouts of a missing resident. A woman tells her table companion that she is not hungry,

but that a cup of coffee would be good. Her companion agrees, saying that they get too much food.

The meal proceeds in a familiar fashion, similar to most other days. All nine residents eat together, and are presented a small variety of bread, spread, and drinks. Finally, those who want it, get coffee or tea... The staff moves constantly, always bringing or fetching something (food or residents), while most of the residents interact during the meal, primarily with each other but also with some of the staff. Two staff members are active in starting or facilitating discussions, always addressing the same residents, three in particular, who appear to be the ones designated to keep the lively get-together going. As such, the staff members facilitate interaction among the residents. After about 20 minutes, the meal gradually comes to an end, when the first residents start to leave. Some, about five, linger on for about 20 minutes more (one of which actually returns after leaving, apparently unaware that he has already eaten), while three remain after everything has been cleaned. A staff member reads the newspaper to the remaining three. (Fieldnote, Norway)

This example illustrates how the community or the collective of residents can be prioritized in nursing homes. Such an emphasis and such an approach does not necessarily take this particular form in other Norwegian nursing homes, although an emphasis on the communal aspects of dining can be described as “typical” for them. The approach seen during this mealtime, in which most residents participated and were offered an arena of “togetherness,” is clearly contrasted to the breakfast experience observed at a Canadian nursing home. During the Canadian meal, residents arrived and ate at their own pace; they did not show up for a fixed time as during the Norwegian meal, but rather arrived when they wanted to. Consequently, the meal lasted far longer than the Norwegian one. No more than three residents (out of the total 20 residents) ate at the same time, and they sat at separate, small tables. There were no interactions between residents. Staff members interacted somewhat with the residents, but had trouble finding time as they were busy preparing more individualized meals, in addition to meals for several residents who chose to eat in their rooms.

With these brief examples, we aim not to juxtapose Norwegian and Canadian nursing homes, but to point to what we see as a perpetual tension in all nursing homes: whether to prioritize the collective and community, or the individual, person-centred needs of residents. Nursing home staff constantly have to relate to this tension, consciously or not, at mealtimes and during most other activities and happenings.

Over the last few decades, nursing homes in Norway, Canada and elsewhere have increasingly adapted ideologies and approaches within what is typically labelled “person-centred care,” advocating that residents in nursing homes should live active and meaningful lives based on their own individual needs and experiences. While it is hard to argue against such a sentiment, when it is put into practice and everything is individualized, important aspects of everyday living are sometimes lost.

Why? Most residents in nursing homes live routine, repetitive lives, do not leave the institution, except for short walks or trips, and do not have a wide array of friends or family to see, if any. For many nursing home residents, other nursing home residents function as the “significant others.” It is with other residents that residents spend most of their time (with the exception of uniformed and paid care providers); it is with other residents that a resident discusses, argues, plays, quarrels or simply nods as they are wheeled by in the hallway. This aspect, *the social life of residents among residents* is an under-communicated aspect of modern nursing home life. Perhaps because today’s nursing home resident is frail, old and in need of constant and complex medical care, their social needs are not fully appreciated. Perhaps it is simply easier to cater to the physical well-being of residents. Or perhaps catering to the physical needs of residents is more in line with the profile of the modern institution and its professionalized staff. In any case, an emphasis on the individualization of residents’ needs by management, staff, health policy, academics and even family members means these needs often remain muted.

The example from breakfast in the Norwegian nursing home does not fit well with what has been described as an “individualistic turn” in health policy and in practice during the last decades, as seen in nursing

home approaches and practices stemming from person-centred care. In the Norwegian home, residents sat together, and were encouraged and expected to “entertain themselves.” There were fewer options in what to eat; a small variation was offered, but more as variations of the same, rather than a different diet altogether. The staff chose not to cater to individual needs, but rather to the collective; prioritizing an ambience of togetherness, perhaps mimicking a family meal. In contrast, breakfast at the Canadian nursing home had more similarities to a hotel breakfast: residents were the guest, “ordered” food, and were not really paying attention to the other guests. Even though not “correct” in relation to popular notions of person-centred care, most residents thrived during the Norwegian breakfast: they talked, listened and seemed to enjoy themselves. Some bickered over the placement of the cutlery, but at least they interacted, a sight not always seen in a nursing home, where daily life is often uneventful, routine and boring.

The Norway example is an illustration of how nursing home staff can facilitate interaction, constructing community and a social life for residents. The staff provide a basis for residents’ actions together, promoting, ultimately, a community. While it might be a stretch to label the effects of this facilitation a “community of togetherness,” it certainly provided residents with much-needed stimuli, interaction and action.

Nursing home staff can also take such an approach “too far,” as seen in an example from another Norwegian nursing home. In the organized activity of the day, an activity worker arranged a musical evening. The activity worker, choosing songs mainly from the 1950s and 1960s that he assumed the residents would like, played songs on a CD player. The residents were expected to sing along. However, the session did not seem to provide an arena for the kind of unhindered social interaction, spontaneity or interaction seen during the breakfast. Residents were hesitant to join in, hardly interacted among themselves and in general seemed uninterested. They did not seem openly bored or displeased but did not seem entertained or enthusiastic either. It seemed like just another part of the routine and slow treadmill of everyday life at a nursing home, as something one simply does because there is nothing else to do. We suggest this happened because the activity was “too orchestrated”; residents could not improvise, play, take initiative or

choose to participate at their own speed; rather the activity leader set the stage.

One cannot force a community on residents. The approach of facilitating community can, as seen from the Norwegian singing activity, be over-emphasized. In that case, the situation changes depending on whether it encourages co-resident interaction on the initiative of residents or on the initiative of staff. Perhaps the Norwegian breakfast can serve as an example of an approach containing both elements. It also illustrates a constant tension in the everyday life of nursing home staff. At the Canadian breakfast, residents' individual needs were clearly (perhaps over-) emphasized and residents did not benefit from each other's company, while during the Norwegian singing activity attempts at creating a "community" did not work, because residents were not given adequate "space" to act. During the Norwegian breakfast, meanwhile, staff seemed to be able to achieve aspects of both worlds — a community of residents in which residents also experience a degree of independence from the staff.

IDEAS WORTH SHARING

The Norwegian breakfast example illustrates an important aspect of nursing home life: staff are caught in a constant tension of providing for the individual and/or collective needs of residents. Caught in this tension, residents have few arenas for unhindered and spontaneous social interaction with each other. The mealtime appears to be a simple, almost banal solution; but perhaps small instances like this would benefit many residents who are accustomed to staff addressing individualized and medical needs in a routine and repetitive setting. We regard this example as promising in these ways:

- Residents were allowed "genuine" social interaction among peers.
- Residents were "challenged"; they had to interact, react and improvise.

- The interaction among residents was not “forced”; it was part of the normal, everyday life of the institution, and residents could participate differently at their own choosing.

Chapter 11

SKILLS

Rachel Barken

The dietary aide, a middle-aged Black woman, is assigned to a specific unit of a care home in a mid-sized Ontario city. She is responsible for heating and distributing food that comes from the care home's main kitchen (where all food is cooked), and for cleaning up after meals. She explains that it is especially important to make sure that the temperature of the food meets the Ministry of Health and Long-Term Care's standards for food safety. The dietary aide shows us the equipment for taking the temperature of food and explains that it must be within a specific temperature range, with ranges varying for different foods. If the temperature falls outside the specified range, the dietary aide must send the food back and find a substitute. She is also responsible for handling the steam tray and for checking the menus.

The dietary aide also says she "has to know each resident," including what they can swallow. She often gets to know family members who visit as well. She treats them like her family, but needs to know how to maintain boundaries so she doesn't get too upset when residents pass away. As we are talking the son of a resident approaches with a plastic pitcher containing some juice concentrate. He asks the dietary aide to make apple juice for his father, who is in palliative care. The dietary aide knows how to prepare the juice so that it is the right texture for this particular resident. She has become especially close with his family because the resident has the same condition as her father did.

This dietary aide describes her work as “basically what I was doing at home.” In fact, she originally took this job because the shifts aligned with her family responsibilities, allowing her to get her children up and ready for school and to prepare dinner before coming to work from 12 pm to 7 pm. Her children are older now, but she has continued working in the same position.

Although her job might be considered “low skilled,” this dietary aide uses a wide range of skills in her everyday work. The duties of her job require her to know how to safely prepare and serve food to residents with complex health conditions. At the same time, she needs skills to build and maintain relationships with residents and their families. Although these relational skills are an integral part of caring labour, they are often difficult to see, count and measure.

This chapter explores contradictions and tensions we have observed regarding the skills of workers in long-term residential care (LTRC).¹ Skills are commonly defined as the abilities or forms of expertise needed to obtain a job or that are used while working. In our research, we also recognize that social, economic and political contexts impact on the ways skills are defined, used and rewarded. Government regulations, educational requirements and technological innovations, among other factors, have an impact on the kinds of skills associated with different jobs. Relations of difference based on gender, race and ethnicity, class, ability and age also shape assumptions about the skills that workers are expected to have or are considered capable of acquiring.²

In this chapter, I outline contradictions and tensions regarding skills in LTRC. I argue that workers in LTRC face two central contradictions: first, while LTRC employers often demand that workers have a wide range of skills, they do not necessarily create the conditions that allow workers to develop and use these skills. Second, the conditions of work in many LTRC facilities serve to recognize certain skills while rendering others invisible. The following discussion focuses specifically on tensions concerning the changing resident and staff population, the gendered and racialized nature of caring labour, training and education, the integration of skills among workers in different occupational groups, and finally, the time to use skills.

The resident and staff population

Changes to LTRC raise tensions between the need for clinical and relational caring skills. Across Canada and internationally, governments and many individuals express a preference for “aging in place” initiatives that encourage older people to remain in their own homes for as long as possible. The consequence is that people enter LTRC when they are sicker and closer to the end of life and more often with dementia. The widespread closure of institutions for people with disabilities also means that some younger disabled people, who cannot access appropriate support in community settings, end up living in LTRC facilities intended primarily for older people. The staff and resident populations are also more culturally diverse, and although women outnumber men among both residents and staff, more men are working and living in long-term residential care.

With the increasing complexity of residents’ health needs, some researchers and policy-makers call for an LTRC workforce with more advanced medical training. More registered nurses, for instance, could be employed in the sector to provide leadership and to give direct care to the growing numbers of residents with complex medical conditions.³ This focus on clinical skills, however, sometimes obscures the relational work that is integral to caring labour. Indeed, changes to the resident and staff population only intensify the need for workers with strong relational and interpersonal skills. Notably, the growing number of residents with dementia calls for a workforce with the skills to communicate with and to support cognitively impaired residents as well as their families. Workers might also need cultural competency skills to give appropriate care to residents from diverse backgrounds — something that is becoming more relevant with increasing diversity among both staff and residents. The contradiction, however, is that while workers are expected to have a wide range of skills, conditions such as understaffing and task-oriented models of care leave them with little time to use these skills.

Gender and race/ethnicity

Deep-seated assumptions about gender and race lead to tensions between the forms of work that are formally recognized as skills and the labour that remains invisible. Care aides, who are typically considered low-skilled workers and yet are on the front lines of work in long-term residential care, provide an apt example. Internationally, nine out of 10 care aides are women,⁴ and immigrants and racialized minorities are highly overrepresented in this workforce.⁵

While care aides' responsibilities vary considerably across jurisdictions, they are often responsible for providing assistance with bodily care such as bathing, dressing and toileting, and with meals and mobility. Equally important, but often less visible, is the relational labour that care aides do to develop and to maintain relationships with residents and their families as well as with other staff, volunteers and paid companions. To give a resident a bath, a worker must not only have the skills for safe lifts and transfers. They also need to know how to coax the resident into the bath if they do not want to take one.

Relational labour is essential in long-term residential care, but it is often disregarded as a learned skill because it intersects with women's unpaid care work.⁶ Because many women learn caring skills at a young age and in their homes rather than in educational or work settings, there is a widespread assumption that all women intrinsically know how to do care work. This is evident in the vignette above. The female dietary aide downplays the skills required for her job as she equates it with unpaid labour, stating that she does "basically what I was doing at home." Relations of difference based on race and ethnicity also lead to assumptions that women from some ethnic groups that are overrepresented among care workers, such as Filipina women, are "naturally" well suited to caring.⁷ These beliefs about gender and race underlie the devaluation of work most often performed by women and ethnic minorities, leading to tensions between the skills that are recognized and that remain invisible in the LTRC workforce.

Education and training

Tensions exist regarding the kinds of education needed for different skills, and where this training should take place. Discussions typically focus on formal education and credentials that signify training for specific skills. For instance, researchers have debated whether doctors employed in LTRC should be trained in geriatrics or in general medical practice.⁸ A focus on formal education, however, often overlooks the skills gained informally, through on-the-job training. Every day and every night, workers teach each other about residents, families and equipment. There is a perhaps inevitable contradiction because informal training does not translate into formal credentials and often remains invisible. In the vignette above the dietary aide learns about residents and their needs while she is working, but the knowledge she acquires is not formally recognized as a skill. By contrast, the skills acquired through formal credentials remain much more visible.

Tensions regarding training also intersect with policies that shape the recognition of migrant workers' skills. Many LTRC workers who are migrants have credentials from their countries of origin that are not recognized elsewhere.⁹ The consequence is that foreign-born workers have education and skills that they use in their labour, and yet remain invisible. This lack of recognition for migrant workers' qualifications serves to obscure the skills that they use in their labour, perpetuating false assumptions that people from certain racial and ethnic backgrounds are "lower skilled."

Integration of occupational groups

Discussions concerning the integration (or segregation) of skills among occupational groups raise tensions between workers' efforts to protect their skills, and the potential value of integrated care. This tension emerges from the contradiction between the need to acknowledge specific skills, and the deep interconnections between many of the skills involved in caring labour. Under supportive conditions, integration among occupational groups can potentially allow workers to use a wide range of skills. Comparative research between Canada and Sweden highlight differences in the integration of care aides with

other occupational groups.¹⁰ Swedish LTRC tends to be less task- and job-specific: workers with distinct job titles often perform the same duties. Although assistant nurses in Sweden have more formal training than care aides, both groups perform tasks that require a range of skills, including body care, practical nursing, social care, housekeeping, and cooking. Long-term care settings in Canada, by contrast, are often characterized by stricter divisions of labour between occupational groups. Care aides tend to be responsible for a set of narrowly defined tasks, including body work, serving food and feeding residents, and sometimes making beds and putting away laundry. In comparison to Sweden, care aides in Canada tend to have fewer opportunities to do relational labour. It is possible that flexibility among workers in jurisdictions like Sweden supports teamwork and allows workers to rely on one another as they learn and use skills. Sufficient time and staffing, however, are also necessary conditions for developing and using skills, including those that underlie relational labour.

Integration has some potential benefits, but flexibility — in the name of teamwork — also risks exploiting workers. Union groups representing Canadian LTRC workers voice concerns that integration can undermine skills and can be used to justify understaffing. Nurses, for example, may seek to uphold divisions of labour and resist the transfer of their responsibilities to care aides to protect their skills and to ensure that an appropriate number of nurses are on duty. When skills are disassociated from specific occupational groups, employers can more easily cut staff under the assumption that a smaller number of “low-skilled” workers such as care aides can provide more of the care and at a lower cost. In these ways, integration among occupational groups has the potential to increase workloads, without recognizing the skills required to perform different types of caring labour.

Time

Time is an often overlooked, yet important consideration in discussions of skill. There are contradictions between the time required to do a specific task and the overall time required to provide relational care. While it may not be possible to overcome this contradiction, tensions emerge because the highly regulated, task-oriented models of care

that exist in some jurisdictions, especially in North America, only allot time for specific tasks. As an illustration, meal schedules might account for the time needed to ensure that foods are prepared safely and that residents are provided with adequate nutrition. And yet, meals are not just about nutrition; they are also social events where workers engage in interpersonal and relational labour. Staff often need time to chat with residents who would like some companionship while eating, to encourage residents with poor appetites to eat, and to communicate with visiting families. With conditions such as understaffing, workers must often rush to help many residents eat within a limited timeframe. Such conditions leave staff with little time to use their skills and to ensure that residents have an enjoyable dining experience, once again undermining the importance of relational labour.

IDEAS WORTH SHARING

Well there are a lot of soft skills needed but it's very clinical. I have to tell you, looking after frail elders is very clinical. It's like their experience of day-to-day life; you have to quietly make life comfortable and that takes skill. When people say you don't need knowledge to work in residential care and people go to work in residential care at the end of their career they really don't get it, you know.... But the best nurses that work in residential care are ... used to working with people who are very frail physiologically. They're used to making people comfortable. They're comfortable with end-of-life care. They're good with working with families. So those are good people. (Interview with Clinical Nurse Specialist, BC)

As this quote emphasizes, LTRC staff use a range of skills in their daily and nightly work. To recognize the contradictions and handle the tensions in ways that ensure a workforce with the appropriate skills, researchers, policy-makers and administrators must consider the following questions:

- How do we ensure that staff have the appropriate clinical skills without overlooking the importance of relational skills?

- What does practical training mean for workers' skills, and how can we make visible the skills that workers acquire while they are on the job?
- What work organization structures are most promising for allowing staff to develop and use different skills?
- Under what conditions can integration among occupational groups serve to support or undermine skills?

NOTES

1. Many of the ideas presented in this chapter are based on R. Barken and P. Armstrong (2017), *Skills of Long-term Residential Care: Exploring Complexities, Challenges, and Opportunities*. *Ageing International*, 43(1):110-122.

2. P. Armstrong. (2013). Puzzling Skills: Feminist Political Economy Approaches. *Canadian Review of Sociology/Revue Canadienne de Sociologie*, 50(3):256-283.

3. C. Harrington. (2015). Skills for Long-Term Residential Care: Nurses. Paper presented in the workshop, "Skills for Long-term Residential Care," sponsored by the Social Sciences and Humanities Research Council, Toronto, ON, 20 May.

M. Kristiansen. (2015). Occupational Categories in Nursing Homes: Reflections on Norway and UK. Paper presented in the workshop, "Skills for Long-term Residential Care," sponsored by the Social Sciences and Humanities Research Council, Toronto, ON, 20 May. Both available at: <http://reltc.apps01.yorku.ca/presentations>

4. T. Daly and M. Szebehely. (2012). Unheard Voices, Unmapped Terrain: Care Work in Long-Term Residential Care for Older People in Canada and Sweden. *International Journal of Social Welfare*, 21(2):139-148.

5. I. L. Bourgeault, J. Atanackovic, A. Rashid, and R. Parpia. (2010). Relations Between Immigrant Care Workers and Older Persons in Home and Long-Term Care. *Canadian Journal on Aging*, 29(1):109-118.

6. E. Palmer and J. Eveline. (2012). Sustaining Low Pay in Aged Care Work. *Gender, Work and Organization*, 19(3):254-275.

7. I. L. Bourgeault, J. Atanackovic, A. Rashid, and R. Parpia. (2010). Relations Between Immigrant Care Workers and Older Persons in Home and Long-Term Care. *Canadian Journal on Aging*, 29(1):109-118.

8. B. James, J. Lexchin, and M. McGregor. (2015). Skills for Long-Term Residential Care: Doctors. Paper presented in the workshop, "Skills for Long-term Residential Care," sponsored by the Social Sciences and Humanities Research Council, Toronto, ON, 20 May. Available at: <http://reltc.apps01.yorku.ca/presentations>.

9. P. Armstrong, A. Banerjee, M. Szebehely, H. Armstrong, T. Daly, and S. Lafrance. (2009). *They Deserve Better: The Long-Term Care Experience in Canada and Scandinavia*. Ottawa, ON: Canadian Centre for Policy Alternatives.

10. T. Daly and M. Szebehely. (2012). Unheard Voices, Unmapped Terrain: Care Work in Long-Term Residential Care for Older People in Canada and Sweden. *International Journal of Social Welfare*, 21(2):139-148.

Chapter 12

FAMILIES AND CARE HOMES

Rachel Barken

Like I've been basically helping my mom when she's bathing. She's a very private person. This whole idea that some stranger is going to be bathing her is really, really upsetting. I say, hey I'm happy it's another mother daughter bonding experience. Now fast forward six months later and the problem is if I'm not here, the bathing doesn't get done.... So the last couple of weeks actually, the first week they said, "Can we join you?" In other words we'll kind of be there and then she was a little hesitant but that worked. And then last week was the first time ever I was there but I said, "Oh mom, I have to go walk the dog." I use the dog as an excuse all the time. So one of the staff who is actually very gentle kind of took over and again was willing to sort of be a little flexible.

This quote, from the daughter of a long-term care resident in British Columbia, speaks to some tensions and contradictions that exist between care homes and residents' families.¹ Initially, this daughter helped her mother, who had dementia, with bathing because her mother was more comfortable with someone familiar. This family involvement in care presented some contradictions: although the daughter enjoyed "bonding" with her mother, she did not necessarily want to be responsible for direct care. Over time, however, staff came to expect that the daughter would help with bathing on a regular basis, placing responsibility on her to maintain significant responsibility for care work. While it may not always be possible to overcome the contradictions involved in family care relations, this daughter and the

care home staff were able to work together to handle this tension in ways that ensured the resident's comfort during a bath, while relieving her daughter from providing body care.

Tensions and contradictions such as this are common in long-term residential care (LTRC), and highlight the complex intersections between paid and unpaid caring labour. Drawing on interviews and observational data, this chapter explores tensions and contradictions between LTRC homes and families in the areas of care work, approaches to care, and knowledge of residents.² It presents some promising practices that served to recognize contradictions and handle tensions in ways that supported the well-being of families and residents as well as staff.

Care work

Families occupy contradictory positions in LTRC. On the one hand, there are popular assumptions that families “abandon” older relatives in nursing homes, and the move to LTRC is often regarded as a failure on the part of families and individuals to provide enough care at home. On the other hand, family involvement in LTRC is both encouraged and assumed. While care homes typically encourage families to visit, tensions arise because conditions such as understaffing, funding cuts and privatization often render families (especially women) responsible for doing more care work than they are prepared for. For example, the wife of a resident in an Ontario facility indicated that certain forms of body care were not always provided in her absence. As a result, this carer took responsibility for grooming her husband and for looking after his dentures. She felt it was important to support her husband's dignity even though dementia limited his ability to care for himself:

My other concern is just the small things like doing the dentures and shaving him every day and make sure his little bit of hair is combed and just wipe his face when you see him in the dining room with jam on it. I come in here and I wipe his face off and I go and give him a shave and do his hair. The dentures are done and sometimes they weren't done and I've raised that issue.... I have talked to them and say, you know, like I said about the dentures or about the shaving.

“Oh, are we supposed to do that?” I said, “Well actually that’s morning care.” When I’m not here I know it’s not always done.... Dave would be devastated if he knew he wasn’t shaved or his teeth weren’t done or that he wasn’t dressed properly.

Some family members indicated a desire to remain heavily involved in care. Others voiced concerns that responsibility for care work — and communicating with staff within a complex, bureaucratic LTRC system — left them with little time to have meaningful visits with their relatives. The daughter of a resident in a British Columbia facility felt that her mother’s room was poorly cleaned, and she expressed frustration that her time was consumed by cleaning and communicating with staff rather than visiting with her mother. She complained to staff about the cleanliness of her mother’s room, but they could not assist her because housekeeping was contracted out to a private company. The daughter assumed responsibility for cleaning her mother’s room herself:

I went to the nursing station and I said “Hey” and I was upset, and I said “Hey, you know what? It’s filthy under my mom’s bed”... She said “That’s contracted out. I don’t have any jurisdiction over it. I can’t help you”... I’m here a lot and I’m the only family member here and I feel that I’m spending time with housekeeping tasks versus spending time visiting with my mom.

An informal reliance on family care work, observed in many North American facilities, also presented challenges for LTRC staff. There was a contradiction between the expectation that families could help, thus reducing staff’s heavy workload, and the fact that staff needed time, energy and skills to build and maintain relationships with families. Organizational constraints including scarce resources, high turnover and a lack of time often left staff with few opportunities to work with families. Tensions emerged because relational labour is rarely accounted for within job descriptions and schedules, leading staff to see family members as another thing to deal with or as an added form of surveillance.

Care aides at an Ontario facility commented: “Families.... They’re hard sometimes.... Like police. Do that. Do that. Do that.” At the same facility,

a cleaner explained that staff had little time for additional tasks like watering the flowers that families brought to residents:

Cleaner: Well that's what I find really sad too is like people bring nice flowers and like the residents can't move to water them or whatever and like they just rot.

Interviewer: And that's not part of the [care aides'] job to water plants.

Cleaner: No.

Interviewer: Or yours.

Cleaner: Or ours. It's the families but like they're not there every day.

Approaches to care

Staff and families also sometimes held conflicting understandings of the types of care that residents needed. There was a contradiction between the role of staff, who are tasked with ensuring the safety and security of the resident population as a whole, and families and friends who are often primarily concerned with the needs and interests of an individual resident. This contradiction could lead to tensions in encounters between staff and families.

Fieldnotes from a British Columbia facility describe a friend care provider arguing that a resident should be taken outside of the facility for a meal and to eat solid food because it would make her life more interesting and enjoyable. For their part, staff were more concerned with risk mitigation:

There is tension between the rec staff guy and Marie, centring over what is "good care" for Lucy. The staff person tells Marie off for feeding Lucy solid food, stressing the danger that Lucy might aspirate and get pneumonia. Marie tells me she is always fighting with this guy... that the rec staff guy refuses to take Lucy out for a meal which is not good because Lucy gets bored — "I want her to have a more interesting life," Marie says.

Here, the staff's focus on safety and security clashed with the social interests of the resident and her friend. To be sure, care homes often encourage families to visit residents and to engage in social activities with

them. At the same time, many North American facilities prioritize safety and risk mitigation, thus limiting some residents' capacity to engage in enjoyable social activities. In this example, Marie felt that a meaningful visit and an interesting life for Lucy involved some level of risk.

Knowing the resident

We also observed tensions between care homes and families with regards to knowledge of the resident and their preferences for care. Aging families face contradictory expectations: they are simultaneously expected to maintain close, caring relationships, and yet must relinquish some aspects of these relationships when a relative moves to long-term care. In interviews, family members often stated that they had the expertise and skills to maintain socio-emotional bonds based on long-term relationships. Some participants indicated that LTRC staff could not replace the love and care of family and friends, who in many cases had an in-depth understanding of residents' personal identity and preferred activities. Visiting her mother at a British Columbia facility, a daughter explained that some older people, especially those with dementia, might simply be more comfortable with someone who is familiar with them rather than a staff person:

I think when you start having dementia you are kind of, like you're uncomfortable with unfamiliar faces and places. So I think... I don't think even if they can, you know, I don't think the staff can do anything but I think it's more like the family maybe.

In some situations, however, LTRC staff's knowledge of residents contrasted with family members' perspectives. At a UK care home, a manager commented that they faced tensions when staff expertise, which accounted for changes in residents' preferences, were at odds with families' knowledge:

There was one lady whose mom was here, 92, and she wanted her mother dragged out of bed, not dragged out but her mom had to be up and dressed and sat in the lounge by half past eight every morning.... She didn't want to get out of bed.... And the daughter was a little bit kind of "Well my mother was always up at six." I said

“Well your mom might have always been up at six but she’s 92 now and she’s changed.”

IDEAS WORTH SHARING

Practices that served to recognize contradictions and handle tensions between care homes and families prioritized the knowledge, perspectives and needs of staff and families as well as residents. Promising practices were observed when families felt welcome in participating in care home life to the extent they desired, but did not feel responsible for doing care work. At the UK care home, the family members of one resident felt confident that their relative was well looked after, and could relax and enjoy visits at times of their choosing:

Granddaughter: Nan used to worry so if she couldn’t get there for two days or something, you know, you had to go and make sure he was okay but here your mind is at rest.

Wife: I don’t worry now if I can’t come. He don’t know who I am. He don’t know who I am but you’ve still got to look after them. But I don’t worry now because I know he’s being well looked after.

I: And your mom, what does she think?

Granddaughter: My mom is a lot happier now because she works full time as well so she can go working now knowing granddad is being well looked after and fed. It’s peace of mind. That’s the biggest thing isn’t it? ... She knows that you’re okay, that grandpa is okay so she can go do her work and not worry basically. If there’s any problems they phone up straight away and say “He’s not too well. He’s in bed today.”

In this example, multiple members of the same family had the autonomy to participate in ways that reflected their desire to be involved in care. Not incidentally, the manager at this care home had implemented organizational changes that prioritized flexibility over strict schedules and task completion, giving staff the time to respond to the needs of residents and families. A nurse explained that such

changes made it possible for workers to strengthen bonds with families:

Before [the new manager] our relationship to the relatives was quite distant and now we have a very good relationship with the family.... You know, they can tell any concerns to us or to me, any problem. Also if you are giving them time as well they will approach you any time, any concern.

At other sites, staff talked about the importance of clarifying approaches to care when a resident was moving into a care home in order to address families' concerns. While contradictions between the interests of the family and of the care home were sometimes inevitable, we witnessed promising practices when workers did not simply outline policies and procedures, but took the time to explain the rationale of care practices concerning issues such as risk and efforts to minimize the use of restraints. In these encounters, workers sought to clarify procedures so that family carers could share staff's knowledge, better understand how and why decisions were made, and feel secure in their relative's care. This knowledge-sharing took time and skilled communication, and it exemplified how some homes prioritized family inclusion in the care process, in ways that could potentially mitigate tensions between the two parties. A nurse in Nova Scotia explained:

I think that's another big piece of my job is that the more contact you have with the families even though it's time consuming, the more transparent you are, the more honest you are about the way things are here, you know, it's really appreciated and the more on board families are. I just find a lot of family education is still needed but we have come a long way with providing them with education like especially if we're talking about restraints.... And talking about the right to be at risk and how agitated people can be to be restrained and how we're trying to provide the residents with the best quality of life.

Finally, we observed some practices that were promising for including both families and staff when sharing knowledge of the resident. In a Manitoba care home, a social worker explained how she was developing processes for learning about the residents and their families and for then sharing this information with other staff, including care

aides. This extended beyond the details normally provided during the admission process, and served to strengthen bonds among individuals directly involved in giving and receiving care:

I: So do you get a lot of rich biographical detail in that first...

A: Not on the admission part.... What I historically have done and which is coming, um, is I give families homework.... But there's a social history that I ask and so families get a little bit of homework about what they want us to know or the resident wants us to know about them and it goes to everything from significant past things to who people are, what's your favourite thing, what do you expect for care, what's your spiritual expectations or non-spiritual expectations, what does family expect from services here, how did you get here, how did you even get to this process? What is your usual... the word is temperament. I'm not a huge fan of that word yet but what is it you usually were like and what's different now compared to what you were previous. I have to say when I get families [to] return it, um, it's full of in-depth [information] and I take it and I write a nice synopsis for the floors.... My idea would be that it's given to the health care aides and where in the care plan would you like it so that you can access it so that you know because I'm not the one providing the day-to-day care for them.

Practices that prioritize the development of strong relationships among workers, families and residents are useful for recognizing contradictions and overcoming some of the tensions that exist between care homes and families. To implement these practices more broadly, staff need the time, resources and skills to build relationships with families and to maintain ongoing, open communication with them. To realize more promising visions of family involvement in LTRC, policies must recognize this relational labour as an essential aspect of care.

NOTES

1. "Family" is an ambiguous term that encompasses a wide range of relationships. We use the term family in the broadest sense possible to encompass close friends as well as direct relatives who support a person living in LTRC. Family includes women and men who are spouses or intimate partners, adult children, family members who frequently visit LTRC facilities and those who care from a distance, as well as unpaid carers who fall outside the traditional definitions of "family," such as LGBTQ partners and close friends.

2. Many of the ideas and data presented in this chapter are based on the following publications: R. Barken and R. Lowndes (2017), Supporting Family Involvement in Long-Term Residential Care: Promising Practices for Relational Care, *Qualitative Health Research*, advance online publication: <https://doi.org/10.1177/1049732317730568>

R. Barken, T. Daly, and P. Armstrong. (2017). Family Matters: The Work and Skills of Family Members in Long-Term Residential Care. *Journal of Canadian Studies*, 50(2):321-347. <https://doi.org/10.3138/jcs.50.2.321>

Chapter 13

TENSIONS IN THE ORGANIZATION OF CLEANING LABOUR

Beatrice Müller and Ruth Lowndes

The housekeeper cleans five rooms a day thoroughly from top to bottom including the resident's belongings although this is not required. She disinfects everything, all surfaces, she washes the floor, she moves the furniture and cleans behind it, she washes down walls and windows. That's five a day. Plus she does thorough cleaning of all hallways and the dining room twice a day and she cleans up other areas as required. In particular, she cleans... the common bathrooms on the floor... two to three times a day from top to bottom, all surfaces, as well as is needed which, she says, tends to be fairly often that someone's had an accident or something's gone wrong and she has to go in and clean the bathroom again.... She says she finds it a heavy job but not impossible.... She also says there's different ways that she can increase the speed of her workload, the completion of her workload... for example, it's supposed to take two minutes to clean a toilet and she has it down to a minute and a half but...she doesn't miss anything.

She's not one of those people who cheats or misses edges. She says she's just really good at working fast on it and getting it done. She seems to be a real addition to the floor, a real positive force. She's cheerful and she's well-liked by the residents and I would say one of those real value-added kind of people on a floor — talks to people, it seems about mostly inconsequential things like the weather; the towels are clean; they're wearing their yellow shirt again, isn't that bright and sunny — those kinds of things. She says the bed changing... is partly injurious and exhausting because you have

to work fast to get your whole workload finished during your shift. So, you can't take breaks, you go home every night and you have an aching shoulder, you can barely move your arm and your back hurts... she would wake up in the night with her arm completely stiffened to the point where she couldn't move it and her back so painful it woke her up. The workload, she described, includes stripping and then making 25 beds a day in addition to doing all personal laundry from the residents and the bibs. (Fieldnote, Ontario)

The way that cleaning work is organized in long-term residential care (LTRC) homes varies in different countries and jurisdictions and even in homes within the same jurisdictions. A variety of tensions become apparent in a segregated work organization, where designated cleaning staff is employed to provide cleaning exclusively. This is especially true when the segregated staff is contracted out. Tensions are created, for example, by a high workload due to understaffing and cost-containment, rules that direct cleaning staff to refrain from relational engagement with residents, and the exclusion of cleaning staff from the rest of the team.

Segregated cleaning models

In the LTRC home described above, cleaning staff were employed by the facility but managed by an employee of an outsourced company that also handled laundry. Cleaning and laundry staff rotated between the two departments. The cleaning staff assigned to do laundry were also responsible for changing the linens on 25 beds. The cleaner explained that two workers used to change the bed linens as a team. Previously, 10 workers had been assigned to change the bed linens, meaning that everybody had changed fewer beds and there were fewer injuries related to the work. Now, with the contracting out of cleaning and laundry, there are fewer workers hired to do the jobs. While this new work organization appears efficient from the employers' point of view, it has direct negative consequences for the workers and for the employer in the long term.

Increasingly, the dominant approach in LTRC homes is person-centred care or relational care. In segregated models, however, and especially

when cleaning is outsourced, the relational engagement between residents and cleaning staff is not supported. We observed that in some sites, it is even prohibited. A cleaner who worked at the Ontario care home where the manager of cleaning was contracted out described the tensions produced by segregation and outsourcing:

It's sad because it's a very simple thing. The resident will want to talk to us. Just a little help, like support. But they don't want us. My boss told me if the resident say hello or family say hello, just say hi and walk away. (Interview with Cleaner, Ontario)

In this care home, staff were discouraged from interacting with residents. The cleaner expressed concern not only about herself but about the residents. Cleaners spend considerable time in spaces where residents sit or lie, and we heard residents talking and engaging with the cleaners in several sites. In fact, many residents build relationships with staff members, including cleaners. For instance, a BC care home resident described one cleaner as his "good friend.... He's one of the cleaners, yes, and he's always happy.... That's very important to be happy. It cheers people up."

Care is about relationships and we heard from many cleaning staff that they value their contact with residents and consider this to be an important and rewarding part of their work. Especially with bedridden residents but also with others, cleaners offer a possibility for social contact and relationships in a situation where loneliness is a common problem.

Sometimes the managerial requirement not to engage with residents is met with resistance, as described by the same cleaner:

I just don't take that. That's the good thing when you work here so long. You can't change the leopard's spots. So I've been trained the way I was trained so I don't, um, listen too much to the manager's thing. If a resident asks me to push them to the room or the dining room, she couldn't wheel herself, I will make sure her foot is on the pedal and I'll take her. And if they ask me, "Why did you do it?" I have no problem telling them, "I made sure her foot was on the pedal and I took her

because I feel my parents, if they were here, I want someone to do that. And if I was here I would like someone to do that." I'd also tell them "Don't forget. You will be here one day and you will have the same problem. Think first before you do something." It's unfortunate the way they change. But other than that I love this place. I really do. Otherwise I wouldn't be here. [laughs] (Interview with Cleaner, Ontario)

The next vignette demonstrates a cleaner's relational engagement with a particular resident that led to sharing of important knowledge about the resident's needs and preferences:

[O]ur conversation is interrupted by a visitor to the unit, who is asking for ice cream for a resident... She wants anything but vanilla. Anne [a care aide] goes to the freezer and pulls out a chocolate single-serving of ice cream, goes to give it to the visitor; but outside the kitchen door a staff person, a cleaner, stops her, tells Anne: for her you have to put it in the microwave for 8 seconds first.... Anne says "8 minutes?" The cleaner laughs, "no no, you will cook it! 8 seconds, here I will show you." They both go into the kitchen and the cleaner watches Anne puts the ice cream in the microwave; they count together: 1, 2, 3, 4, 5, 6, 7, 8, DONE! And take out the ice cream, give it to the visitor. The visitor turns to me and says yeah she doesn't like it straight out of the freezer, it's too hard for her. The care aide and cleaner had been joking around while doing this, laughing at how the care aide does not know but the cleaner knows what the resident needed. Anne says... "how did you know that?!" and "I didn't know that, this is news to me!" (Fieldnote, Ontario)

Teamwork is touted as the dominant approach to care but outsourcing contradicts that approach. If a department or a head of a department is contracted out, the logic of the regulation of work in that department is separate from the rest of the LTRC organization. Cleaning staff face tensions in terms of their relationships with other workers. Outsourced cleaning staff are not employees of the care home and often do not feel they are part of the team. They may experience insecurity in their contracts, resulting in high rates of turnover that also make relationships among workers difficult. Contracted workers often have less autonomy than the employees of the home and a

very high workload, factors that may further separate them from others who work there. They often provide relational care even if they are not supposed to and have not had the training to do so, possibly creating tensions not only with their employer but with other workers. Furthermore, ordering cleaners to refrain from interacting with residents contradicts the very popular request for a “home-like” approach in LTRC and illustrates a tension that accompanies the outsourcing of staff or even of whole departments that are actually “critical to care.”²

Integrated cleaning models

We saw more integrated and more promising approaches to cleaning. In integrated models, cleaners are employed by the care home itself and have a broader scope of practice or alternatively, care staff are responsible for cleaning as part of their role. This work organization offers better support for relational care and better working conditions because care and cleaning responsibilities are not divided into separate tasks. Instead, they are amalgamated and carried out as part of the overall team approach to care. Here’s an example of such an approach in Sweden:

After breakfast, many of the residents were encouraged to sit in the TV room for a while so staff could clean the residents’ rooms.... When they finished cleaning, they served coffee, something that some of the residents had already smelled and were eagerly anticipating.... The staff here do all the work required in the home, including cleaning the lift and dispensing the medicines to residents. A broad spectrum of skills is required. (Fieldnote, Sweden)

In the Swedish example, assistant care staff carry out the cleaning. Other examples from fieldnotes show that residents also participate in daily housework activities. In some sites we visited, cleaning staff provided relational care as part of their job description. In Nova Scotia, former cleaning and kitchen staff positions have been combined into one new occupation. In this role they clean, perform light kitchen work, and assist residents with eating. Cleaning and kitchen staff receive training on some aspects of relational care. Even if this training is very

basic, the integrated work organization is more promising than the care that the segregated cleaner offers without any recognition and/or training. However, the more flexible division of labour is not without tensions. It is sometimes introduced as a way of reducing the overall staff complement, with the result that everyone is working harder. It may also mean that the skills and training involved in the work are not recognized. We have also heard families complain that they cannot identify who is responsible for what when things go wrong or when they want something done.

IDEAS WORTH SHARING

- An integrated approach to cleaning is likely to be more resident-centred and relational. The preconditions that make such an approach to cleaning a promising practice: ensure sufficient staff, relational care training, and appropriate remuneration for the various tasks the cleaner/carer provides, and recognition of the skills that are involved.
- Recognize that cleaners are critical to care within LTRC homes: hire cleaners as part of the organization's employees and include them as integral team members, rather than contracting out this service.

NOTE

1. P. Armstrong, H. Armstrong, and K. Scott-Dixon. (2008). *Critical to Care: The Invisible Women in Health Services*. Toronto: University of Toronto Press. <http://site.ebrary.com/id/10382237>, p. 4.

Chapter 14

NEGOTIATING TENSIONS IN LONG-TERM CARE: IDEAS WORTH SHARING

Pat Armstrong and Ruth Lowndes

There is no simple way to eliminate the tensions we identified in our studies of long-term residential care in six countries. Indeed, we see these tensions as continuing, whatever the approaches to care. Nevertheless, we did encounter a number of means for reducing these tensions. Tension-reducing strategies begin by recognizing that there are tensions, some of which we set out below.

1. Homes and communal living. The emphasis, especially in North America, on long-term residential care as homes for individuals often means that they do not take advantage of the benefits that can come with communal living. Similarly, a focus on person-centred care can conflict with the needs of the community that is long-term residential care. Single rooms help ensure privacy but shared accommodation offers company and allows residents to assist each other. Norway provides just one example of how embracing shared living and encouraging interactions among residents helps counter the isolation that results from too much emphasis on the privacy of home and on occasional formal activities for residents.

2. Medical and social care. The increasing pressure to give priority to medical care is not surprising, given that residents who enter care homes today usually have complex medical needs. At the same time, managerial strategies for work organization taken from the for-profit sector, combined with limited funding and growing demands for record-keeping, leave little time for the more-difficult-to-count

chatting, listening, consulting and comforting aspects of care. Yet as the example of Germany illustrates, responding to the equally important need for social interaction is possible with enough staff, a flexible division of labour, and an approach to care that recognizes social needs as critical to care.

3. Safety and risk. The safety of residents is obviously a concern, especially in light of some high-profile scandals. The safety of staff has received less media attention but is nonetheless a critical concern. However, life without risk or the ability to take risks is boring, and detailed regulations designed to ensure care staff keep residents safe can prevent attending to individual needs. If we are to put some life into years rather than focus solely on keeping people alive, we need to tolerate some risks and allow staff some autonomy in providing care. In the German home we studied, for example, residents are allowed to continue some of the familiar activities from home, and the home we studied in Norway illustrates how allowing staff to determine the risk of falling can help keep residents mobile and staff engaged.

4. Gender, race and culture. Increasingly, resident and staff populations are from different cultures and different racialized groups. And more of both residents and staff are men. Although there can be benefits to this rich diversity, the inequitable relations of gender, race and culture affect both residents and workers. Such tensions have to be acknowledged in order to be addressed with training, consultation, policies and planning. For example, a British home makes it clear to families that racism towards staff is not tolerated and may mean that a resident is asked to leave, although this is easier said than done. In a Canadian home, we saw one strategy for dealing with the gender issue. A man providing care for a woman was accompanied by a female care provider until the resident and family became accustomed to his care. As for cultural divides, another Canadian home that has a kosher kitchen allows families who want alternatives to have a fridge of food in the resident's room.

5. Technology and people. There are obviously many benefits to new technologies. In care homes they can provide entertainment, track medications and support staff in their work, for example. At the same

time, there is increasing pressure to replace care work with technology and to use technology to supervise the care work that remains. As the example of robots illustrates, however, these technologies are most effective when they are used with and by staff rather than as a replacement for staff.

6. Skills and flexibility. The kinds of skills required in long-term residential care are changing, leading to demands for more training and a detailed division of labour in order to ensure that staff have the required skills. However, working conditions and lack of autonomy often mean staff are unable to use the skills they have, while a detailed division of labour can make it difficult to treat residents as people rather than as a collection of tasks. We studied places that taught skills and worked to support these skills through teamwork that included everyone who worked in the home, and through working conditions that left space for skills to be used. In Manitoba, for instance, we learned about in-house training that allowed staff to experience what it feels like to be bathed by someone else. A worker told us that this training completely changed how he approached bathing residents. At the same time, regular team consultations, as well as a division of labour that encouraged RNs to provide some of the hands-on care, supported a broad application of skills.

7. Regulations and trust. Regulations, and inspections to see if homes meet the standards, can help ensure appropriate care and some democratic accountability. However, very detailed regulations — especially when they involve extensive reporting and when they focus mainly on staff — can mean less time for care and a more rigid hierarchy among care staff, while leaving staff with little ability to apply their skills to respond to individual needs. In Sweden, inspections were designed to promote care rather than to discipline homes, as they were in the North American homes we visited. The Swedish system was based more on trust and support than on detailed regulations, surveillance and punishment. And yet there was no evidence of inferior care.

8. Big and small. On the one hand, small care homes can feel more like home and promote care relationships while large ones can feel institutional and limit care relationships. On the other hand, units are

sometimes so small that they limit social interaction and protections for staff, while larger organizations can offer both economies of scale and more options for workers as well as for residents. Norway provides one example of embedding a care home within a larger organization, an approach that helps promote the benefits of both small and large. Similarly, a small Canadian home we visited was part of a hospital and medical centre. This integration allowed the home to have a cost-effective kitchen, serving appealing meals for those in all the facilities and more options for staff in moving among services.

9. Families and staff. Families can provide significant contributions to the life and care in a home. However, there are often tensions between staff and residents over what families want to do and what families want staff to do. Moreover, family members may disagree with each other about what they expect in terms of care and may also disagree with the residents. We did see places that had strategies to limit these tensions. A Manitoba home ensures that everyone who works there has regular direct contact with the resident and their family in order to try to avoid or address issues. A Texas home does this by designating a “responsible nurse” who knows the family and the resident and thus both provides information and addresses tensions.

10. For-profit, not-for-profit and public. The pressure to introduce for-profit ownership, care delivery and managerial strategies has grown enormously over the last several decades. This growth has been justified not only as a means to address government debt and to lower costs but as a way to ensure quality through competition and the application of for-profit managerial practices. However, an impressive amount of evidence indicates that the quality of care is better when profit is not the driving force. Moreover, little if any government money is saved in situations of for-profit ownership and care becomes more precarious with risks of bankruptcy or sales. Nevertheless, some for-profit homes provide decent working and living conditions that we can learn from at the same time as we work to remove the profit from care. For example, a for-profit home in the US has a dining room arrangement that allows residents with similar cognitive abilities to eat together in their own separate spaces, and has laundry facilities on each unit that help ensure clothes are returned to their owners.

11. Models and approaches. In the search for better ways to provide care, new models are regularly being introduced into long-term residential care. A number of these seek to incorporate the promising practices we have observed in the six countries in our project. However, we studied places that had formalized their model into a rigid set of rules and practices. But we also studied a Manitoba home that seeks to avoid models altogether, and instead to agree with staff and funders on a set of guiding principles. These principles are based on ensuring that all staff have regular contact with residents and families; all staff have appropriate training and continuity in care, safeguarded by a roster of part-time staff; there are as many full-time staff as possible; and all services are provided in-house.

These are not the only tensions we identified and debated during our site visits. The tensions were sometimes related to issues that seem quite minor. For example, in one place most of the pictures depicted people in old age and we were told the art was intended to celebrate age. In another place, there was an emphasis on pictures of residents when they were young and we were told this was intended to remind staff that these people had once been their age and had actively contributed to life outside. In several places, there were old sewing machines and other objects from another era. We were told these were intended to remind residents of their past. In another place, all the furniture, art and objects were very modern. We were told this was intended to keep residents looking to the future and to make them proud of their home.

What we learned in debating our preferences as well as the arguments behind each position was that these are not simple alternatives that can be easily solved by choosing one way or another. This is also the case when we are considering larger-scale tensions such as those between government's need for accountability and staff's need for flexibility. But all of these tensions require rigorous questioning and a search for ways to reduce them. Here we have identified some examples of how that can be done.

What we have concluded is that tensions need to be identified and negotiated, not just once but on a regular basis, as the nature of the

tensions change over time and new tensions arise. Depending on the tensions, such negotiations need to involve all those who live, work and visit in long-term residential care.

The fourth in a series, this book is about the tensions in long-term residential care. By tensions, we mean ideas, approaches, practices, programs, interests and communities that have conflicting demands and/or consequences. This book explores some of the tensions we encountered and debated together as a research team that shared the experience of conducting 27 rapid, site-switching ethnographies in six countries: Norway, Sweden, Germany, the UK, the US and Canada. We identify promising practices for negotiating and addressing these tensions in ways that can work for both those who need and those who provide care, while recognizing that tensions will remain. Our intent with these books is to share what we have learned so that we can make long-term residential care as good as it can be.

For more information about our research on long-term residential care, go to our website: <http://reltc.apps01.yorku.ca/>

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