



# Promising Practices in Long-term Care

*Ideas Worth Sharing*

Co-edited by Donna Baines and Pat Armstrong

# **Promising Practices in Long-term Care Ideas Worth Sharing**

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Donna Baines and Pat Armstrong**

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The opinions expressed in *Promising Practices in Long-term Care: Ideas Worth Sharing* are those of the authors, and do not necessarily reflect the views of the Canadian Centre for Policy Alternatives.

All names of participants and the long-term care homes have been changed to pseudonyms in order to maintain anonymity.

# TABLE OF CONTENTS

<b><u>PROJECT RESEARCHERS</u></b>	<b>7</b>
<b><u>INTRODUCTION</u></b>	<b>11</b>
<i>Donna Baines</i>	
<b><u>SOME HARD FACTS ON LONG-TERM CARE</u></b>	<b>17</b>
<i>Donna Baines and Curran Stikuts</i>	
<b><u>VIGNETTES OF PROMISING PRACTICES IN LONG-TERM CARE</u></b>	<b>31</b>
<b>CANADA</b>	
BRITISH COLUMBIA	33
<i>Jim Struthers</i>	
BRITISH COLUMBIA	36
<i>Megan J. Davies</i>	
ONTARIO	38
<i>Jacqueline Choiniere</i>	
MANITOBA	41
<i>Ruth Lowndes</i>	
NOVA SCOTIA	44
<i>Tamara Daly and Martha MacDonald</i>	
<b>GERMANY</b>	
SMALL TOWN 1	47
<i>Ruth Lowndes and Beatrice Müller</i>	
SMALL TOWN 2	51
<i>Ruth Lowndes and Beatrice Müller</i>	

## **NORWAY**

SMALL TOWN 54  
*Pat Armstrong*

BIG CITY 57  
*Donna Baines*

## **SWEDEN**

BIG CITY 60  
*Albert Banerjee and Susan Braedley*

## **UNITED KINGDOM**

BIG CITY 63  
*Sally Chivers and Martha MacDonald*

## **UNITED STATES**

BIG CITY 66  
*Hugh Armstrong*

BIG CITY 69  
*Tamara Daly and Ruth Lowndes*

**CONCLUSION: WHERE DO WE GO FROM HERE?** 73

*Pat Armstrong*

**ADDITIONAL RESOURCES** 81

## ACKNOWLEDGEMENTS

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*A special thanks goes to Ruth Lowndes for her updates to the chart data in this 2019 reprinted edition.*



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Canadian Federation of Nurses Unions

Canadian Union of Public Employees

National Union of Public & General Employees

Service Employees International Union Healthcare

The Swedish Association of Local Authorities and Regions

The Council on Aging of Ottawa

Unifor



# INTRODUCTION

*Donna Baines*

There is no question that our population is aging. It affects everyone — whether it is our self, our parents, our spouse/partner, our neighbours or our friends. We are often warned that the demands for residential care for the elderly are growing rapidly. Yet there is no reason to view this as a disaster waiting to happen.

As this short book will confirm, excellent ideas abound on how to ensure that high quality long-term care (residential care housing and caring for the elderly and some younger people with serious disabilities) is available to fit all needs and the resources exist to fund high quality care that respects the needs of residents, families, workers and managers.

The goal of this book is to present some of those excellent ideas and to show how countries with a Gross Domestic Product (GDP) similar to Canada's (for example Sweden) provide promising practices in long-term care. So, when our governments or popular discourse says "we can't afford it", data show that we actually can.

The book also presents promising practices in countries with very different GDPs from Canada and argues that despite the differences in countries and context, these kinds of promising practices draw on important principles of care which are outlined below and can be reproduced in Canada.

The practices discussed in this short book are drawn from a six country study of promising practices in residential care. Rather than expose and indict shortcomings of the existing system as many studies of aged care have done in the past, our study wanted to build a vision of what high quality care could look like. We gathered data in six countries (Canada, the United States [U.S.], the United Kingdom [U.K.], Germany, Sweden, and Norway) and together generated a collection of practices at all levels of long-term care that meet the following principles:

- The practice treats both residents and providers with dignity and respect
- The practice understands care as a relationship
- The practice takes differences and equity into account

Using these principles of promising practices, we looked at four main areas in care facilities:

1. approaches to care;
2. work organization (or who does what and how they are organized, trained, and rewarded for doing care);
3. accountability; and
4. finance and ownership.

As mentioned above, the practices reported on in this short book are drawn from intense case studies our international team of 26 researchers and numerous students undertook in long-term care facilities in Canada, the U.S., the U.K., Germany, Sweden and Norway exploring these four main areas noted above.

The case studies included interviews, participant observations and document reviews. We interviewed staff from top to bottom, management, residents, volunteers and family members in each facility. We also did participant observations in multiple units in the facilities, taking notes and having conversations with anyone who would talk to us on the units. Finally, we did a review of all publicly available documents regarding the facility and together reflected on what we had seen.

We had two styles of case studies\*. One was a full case study which took place over several days (usually around a week) which we prepared for extensively in advance in the form of review of documents and interviews with key players like the Executive Director, leading care staff and union representatives. The full case study involved an interdisciplinary team of researchers and graduate students (usually about 15). In the full case studies we undertook participant observations in pairs of researchers from different disciplines (e.g. pairing a nurse researcher with a historian, or a social work researcher with a physician) and observed the units from 7 a.m. to after midnight for multiple days. We also undertook multiple interviews with all kinds of staff, with residents and family members, with volunteers, with union representatives and with management. Before and after the study we reviewed all publicly available statistics and documents relating to the facility studied. In addition, we met midway and at the endpoint in the case study to reflect on what we found and what we needed to investigate further, clarify, etc.

The second form of case study we called a “flash ethnography”. The “flash” followed several days of intensive study at the main site so that we had some clear ideas about what we were looking for and the kinds of regulations, policies and funding shaping care in a particular jurisdiction. Following careful preparation and pre-interviews, a team of researchers would then undertake a very intensive case study in a single day. We started the day with a guided tour of the facility and a presentation from the management of the facility. Like the full case studies, we interviewed as many people as possible within the facility and observed on as many wards and units as possible over the course of the day. At the end of the day, we met again with management, provided feedback and asked questions. We also reviewed documents and website information on the facility before and after the study. This style of rapid case study permitted us a fulsome glimpse into the operating of a care facility and sharpened our capacity to compare findings within a single city or country, and introduced us to a number of promising practices.

---

\* Ethics approval was received at all the universities and facilities involved in the studies where they had ethics review processes.

The following four questions focused our data collection during the case studies and our writing about the data afterwards:

1. What care approaches support long-term care as a viable, desirable and equitable option for individuals, families and caregivers?
2. What kinds of work organization are most promising in meeting the needs and balancing the rights of residents, providers, families and communities?
3. What promising practices to accountability nurture care and inspire quality workplace relations in long-term residential facilities?
4. What financing and ownership models are promising in ensuring equitable access to quality long-term residential care while reducing the offloading of both material and other costs onto workers, employers, families or individuals?

The book is organized in the following way.

The first section presents some basic statistical data on the countries studied. This is to provide a sense of the larger context and to answer questions about whether we can compare across these six countries. We focus on the GDP of each country to highlight the fact that these countries are among the world's wealthiest and have ample resources to provide to long-term care. We also provide as many comparisons as we can on resources currently spent on long-term care to help give a sense of context for the next section of the book.

The second section provides short vignettes of promising practices in action in long-term care. These vignettes are real stories drawn from our data that show how real people interacted in ways that were caring, respectful and supportive, and met our principles of promising practices. In this section, we also explain why we think these practices worked so well and clearly identify each of these practices in the form of short bullets to permit readers to access them more easily.

The third and concluding section of the book is written by the Primary Investigator and lead on this international project, Distinguished

Research Professor Pat Armstrong. She provides further food for thought and analysis, and some principles for building a strong, supportive, integrated system of long-term care.

A list of additional resources is included at the end of the book.





## **SOME HARD FACTS ON LONG-TERM CARE**

*Donna Baines and Curran Stikuts*

The first question people are likely to ask when they read the promising practices in this book is “can we afford it”? This section attempts to answer this key question with a series of measures and publicly available statistics to confirm that yes, we can afford it. For example, we compare GDP to show that countries with GDPs lower or similar to ours, provide more promising practices in long-term care. The issue, then, is not whether we can afford it but whether we want to provide high quality, meaningful care to those who require it.

The second question people are likely to ask is “why don’t we have all these promising practices here in Canada”? Part of it is the political will to spend on the needs of elderly people and others in need of residential care. However, there are other factors that are also important. For example, the data show that Canada has comparatively more long-term care beds than some of the other countries we studied (though overall we spend less) and yet the promising practices we uncovered in our research did not exist in all the facilities in Canada. In fact, they only existed in a few.

This tells us that it is not just the number of beds that ensures quality care. Factors such as: whether staff are permanent or constantly changing (which often depends on wages and working conditions, whether they are unionized, the skill and commitment of supervisors, etc.); the skill mix of staff and how staff mix their skills; the presence of well-trained, well-supported staff with sufficient time to spend with

residents; the presence of supervisors and management who provide leadership that inspires and rewards promising practices; whether food is prepared in-house using quality ingredients, or privatized and prepared off-site; and whether there is a commitment to ensuring ways for staff, residents and families to suggest new approaches to meet residents' needs, and whether they are provided with the time and resources to develop them into promising practices. In the next section following this one, we show how some of these factors work together to create promising practices and we provide some ideas on how we can make constructive change in long-term care. In this chapter, we look at the hard facts in long-term care.

**STATS AT A GLANCE: DATA BY COUNTRY****CANADA**

Population (in millions): 37.4 (2019)
Population over 65 (%): 17.2 (2018)
GDP per Capita (2019/USD/INT\$): \$46,420 (19 <sup>th</sup> )
Health Expenditure as % of GDP (2018): 10.7% (7.5 public, 3.3 private)
LTC public expenditure as % of GDP (2015): 1.2% (17/28)
Number of LTC beds per 1,000 persons 65+ (2017): 55.4 (7/33)
Trade Union Density (2015): 29.44%
UN HDI (2017): 0.926 (12 <sup>th</sup> )
Social Progress Index (2019): 88.81 (9 <sup>th</sup> /149)
OECD Better Life Index: Health Rating (2019): 9.6 (2 <sup>nd</sup> )
OECD Better Life Index: Life Satisfaction Rating: 7 <sup>th</sup> /40
World Happiness Report (2018): 7.278 (9 <sup>th</sup> /156)
Welfare state: Liberal

**UNITED STATES**

Population (in millions): 329.7 (2019)
Population over 65 (%): 15.2 (2016)
GDP per Capita (2019/USD/INT\$): \$64,770 (8 <sup>th</sup> )
Health Expenditure as % of GDP (2018): 16.9% (14.3 public, 2.6 private)
LTC public expenditure as % of GDP (2015): 0.5% (23/28)
Number of LTC beds per ,1000 persons 65+ (2016): 33.4 (23/33)
Trade Union Density (2015) Survey Data: 10.63%
UN HDI (2017): 0.924 (13 <sup>th</sup> )
Social Progress Index (2019): 83.62 (26 <sup>th</sup> /149)
OECD Better Life Index: Health Rating (2019): 8.9 (11 <sup>th</sup> )
OECD Better Life Index: Life Satisfaction Rating: 17 <sup>th</sup> /40
World Happiness Report (2018): 6.892 (19 <sup>th</sup> )
Welfare state: Liberal

## NORWAY

Population (in millions): 5.3 (2019)

Population over 65 (%): 16.71 (2019)

GDP per Capita (2019/USD/INT\$): \$79,730 (4<sup>th</sup>)

Health Expenditure as % of GDP (2018): 10.2% (8.7 public, 1.5 private)

LTC public expenditure as % of GDP (2015): 2.5% (4/28)

Number of LTC beds per 1,000 persons 65+ (2017): 46.2 (16/33)

Trade Union Density (2015): 52.49%

UN HDI (2017): 0.953 (1<sup>st</sup>)

Social Progress Index (2019): 90.95 (1<sup>st</sup>/149)

OECD Better Life Index: Health Rating (2019): 8.7 (10<sup>th</sup>)

OECD Better Life Index: Life Satisfaction Rating: 2<sup>nd</sup>/40

World Happiness Report (2018): 7.554 (3<sup>rd</sup>)

Welfare state: Social Democratic

## UNITED KINGDOM

Population (in millions): 66.4 (2019)

Population over 65 (%): 18.3 (2018)

GDP per Capita (2019/USD/INT\$): \$42,310 (23<sup>rd</sup>)

Health Expenditure as % of GDP (2018): 9.8% (7.5 public, 2.2 private)

LTC public expenditure as % of GDP (2015): 1.5% (11/28)

Number of LTC beds per 1,000 persons 65+ (2017): 45.6 (18/33)

Trade Union Density (2015) Survey Data: 24.68%

UN HDI (2017): 0.922 (14<sup>th</sup>)

Social Progress Index (2019): 87.98 (13<sup>th</sup>/149)

OECD Better Life Index: Health Rating (2019): 7.7 (21<sup>st</sup>)

OECD Better Life Index: Life Satisfaction Rating: 18<sup>th</sup>/40

World Happiness Report (2018): 7.054 (15<sup>th</sup>)

Welfare state: Liberal

**GERMANY**

Population (in millions): 83 (2019)

Population over 65 (%): 22.36 (2019)

GDP per Capita (2019/USD/INT\$): \$47,790 (18<sup>th</sup>)

Health Expenditure as % of GDP (2018): 11.2% (9.5 public, 1.7 private)

LTC public expenditure as % of GDP (2015): 1.3% (14/28)

Number of LTC beds per 1,000 persons 65+ (2017): 54.4 (8/33)

Trade Union Density (2015): 17.58%

UN HDI (2017): 0.936 (5<sup>th</sup>)

Social Progress Index (2019): 88.84 (8<sup>th</sup>/149)

OECD Better Life Index: Health Rating (2019): 7.4 (21<sup>st</sup>)

OECD Better Life Index: Life Satisfaction Rating: 13<sup>th</sup>/40

World Happiness Report (2018): 6.985 (17<sup>th</sup>)

Welfare state: Corporatist

**SWEDEN**

Population (in millions): 10.29 (2019)

Population over 65 (%): 19.9 (2018)

GDP per Capita (2019/USD/INT\$): \$53,000 (12<sup>th</sup>)

Health Expenditure as % of GDP (2018): 11% (9.3 public, 1.8 private)

LTC public expenditure as % of GDP (2015): 3.2% (2/28)

Number of LTC beds per 1,000 persons 65+ (2017): 70.6 (3/33)

Trade Union Density (2015): 66.81%

UN HDI (2017): 0.933 (7<sup>th</sup>)

Social Progress Index (2019): 89.45 (5<sup>th</sup>/149)

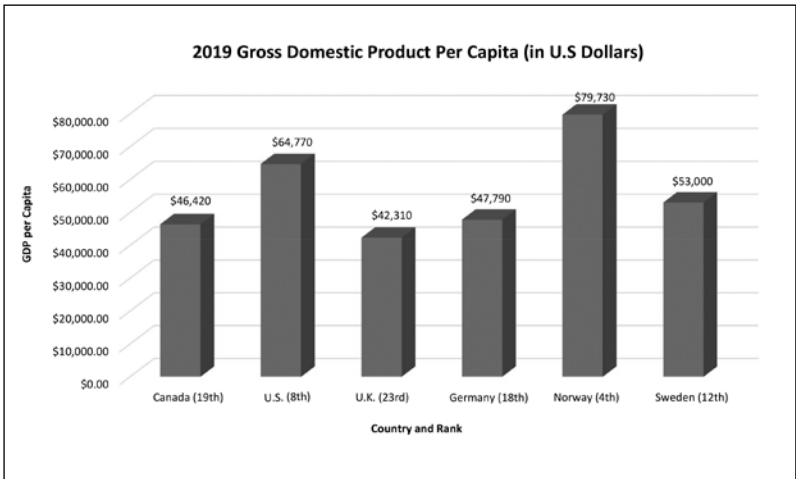
OECD Better Life Index: Health Rating (2019): 8.5 (6<sup>th</sup>)

OECD Better Life Index: Life Satisfaction Rating: 9<sup>th</sup>/40

World Happiness Report (2018): 7.343 (7<sup>th</sup>)

Welfare state: Social Democratic

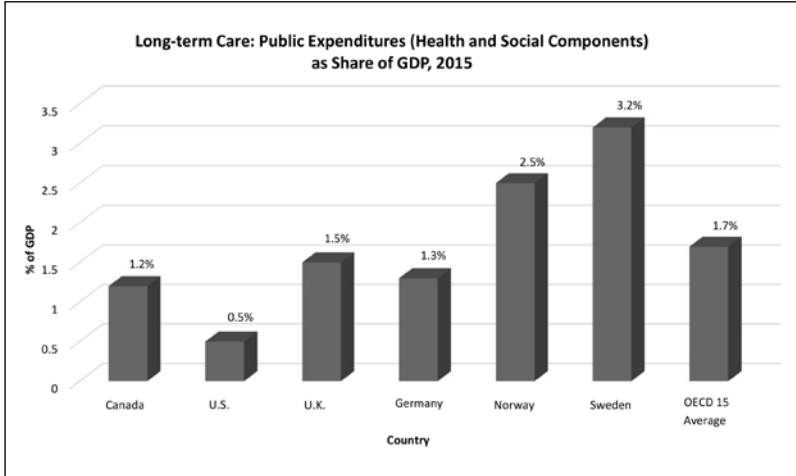
**2019 GROSS DOMESTIC PRODUCT PER CAPITA (IN U.S. DOLLARS)**



Sources: <https://www.imf.org/external/datamapper/NGDPDPC@WEO/OEMDC/ADVEC/WEOORLD>; <http://statisticstimes.com/economy/projected-world-gdp-ranking.php>

This chart represents the Gross Domestic Product (GDP) per person of each country studied. GDP is the total dollar value of all goods and services produced in a country over a set period of time. It is used to measure the size and health of a country's economy. When the GDP of a country is divided by its population it is easier to compare countries to each other. Out of the six countries studied, Canada ranks 5<sup>th</sup>, and ranks 19<sup>th</sup> worldwide. Canada's GDP is similar to Germany's and relatively close to Sweden's. This suggests that if they can afford something, so can we, and vice versa.

## **LONG-TERM CARE: PUBLIC EXPENDITURES (HEALTH AND SOCIAL COMPONENTS) AS SHARE OF GDP (2015)**

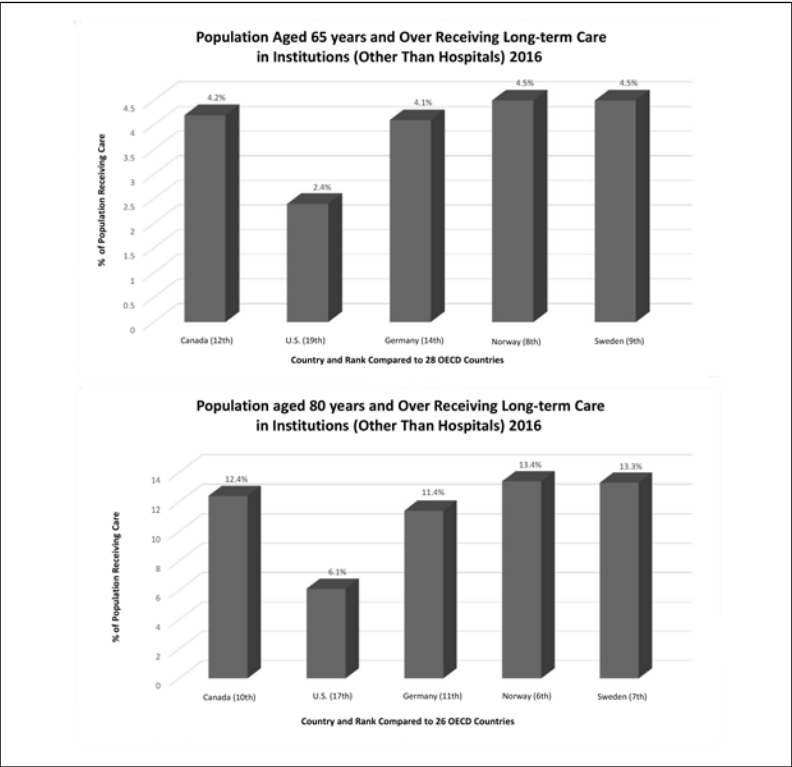


Source: OECD (2017). "Long-term care expenditure", in Health at a Glance 2017: OECD Indicators, OECD Publishing, Paris. DOI: [https://doi.org/10.1787/health\\_glance-2017-81-en](https://doi.org/10.1787/health_glance-2017-81-en)  
[https://read.oecd-ilibrary.org/social-issues-migration-health/health-at-a-glance-2017\\_health\\_glance-2017-en#page216](https://read.oecd-ilibrary.org/social-issues-migration-health/health-at-a-glance-2017_health_glance-2017-en#page216)

This chart examines how much of a country's GDP is spent on long-term care (residential care housing and caring for the elderly and some younger people with serious disabilities). It looks only at *public* expenditures, meaning that out of pocket spending by citizens on services such as housing and care not covered by the government are not included. Out of the six countries studied, Canada ranks 5th, spending nearly two-thirds less than the top ranked country, Sweden. Canada spends less on long-term care than in 2011, when public expenditures was 1.3%. Canada also spends less than the average across the 28 countries included in the Organisation for Economic Co-operation and Development (OECD) survey, ranking 1.7%.



**POPULATION AGED 65 YEARS/80 YEARS AND OVER RECEIVING LONG-TERM CARE IN INSTITUTIONS (OTHER THAN HOSPITALS), 2016**

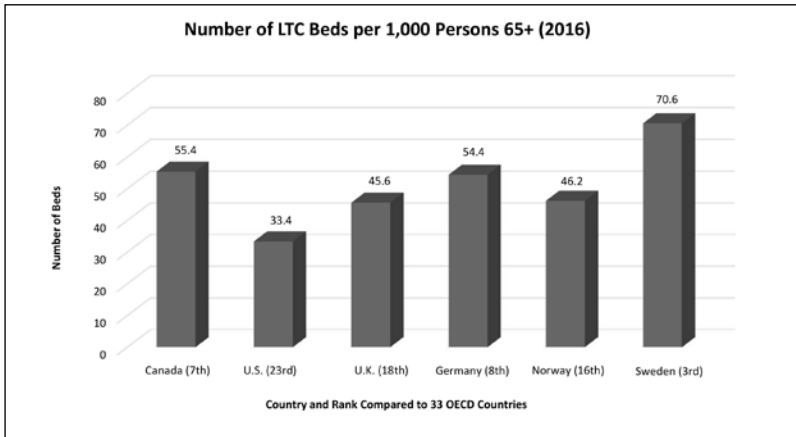


Source: [https://stats.oecd.org/index.aspx?DataSetCode=HEALTH\\_LTCR](https://stats.oecd.org/index.aspx?DataSetCode=HEALTH_LTCR)

\* U.K.: no recent data available

These charts show the percentage of seniors age 65 years and over, and 80 years and over respectively who are receiving long-term care in institutions other than hospitals. In the 65+ chart, the U.S. is lower than the other countries at 2.4%. The 80+ chart shows the rise in numbers of older, frailer people in long-term care, 12.4-13.4% being in this category among the homes studied.

## **NUMBER OF LONG-TERM CARE BEDS PER 1,000 PERSONS AGED 65 YEARS AND OVER**

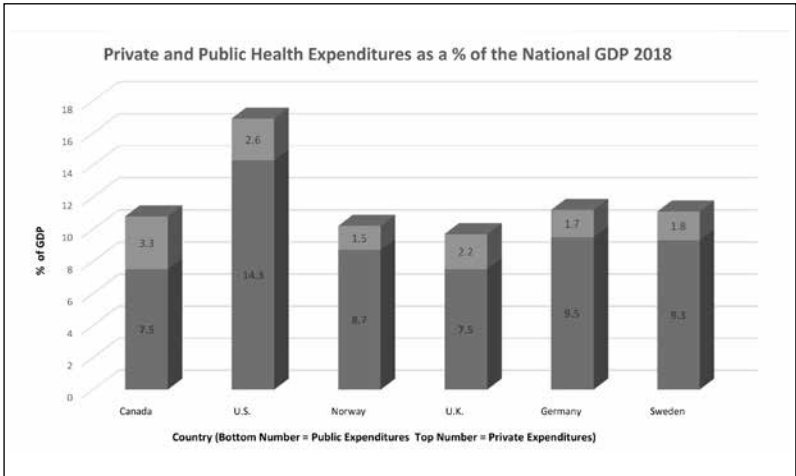


Source: <https://stats.oecd.org/index.aspx?QueryId=30142>

The number of long-term care beds per 1,000 people over the age of 65 essentially measures how many long-term care beds there are available in each country studied. In Canada's case, there are 55.4 long-term care beds per 1,000 seniors. This is the second most of the countries studied, and 7<sup>th</sup> out of the 33 countries studied by the OECD. Of the six countries studied, Sweden has the most long-term care beds at 70.6 per 1,000 persons 65 and over, ranking 3<sup>rd</sup> across the 33 OECD countries. The beds measured by the OECD are long-term care beds for people with moderate to severe functional restrictions. It does not include beds for seniors in adapted living situations, such as beds for seniors who require minimal mobility and care support.

This measure shows that it is not just the number of beds that is important to good care. Our research shows that it is also factors such as: the permanency of staff; support and training for staff; skill mix and flexible, trained staffing; and most importantly, sufficient time; and resources for staff to spend with residents and to innovate new projects to meet residents' needs.

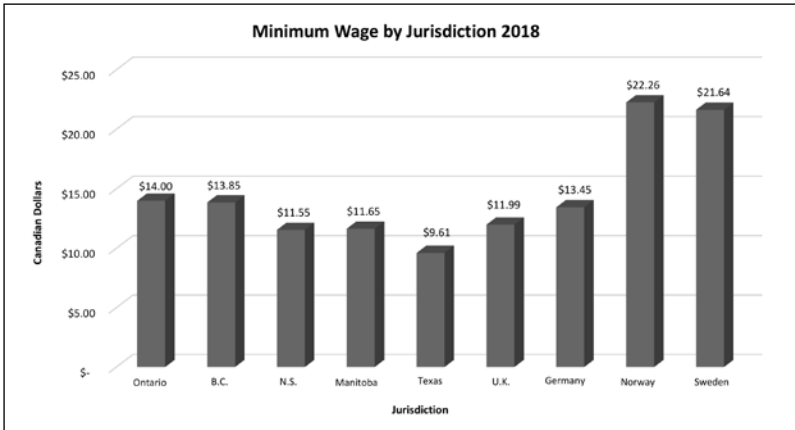
## **PRIVATE AND PUBLIC HEALTH EXPENDITURES AS A % OF THE NATIONAL GDP 2018\***



Source: <https://data.oecd.org/healthres/health-spending.htm>; OECD (2019), Health spending (indicator). doi: 10.1787/8643de7e-en; <https://www.statista.com/statistics/268826/health-expenditure-as-gdp-percentage-in-oecd-countries/>

\* There is a large unexplained difference between the U.S. 2011 data on private and public expenditures and those for 2018, with private expenditures dropping from 8.9% to 2.6% and public expenditures rising from 8% to 13.83%. Some of this difference may be the result of Obama Care.

Health expenditures include the amount spent on health services and goods. This includes costs such as pharmaceuticals, acute and long-term care, as well as spending on items such as healthcare infrastructure, administration, and public health. This chart measures this spending through demonstrating how much of a country's GDP is spent on health expenditures.

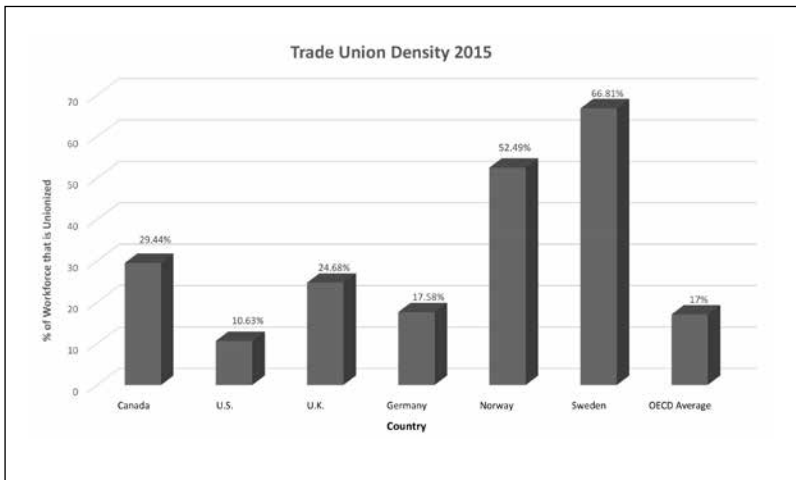
**MINIMUM WAGE BY JURISDICTION 2018**

Sources: <http://srv116.services.gc.ca/dimt-wid/sm-mw/rpt1.aspx>; <http://www.ncsl.org/research/labor-and-employment/state-minimum-wage-chart.aspx>; <https://gov.uk/national-minimum-wage-rates>; [https://www.destatis.de/EN/Themes/Labour/Earnings/Minimum-Wages/\\_node.html](https://www.destatis.de/EN/Themes/Labour/Earnings/Minimum-Wages/_node.html); <https://www.ssb.no/en/statbank/table/11419/tableViewLayout1/>; <https://www.scb.se/en/finding-statistics/statistics-by-subject-area/labour-market/wages-salaries-and-labour-costs/wage-and-salary-structures-and-employment-in-the-primary-municipalities/pong/tables-and-graphs/average-monthly-salary-by-occupation/>

The minimum wage is the lowest amount that employers must pay their workers. Norway and Sweden do not have legislated minimum wages. Instead, minimum wages are set by industry-wide bargaining between labour and employer groups. The data for Norway comes from Statistics Norway, extracted from the Statbank. The lowest average wage of care workers, the basic monthly salary of “lower quartile” “service and sales” employees (which includes personal care workers) in “residential care activities” (a category that tracks employment in nursing homes and sheltered accommodation for children) in both “private and public enterprises” was combined. The basic monthly salary of this group, 27280 NOK, was converted to a yearly rate of 327360 NOK, from which the hourly rate (40 hours/week for 52 weeks) of \$22.26 was calculated. For Sweden, Statistics Sweden tracks the average monthly salary for personal care providers, which is 27900 SEK. This figure was converted to a yearly rate of 334800 SEK, from which

the hourly wage (40 hours/week for 52 weeks) of \$21.64 CAD was derived. (Conversion rates as of October 2019.) Norway and Sweden data may not be completely representative of the long-term care industry as a whole.

## **TRADE UNION DENSITY 2015**



Source: <https://stats.oecd.org/Index.aspx?DataSetCode=TUD>

\* U.S. and U.K. survey data; CAN/ NOR/ GER/SWE administrative data

Trade union density simply measures the percentage of paid workers in a country who are trade union members. Canada has a trade union density of 29.44%, much higher than the OECD average and our neighbours to the south, but much lower than Norway and Sweden. In addition, many workers in Sweden and Norway who are not union members are still covered by collective agreements as bargaining happens on a sector (or industry) wide basis, rather than with just one employer as is the case in Canada. On the whole, across the OECD countries unionization is steadily decreasing.

**POPULATION**

Measurement	Canada (2019/2018)	U.S. (2019/2016)	U.K. (2019/2018)	Germany (2019)	Norway (2019)	Sweden (2019/2018)
Population (in millions)	37.4	329.7	66.4	83.0	5.3	10.29
Population over 65 (%)	17.2	15.2	18.3	22.36	16.71	19.9

Sources, Canada: Population: Statistics Canada Quarterly Demographic Reports, April 2019 <https://www150.statcan.gc.ca/n1/daily-quotidien/190619/dq190619c-eng.htm?indid=4098-1&indgeo=0>

Population over 65: Statistics Canada Age and Sex Estimates, 2018 <https://www150.statcan.gc.ca/n1/daily-quotidien/190125/dq190125a-eng.htm>

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**LIFE EXPECTANCY AT AGE 65**

Measurement	Canada	U.S.	Norway	U.K.	Germany	Sweden
Life expectancy at age 65, Women	21.6	20.6	21.6	21.1	21.2	21.5
Life expectancy at age 65, Men	19.3	18.1	19.3	18.8	18.1	19.2

Source: <https://data.oecd.org/healthstat/life-expectancy-at-65.htm>

## **VIGNETTES OF PROMISING PRACTICES IN LONG-TERM CARE**

In this section, we present short stories or what we call “vignettes” of promising practices. The promising practices contained in the vignettes are presented in bullets at the end of each discussion. These vignettes offer a quick snapshot of how promising practices played out in real long-term care settings.

The studies took place in large cities, small cities and rural areas. We do not specifically identify which cities or rural areas as we need to protect the anonymity and confidentiality of the residents and staff at the facilities. We do identify each vignette as happening in either a big city, small city or rural area, as well as in what country or what Canadian province.





## CANADA

### BRITISH COLUMBIA: BIG CITY

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#### **PROMISING PRACTICE: “NUTRITION IS NOT JUST THE THREE MAIN MEALS. IT’S 24 HOURS.”**

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*Jim Struthers*

In this 117 bed non-profit long-term care home the preparation, variety, quality and delivery of food underscore an approach to care in which, “nutrition is not just the three main meals. It’s 24 hours” (interview with Support Services Manager). Several factors are crucial to the success of this “food-first” strategy. The starting point is the home’s commitment, throughout its 28-year history, to hiring its own staff for dietary as well as health, housekeeping, and maintenance services (meeting with Director of Care; interview with Support Services Manager). The result is low staff turnover, smooth teamwork in cooking and serving food, and a willingness to procure ingredients from local sources, including some fruits and vegetables grown on-site by residents in the home’s own “Green Thumbs” garden, to reflect the dietary tastes of a resident population which is now 50% of Asian origin. Residents who are able can also eat outside in the garden during summer months (interview with family member). The “Asian Fusion” cuisine, which changes seasonally, incorporates fresh Chinese vegetables, sauces, and seasonings, rice and lotus seed (as well as salt and sugar) and fish purchased from local Chinese-Canadian vendors, resulting in a more “home-like” diet (interviews with Dietician and with Support Services Manager).

The experienced dietary staff know each resident and their likes and dislikes “like the back of their hand” (interview with Dietician). They are also trained to consult regularly with family members, and to closely observe what residents are actually eating and what gets thrown away. “You have to work with the families. You have to be able to go into the dining room to look at how they eat or whether they need changes or what will work better for them. So it’s the staff feedback and the care

staff feedback...It's a holistic team in order to provide the best care" (interview with Support Services Manager). Since food services are not contracted out, the kitchen staff can respond quickly to unpopular menu items. Their unique "fortified porridge" for breakfast and a changing rota of homemade soups at dinner are popular favourites (interview with Dietician and with Support Services Manager). Staff take pride in the texture and flavour of their minced and pureed meals which are all cooked and prepared on-site for the regular diet rather than purchased off the shelf. "People actually eat. The food has taste. There's some love put into it" (interview with Nurse Practitioner).

Choice is essential to dignity and respect. Diners are given two options for their main courses each day, which are delivered to their tables in hot carts. Clothing protectors are optional (a small green dot at each place setting indicates their preference). And residents are not rushed to finish (interviews with residents and with Support Services Manager). Staff sequence their dishwashing so that individuals can dine "as long as they want." In the morning residents can sleep in until 10 a.m. if they so choose and still be served breakfast since "this is their home" and breakfast is "the most important meal of the day" (interviews with residents and with Support Services Manager). Extra sandwiches are prepared for those who don't eat much at dinner "because it is a long time between breakfasts" (interviews with residents and with Support Services Manager). Individually labelled boxes with bananas, yogurt, and homemade cookies are provided to residents at 7:30 p.m. before bedtime. Regular "teatime" snacks of freshly baked loaf cake are also served each day at 10 a.m. and 2 p.m. The home's 24-hour nutrition program also ensures that food is available any time of the day or night. (interview with Support Services Manager).

A highlight of the home is the design and location of its large open kitchen situated beside the main residential dining, recreational, and lounge area on the ground floor. "You get to see the food. You get to smell the food." "You know, when we first renovated this kitchen, the day the kitchen opened, you had to see the residents' faces. They were all 'Wow! Look at all these things'. It's like a show to them" (interviews with Director of Care and with the Support Services Manager). An adjacent and smaller "Residents' Kitchen" is also available for family

members and volunteers to prepare special dinners. Each Thursday a community group, accompanied by singers, prepares and serves a popular vegetarian “Buddhist Lunch.”

Food is also an essential part of the home’s 24-bed secure dementia care unit on the second floor which is equipped with its own large kitchen and dining area that provides unrestricted resident access to a spacious semi-covered outdoor garden terrace which family members describe as “a big plus”. Asian residents unable to come downstairs are provided with Chinese cuisine from the central kitchen (interview with Dietician). Regularly scheduled group baking activities on this unit involve residents in the smells, tastes, and memories of their earlier lives. A “Home-Life” activities program engages those who are capable of helping out in preparing vegetables, setting tableware, washing dishes, folding napkins, and sweeping floors.

**PROMISING PRACTICES:**

- *No contracting out of staff promotes low turnover, better teamwork, and a deeper knowledge of residents’ food preferences and eating practices.*
- *Local food procurement facilitates a healthier cuisine more reflective of the care home’s ethno-cultural composition.*
- *The in-house garden and separate “Residents’ Kitchen” involve residents, volunteers, and family members in food production.*
- *Pureed and minced foods are prepared on-site, with a focus on flavour, aroma, and texture.*
- *Dignity and choice are reinforced through giving residents sufficient time to eat, changing menu options, and a choice of whether or not to wear clothing protectors.*
- *The open kitchen creates a rich sensory food environment.*
- *Food is available in various forms and settings 24 hours a day.*

BRITISH COLUMBIA: BIG CITY

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**PROMISING PRACTICE: SOCIALLY CONNECTED AND ACTIVE**

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*Megan J. Davies*

I find myself wondering how can we foster “the self” when home is a nursing care facility and the self is old and in frail mental and physical health? The following vignette provides some promising practices that seemed to support a healthy, socially connected and active version of “the self”.

In the afternoon I went into a room adjacent to the dining room, an institutional space that I had not ventured into before. The sun streamed in through the south-facing windows, and I located notes of “home” in this room that were absent from other spaces at the facility, with a fireplace at one end, a few comfortable chairs, and bookshelves. A rehabilitation / physiotherapy session was underway with L, the music therapist, playing the piano. The physiotherapist was an Asian-Canadian woman who was speaking what I assumed was Cantonese to residents for whom that would have been their first language. I was struck by her lovely way of encouraging and affirming all participants. Three younger volunteers, in their late teens or early twenties, were on hand to help. The resident participants (all in wheelchairs) were clustered to one side of a long set of parallel bars which had a full-length mirror mounted at the far end.

Each resident was brought in turn to sit alongside the piano, at the beginning of the parallel bars, lifted out of their wheelchair, and a belt with grips strapped around their waist. And then for a few minutes they seemed to become someone they used to be, promenading down between the parallel bars, to music clearly selected with the individual in mind, performing for themselves in the mirror and for the rest of those assembled. Everyone clapped when a resident finished walking down and back once, twice, even three times. The physiotherapists stayed close, greeting people as they stood up, talking to them as they walked down the promenade and returned. “Look at yourself in

the mirror," I heard her say. I saw a woman sashaying down the bars, swaying — almost dancing — to the music. And F, eager for her turn, so animated, and so regal when she walked.

For a few moments these people were released from the world of wheelchairs, belts, trays, and the limitations that this facility and their age have imposed upon them — and it was beautiful.

**PROMISING PRACTICES:**

- *Home-like environments, where attention is paid to light, décor and the social arrangement of furniture and other structural elements of domestic space.*
- *Blended physiotherapy with creative arts (music) therapies as frequent and hopefully daily activities.*
- *Using favourite songs and music to motivate and support residents.*
- *Celebration of the individual interests and achievements of residents and caregivers.*

ONTARIO: SUBURBAN CITY

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**THE PROMISE OF A PROMISING PRACTICE: HOUSEKEEPING WORKERS AS PART OF THE TEAM**

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*Jacqueline Choiniere*

We encountered the promise of a promising practice in an urban Ontario long-term care residence. A woman who worked full-time in housekeeping was observed frequently interacting with residents, families and staff, as she performed her work, giving every indication that she was enjoying her work. While dusting/cleaning along one of the long hallways, she spoke to different residents by name and many were clearly pleased to see her, their faces lighting up when she approached them. She touches them on the arm or hand and her enjoyment from engaging with them is obvious. She was also observed interacting easily with other staff members and residents' families, even inquiring about the health of other family members. When one resident's door is closed for a long time, she checks with other staff about what is going on. Her interest and concern are clearly more than a desire to get into the room to clean. She joins in a discussion about one resident missing a piece of clothing that was sent to laundry. Together with one of the care aides, she discusses the likelihood that the missing piece of laundry will return the next day.

She also chats with the RPN who is distributing medications, agreeing with her that one of the residents is very drowsy/tired today. She greets the RN by her first name, and they have a short discussion. It is clear that she feels comfortable in this setting and that she feels, and is considered, part of the team. It is also clear that other staff members value her opinion.

During an interview, she recounts her efforts to have a work problem addressed. The garbage cans, when full, were getting too heavy for the housekeeping staff, and people were hurting their backs when emptying them. She shared the following experience during an interview: "We called our boss and said 'Come and have somebody

do this because it's too heavy. It's putting our health in risk... They suddenly got smaller garbage cans..." In another comment, she refers to the ability to make important decisions regarding the flow of her workday. "...I use my logic and I say 'Well I'm going to get this done today and that's it.' I work it out with the staff that when I really need a room empty without the resident, I can have it. I just ask them the night before or I write it down in the book, the log book, and they'll get it done early in the morning and then I can go in there as soon as I start work and get everything done..."

She characterized her relationships with co-workers and residents as family-like, emphasizing how important it is to be part of the team, and to be counted on and to be able to count on others, when help is needed.

What makes this only the promise of a promising practice is that we failed to encounter a similar level of support for other housekeeping staff in this nursing home. There are important reasons why the inclusion of cleaning staff as part of the care team is more important than ever. Residents are older, with higher and more complex needs, including those related to dementia. Indeed, the residents in this long-term care home were assessed as requiring a higher level of care than the provincial average, meaning that nursing homes are increasingly medicalized. At the same time, nursing homes are people's home. This makes the relationships with all of those who take care of them and their surroundings even more important. Many residents experience a lack of support from family and friends due to location, age or estrangement, which only heightens the importance of close, trusting relationships with all staff members, within a clean, familiar and caring environment. In short, care is more coordinated, effective and relevant when nurses, care aides, housekeeping, dietary and other staff are collaborating as part of a coordinated team.

**IN ORDER FOR ORGANIZATIONS TO EFFECTIVELY INCLUDE HOUSEKEEPING WORKERS AS PART OF THE TEAM, THE FOLLOWING PROMISING POLICIES AND PRACTICES ARE NEEDED:**

- *Stable, permanent employment and consistency of assignment to facilitate relationship building with other staff and residents.*



- *High staff-to-resident ratio to enable staff to spend more time with residents and ensure their environment is safe, clean and comfortable.*
- *Housekeeping staff included in team meetings to keep them updated on changes in residents' needs and care and to convey the value of their work.*
- *Management who acknowledge the value of housekeeping work for health and comfort.*
- *Management who are responsive when the conditions of work require change.*
- *Staff who are encouraged to work as a team.*
- *All staff included in education/in-service sessions.*
- *Adequate staffing and wages to increase staff morale and retention.*

## MANITOBA: BIG CITY

**PROMISING PRACTICE: RESIDENT-CENTRED APPROACH TO CARE***Ruth Lowndes*

This personal care home (PCH) has a philosophy of “always putting the resident first”. This approach was initiated by two people with a dream of how long-term care should look. This approach to care has been successfully embedded and can be seen in everyday practice in this 80-bed urban facility. Various processes are implemented to ensure that residents remain central. These include but are not limited to: staffing in a manner that facilitates continuity of care; having a team-oriented focus with a blurred division of labour to enable relationship building; maintaining an in-house kitchen, housekeeping, maintenance, and laundry services; and documenting in a resident-centred way, which leads to less time spent on charting and more time for relational care.

Management, kitchen, maintenance, laundry, housekeeping and care personnel are all employees of the organization (none of the services are privatized and contracted-out). The staff are autonomous and given wide decision-making capacity. The philosophy of care drives how work is organized. The PCH home is described by staff as being like “a big family” (interview, health care aide).

Staff turnover is low, in part due to having full-time and regular part-time positions and very few casual positions. Many staff members have been employees here since the home opened and are positioned on a regular permanent shift and unit. This facilitates resident/staff familiarity, along with knowledge of routine tasks and responsibilities.

To further facilitate relationship building, all staff, including housekeeping, dietary aides, and administration, have contact with residents in each of the four units or “houses” on a daily basis. For example, the Chief Executive Officer/Director of Care is visible, approachable, and is addressed by residents (and staff) by her first name. Dietary aides know residents by name and engage in conversation

during mealtimes. The security guard conversed and played games with residents; and the receptionist connected with residents in their respective houses everyday while changing menu cards.

There is a blurred division of labour in their team-based approach, with Registered Nurses (RNs) and Licensed Practical Nurses (LPNs) doing administrative functions within scope as well as direct care work alongside care aides. For example, LPNs and RNs set residents up at the tables, pour water, ask food and fluid preferences, while often knowing each individual's favourite, and they assist with eating. The registered staff was observed at times orchestrating the entire meal, from serving to cleaning up.

Charting is done according to resident care needs rather than being organized by discipline and is done by exception, which reduces duplication and the amount of time required to complete documentation. For example, staff does not document how much each resident eats at a meal unless there is a specific need to collect this information.

This PCH is viewed as the residents' home and various organizational practices reflect this philosophy: a) there is minimal signage throughout the building with a focus on only posting resident-related information; the assumption is that residents would not have signs at home; b) there are conveniently located storage areas for equipment to keep the home-like appearance; c) houses and doors, for example to the conference room, are intentionally left open so that residents have freedom to move around; d) beds are not made until after breakfast so staff can focus on resident dining, which is felt to be more important to resident quality of life; and e) recreation is geared towards helping "the residents to live in the world we all live in" (interview, Manager) by, for example, preparing and enjoying home-cooked meals and going fishing.

**PROMISING PRACTICES:**

- *Management had a vision of how long-term care should look, putting the resident first, which has been successfully embedded in practice.*

- *Kitchen, housekeeping, laundry, and maintenance services are in-house, which among numerous other benefits, promotes a sense of belonging and collegiality.*
- *Management provides decision-making capacity and empowers staff to work autonomously.*
- *Stable, permanent employment and good working conditions that contribute to staff retention and morale.*
- *Staff is given permanent shifts and units, which facilitates continuity of care.*
- *Team-oriented approach and work is organized with the main focus on resident quality of life eg. dining is prioritized over bed making.*
- *Limited division of labour.*
- *All staff in the facility has contact with residents on a daily basis to enhance relationship building.*
- *A home-like atmosphere is created by, among other things, maintaining unlocked, and open doors for freedom of movement, posting minimal signage, and staff being mindful of their passage through physical spaces.*
- *Charting by exception, which reduces the amount of time spent on documenting. Record keeping in a resident-centred manner, focusing on broader social, environmental, physical and intellectual outcomes rather than a more narrow, medicalized focus on medications, dietary intake, output, etc.*

## NOVA SCOTIA: RURAL COMMUNITY

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### **PROMISING PRACTICE: REALIZING PERSONAL CARE THROUGH DINING**

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*Tamara Daly and Martha MacDonald*

The care home is a 100+ bed not-for-profit nursing home located in a semi-rural community in Nova Scotia. This section describes how the physical design, work organization and approach to care reinforce their promising approach to dining care.

While the organization is almost half a century old, the current building was constructed as part of the Nova Scotia Continuing Care Strategy started in 2007 with design requirements favouring small units and a less medical approach to care. In terms of its design, the home is physically organized into three neighborhoods, each with two households of 18, further divided into two houses of nine residents. Residents eat in their houses, and the small dining rooms make mealtimes more relaxed and familiar. The dining rooms in the houses have different table configurations. Some opt for one big communal dining table, while others have as many as four and as few as one person per table. The main living space is configured like a large family kitchen, complete with cabinets that look “home-like”. The eat-in kitchen space is open to outdoor views of the gardens and is attached to a great room style sitting room. The space is airy and open, but made cozy with the placement of furniture that create separate spaces to watch television and sit.

Work organization is driven by the Nova Scotia funding, which includes a protected envelope for care-related expenses, normally provided by Continuing Care Assistants (CCAs) and nurses. Consistent nurse staffing at the care home is allocated by neighborhood, while consistent CCA staffing is by household. There is also an unprotected envelope for accommodation-related expenses for housekeeping and food service workers in Nova Scotia. Even though an important part of the care team, the latter group of workers typically would not be doing any hands-on care in most Nova Scotia homes. The care home has

re-imagined their role and given them the title of Resident Support Assistant (RSA). Their work involves housekeeping and food work at the house level, meaning that there are 12 RSAs across the building. Their enhanced job description involves duties such as “ensuring ... living areas, rooms and bathrooms are clean, comfortable and efficient”, doing on-unit laundry like delicate sweaters and blankets, and setting the dining table and serving meals. During the morning the RSA is in the kitchen/dining area greeting residents as they get up and setting out their favourite breakfast items from the well-stocked kitchen. This could include cooking an egg, and making toast or porridge. Service is geared to the needs of the individual. While the RSA is taking care of those who are up for the day, the CCAs are able to concentrate on getting people out of bed and providing personal care. In terms of job satisfaction, the RSAs feel very involved in caring for residents and describe it as a sharp contrast to the old model when they would simply be doing housekeeping behind the scenes. This job change integrates them more fully into the care team. They are trained to assist with lifts and to help residents with eating, and are responsible for keeping the unit kitchens well stocked and clean.

The province’s care model was influenced by the Eden Alternative philosophy and some homes, including VV, have formally affiliated with Eden to ensure the approach emphasizes a focus on the needs of the resident, small units, consistent staffing, residents’ choice, and flexibility in the day’s scheduling. Dining is a critical part of providing residents with choice and flexibility, and it is important for residents’ quality of life. Breakfasts at VV are leisurely and personable. Hot food comes up from the main kitchen at a certain time, but most residents have already eaten something prepared by the RSA by the time food arrives. For instance, some breakfast foods like eggs, cereals and porridge and snacks are prepared in the house by the RSA, while some hot breakfast items, the hot lunches and hot dinners are centrally prepared for the whole facility and then delivered to each house. This year VV prioritized food as a strategic priority and they are working to enhance the dining experience, which is central to good care. Food is made on-site from good quality ingredients by red-seal certified chefs. The on-site kitchen enhances the quality, freshness and personalization of the food. The “home-cooked” food reflects the food tastes of the region and the

residents. Desserts are also prepared daily. Furthermore, the kitchen also runs a hot and cold menu for the staff and visitors. Some members of the community come to dine there. The facility makes no money on the food, but it allows staff and visitors to get a selection of hot and cold menu items, which is particularly important in a rural setting where there are not any places for community dwelling older adults to go out for lunch or dinner. It also creates a “café” where residents and visitors can ‘go out’ while staying in.

In summary, their approach to dining care — at once flexible and personal — is accomplished with food preparation on the unit (house); with a worker trained to provide care, prepare meals and take care of the space; and in an atmosphere that allows residents to eat communally or solo, as the need arises. Furthermore, having an on-site kitchen, with well trained staff who can make regional dishes and homemade desserts that appeal to the residents, staff and visitors promotes a sense of community and good care.

**PROMISING PRACTICES:**

- *Small dining rooms.*
- *Flexibility in mealtimes.*
- *Incorporating housekeeping and food service staff into the meal routine.*
- *Consistent staffing on the units so resident preferences are known.*
- *Staff menu items available at cost.*
- *Innovative use of restrictive funding.*

## GERMANY

### GERMANY: SMALL TOWN 1

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#### **PROMISING PRACTICE: FOOD, DINING AND QUALITY OF LIFE**

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*Ruth Lowndes and Beatrice Müller*

It is 4:30 p.m. and in the common unit pizza preparation is underway. One of the residents, Louis, is unloading clean dishes from the dishwasher and re-loading dirty dishes. Some items he puts away in the cupboard, others he leaves on the counter and one of the assistants puts them away later. He also cleans the counters. Louis is one of the residents receiving a small stipend for performing certain duties in the unit. Marie, the qualified elder care provider, is rolling out the pizza dough. Meanwhile, another resident, Leah, is using a sharp knife to cut peppers and onions for the pizza. Another resident is adding parchment paper to the baking tray, on which the pizza will be baked. Marie helps him cut the paper. There is considerable chatter in the room, a very active, warm, home-like feel. Another resident, Fynn, walks from the table to the island where there is a bowl of fruit, and he takes an apple. One of the apprentices asks him if he wants it peeled and brings him a peeler. He proceeds to peel the apple, cuts it into pieces and eats it at one of the two tables. Fynn seems to be a potential wanderer. He starts for the door a few times and each time Marie or one of the apprentices stops him by distracting him, drawing his attention to something else in the room. Marie gets Leah to assist in adding the vegetables to the pizza. She then hands a glass of wine to Louis, who sips it, and then she gives wine to other residents. Marie hands spoons to Gisele and she hands them around. Gisele is sitting beside a male resident who is pouring wine for four other residents. The residents clearly enjoy the pizza and the staff members know who has a good appetite, who is best with a small piece of pizza, etc. As they finish eating, some medications are given. There is very little oversight of most residents to ensure they actually take the medication. Louis is now busy clearing dishes and loading the dishwasher. It is 6:50 p.m. and the dishwasher is on. There is a lively conversation going on, some



singing of old German folk songs, and laughter amongst residents and staff. One resident is dozing in her chair as the sun goes down in the window she sits beside.

The above vignette is a compilation of observations taken during mealtimes at one long-term care home in Germany. Food is socially organized in such a manner as to positively influence resident quality of life: the main on-site kitchen is not outsourced. Local produce is purchased, along with some organic products, and a local bakery is used for pastries. As indicated above, food is also prepared in the five common shared units, each of which have a full kitchen, sitting area and dining space for a maximum of 12 people. Food cooked on the unit enables resident involvement, flexible dining schedules, and the appetite-enhancing aromas of food being cooked. The common shared units are bright with natural light streaming in from the big windows in three of the four walls. There are real plants, spices and oils, making it feel very home-like.

Observed staff-to-resident ratio is 1:3 or 4 with a large apprenticeship program: there are 110 apprentices for 90 residents in this home, which allows plenty of time to complete mandated tasks in a relaxed atmosphere and also to engage in social care with the residents. For example, staff was observed sitting during meals and having conversation with residents while they ate, as well as singing, playing games and doing crafts throughout the day. The staffing ratio also enables the watching and redirecting of residents, as noted above, who tend to wander, rather than using locked doors and other forms of restraint.

Further, there is limited division of labour on the units, thus promoting the development of staff/resident familiarity and the deepening of relationships. Noted above, Maria, the qualified worker who oversaw the unit, made the meal, and the apprentices gave out the medications. The staff had knowledge of resident preferences, and their individual skills and abilities. They also connected with residents in a very meaningful way, joining in conversations and singing, while also working with them to maintain skills, for example, through facilitating the cutting of apples by a resident who suffered from dementia.

There is freedom and autonomy for both residents and workers. Staff has the freedom to interpret regulations to accomplish the care approach exemplified in the pouring of wine so that residents could enjoy a glass while preparing and eating dinner as they would've done at home.

Philosophy of care in this home is to fill days with life rather than extend days of life. "Living" and "independence" are embraced, with residents' involvement in activities of daily life being encouraged in such things as food preparation and socializing together.

In their approach to care it is further recognized that with real life comes real risk, and this philosophy is embraced in practice. There are living plants in the units and real candles are lit in the dining room. Residents use sharp knives and hot irons. The residents also handle food as at home without worrying about having to comply with stringent health and safety regulations. This extends to the relaxed viewpoint towards the giving of medications, which are given by apprentices, as noted above, without signing for and double-checking and often without ensuring residents have actually taken them. Staff also do not awaken a resident at 10 p.m. to give them a sleeping pill just because it is ordered. This approach is meant to provide a home-like atmosphere, where a person may forget to take a pill, or sleep through a dose of medication, rather than following a medicalized approach to care.

### **PROMISING PRACTICES:**

- *On-site kitchen operated by the LTC home.*
- *Management who are interested in maintaining resident skills and abilities, encouraging resident involvement in everyday household activities such as food preparation.*
- *Small common shared units with kitchens for maximum 12 residents. Cooking on units facilitates smells and sounds that enhance appetites and enables flexible dining schedules (as does the heated food carts).*
- *Limited division of labour on the units, thus promoting the development of staff/resident familiarity and the deepening of relationships.*

- *Apprenticeship Program that allows for observed staff to resident ratios of 1:3 to 1:4 during the day/mealtimes.*
- *The high staff to resident ratio enables time to focus on such aspects of care as socialization, and watching residents at risk rather than using restraints and locks to contain those with moderate to severe dementia.*
- *Risk vs. Safety: The acceptance of some risks (e.g., resident use of sharp knives during meal preparation) with a view that the goal is to promote more life into days rather than extending the days of life.*

## GERMANY: SMALL TOWN 2

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**PROMISING PRACTICE: TIME FOR RELATIONAL ENGAGEMENT AND SKILLS**

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*Ruth Lowndes and Beatrice Müller*

There is a very easy and comfortable feeling in the room. No music is playing; rather, there are everyday sounds as there would be at home. It is time to just sit and be there — lots of chatter, touching residents on the arm, rubbing a shoulder, patting a hand almost as one would touch a grandparent — with restrained affection. Often staff members will sit beside a resident while engaging or squat beside them. Apprentices pay attention to the residents, hold the residents' hand (one resident likes to kiss people's hands). A housekeeper enters the room and is very welcomed. She knows the residents, and gives one resident a back massage. She ends up giving a back massage to all the residents at the table. The atmosphere is very delightful. Care staff is available for activation for the whole afternoon, with no other tasks except light kitchen work. Care workers at all levels of qualification engage in social care work. It feels natural and not like artificial activity, very much like home or like one could imagine home. Later a care worker is peeling potatoes and gives a resident Clara, whose hands shake quite a bit, a potato peeler. Clara seems pleased, takes it and attempts to peel potatoes; she is focused on her task. The worker stays near her and supervises the peeling. At the end, the worker collects the peels, shows them to the resident, and says "thank you". After supper the residents are still taking their time at the tables. There is also a lot of communication going on. While a care worker Jane and a resident Betty, who has moderate to severe dementia, are cleaning the tables they talk in a very special way. Jane stays with Betty in her world and answers her question even if she doesn't understand what she is talking about. Another resident starts sweeping the floor, and a next one is doing dishes while laughing with the care aide. At 7 p.m. it is quiet: six residents are sitting at the tables. One is still with the care aide at the counter in the kitchen area doing dishes. The other staff member comes back in and the care aide takes one woman, arm in arm, to get ready for bed.

The vignette was developed using observations taken during daytime at one long-term care home in Germany. Living in this care facility is organized around so called Hausgemeinschaften common shared units to which eight to 12 residents belong. In all five units, a responsible care provider is present all day long and helps residents to structure their everyday life. This organization of care and life provides time because at least one person (often more because of the apprenticeship program — see below) is always in the unit and does not have to rush doing bodily care. The body care is organized resembling home care. As in home care, so called rounds/tours are developed and structured in the sense of primary nursing. One carer provides direct care according to his/her tour plan that is not necessarily restricted to one floor or one common shared unit but is designed around the individual needs of the residents and the skills of the carer. The daily living and relational care is not restricted to this schedule. Because of this structure there is time to engage with the residents and to use the relational and communication skills the care workers have.

Time to use skills relates to both to workers and the residents. The example of peeling potatoes shows that time to supervise and support the residents' work on an everyday task stimulates the residents' skills and gives them the feeling of doing something real. Through the staff showing the residents the results (the potato peels) and by thanking them, there is an emphasis on accomplishment of something meaningful.

The apprenticeship program is a further promising practice that enables more time to be dedicated to social care. The 110 apprentices working at this care home have time to engage with the residents and be with them and likewise to train not only their physical care skills but also their relational skills.

Furthermore, the blurred division of labour supports the possibility to sit and be with the residents and allows a relationship between staff and residents to emerge. The less strict division of labour emphasizes and focuses on daily needs, and relies therefore on the decision and responsibility of the worker and does not follow a particular, rigid, standardized routine.

**PROMISING PRACTICES:**

- *Organizing work around the concept of the common shared units (8-12).*
- *One responsible care giver stays all day in this living area.*
- *On-site kitchen which allows the group to have their own rhythm.*
- *More hands – 110 apprentices.*
- *Additional staff.*
- *Risk of real relationships vs. standardization.*
- *Bright and not very institutional facility, more home-like.*
- *Management with many ideas and interest in providing good care and good working conditions.*
- *Limited division of labour.*

## NORWAY

### NORWAY: SMALL TOWN

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#### **PROMISING PRACTICES: COMMUNITY INTEGRATION, GREAT PHYSICAL DESIGN, EXCELLENT FOOD**

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*Pat Armstrong*

The nursing home has 24 single rooms each with its own bathroom, kitchen and direct access to the secure garden, as well as 23 assisted living apartments. The staff has the full-time equivalent of 0.29 physicians, 13.0 registered nurses, and 15.5 auxiliary nurses and 1.75 nursing assistants, which may help explain why their rates of sick leave are relatively low.

The space was the most immediately impressive feature. The nursing home has a wheelchair accessible therapy pool, brightly coloured art on the walls and new, Nordic style furniture. The home was fully integrated into the community centre that included a day care centre, an Olympic-size swimming pool with slides, a sauna, a solarium, a climbing wall, the multiplex cinema, a café, an ice cream parlour and conference rooms. Across the square in front of the main door is a shopping centre, with a bookstore, hairdresser and other businesses. The sound of laughter and many voices filled the space, making it an inviting place for workers as well as for families and staff. Workers had convenient access to an amazing array of services and so did residents and their families, making visits easier in ways that also made it easier for workers to care for residents. As an assistant nurse put it “so if you have children that you are driving to the cultural school and so you can go and visit your parents or if you are going to the shopping mall or whatever so it’s easier to go by”.

The space reflects the philosophy about work and care. Conscious and explicit decisions were made about design; decisions that involved the staff and the staff thinking about residents. We are told that their goal is to ensure that workers have a positive environment, where they enjoy

their work, find it interesting and can grow. For example, the beautiful spa room means that bathing patients becomes more pleasant and less a chore. Allowing workers to have responsibility is key we were told, as is the bright and pleasant staff room where the workers are encouraged to have coffee and chat.

It is not only workers who are involved in decision-making about space as a result of the care philosophy. Residents are consulted on routines, and can make their own choices about when and what to do. The modern furniture and colours are intended to be forward looking as well as to make residents proud of their space.

There are, then, rewards for both the worker and for the person with care needs.

### **PROMISING PRACTICES:**

- *The physical integration with the community was particularly impressive, providing an excellent model for bringing generations as well as activities together.*
- *The physical design of the building. The modern, spacious, and well-lighted design provided welcoming spaces and the art, as well as the colours, offered stimulation to the senses.*
- *The rooms with doors opening on a secure, enclosed garden provided a sense of freedom that was combined with safety.*
- *The commitment to modern design and furniture that would make residents and families feel proud of the space and think of the future, rather than focusing solely on yesterday.*
- *The therapy pool not only offered residents a space for care but also provided support for the community.*
- *Nature/Culture/Health approach which sees them as a unity, stressing that life is at this moment and aspiring to make significant moments, is an innovative strategy that is evident in practices.*
- *The staff room, which was bright and airy, was located close to residents while providing some communal space for workers.*
- *Volunteer and community engagement was supported and the fact that some staff returned as volunteers after retirement attests to the*



*quality of working conditions and social relations. It was refreshing, and new to us, to have a staff member defend the quality of care and the environment as being so good that they would want to live in the facility in which they are working when the need arises.*

- *The food we were served was excellent and we were told that the same quality is provided to residents.*

## NORWAY: BIG CITY

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**PROMISING PRACTICE: MUSIC IN EVERYDAY LIFE AND MUSIC THERAPY**

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*Donna Baines*

Wages and working conditions in Norway are good enough that staff turnover is low. This means that care staff can really get to know the residents and develop individualized and collective ways to improve their care and quality of life. Staff-to-resident ratios are low enough (1:4 on the regular units; 1:3 on the dementia unit) that staff have time to complete their regular duties and to identify areas where a new program or a new idea might improve care. They are also provided with time by their supervisors to investigate these options, and sometimes to develop innovative, brand new programs.

For example, the nursing staff on the dementia unit noticed that residents responded positively to music — it calmed and engaged them when they were sad, agitated or withdrawn. It energized them when they seemed blue, uncommunicative or fatigued. It provided a way to relate to staff, family and other residents.

The dementia unit applied for and received a grant to investigate music's possible use in everyday life. One RN took on much of the research work, with the support and interest of the rest of the staff.

The RN reported that once they understood some of the theory and possible uses of music on the unit, they made specific goals for the music project to: heighten the competence of staff and residents; improve quality of life; make the unit safer for residents and workers; heighten resident well-being; reduce anti-psychotic and sleeping medicine; strengthen attention span and the ability to listen; strengthen concentration; and so forth.

They developed two parts to the program: 1) the use of music in daily life (systematic and individual use of music and music therapy

in everyday life provided by the nursing staff); and 2) music therapy provided by a trained music therapist for specific issues and challenges facing residents.

Music in everyday life injects music into everyday routines and special events on the unit. One aspect of this is a list of music that is well-loved by each resident is composed by staff, family and the resident (where possible). The list is posted by each bedside along with taped or DVD recordings of the music. The staff members sing bits or all of the songs, generally with the residents, during regular care routines. Most staff did not “sing” before this program but quickly learned to croon along with the tapes or just sing as best they could. They reported that the immediate affirmation from residents motivated them to keep trying and overcome personal embarrassment or feeling unskilled at singing.

Much loved songs or bits of them are also sung with residents when they are encountered on the unit — in the hallway, in their rooms, in the bath if they are agitated and anywhere that a musical interaction might add comfort, fun or connection. We frequently saw staff and residents singing a verse or two of a song, and sometimes holding hands or dancing together in the hallways while they did it.

In addition, much loved music is used individually and with groups of residents to get them up and dancing at various points in the week – a rewarding form of socialization and exercise. Even people who are rarely verbal seem to love to dance to their favourite tunes.

Plus, the nursing home has possibly the world’s only choir with a majority of participants with dementia (led by the music therapist). The choir offers an opportunity to connect with others, share some pleasure and experience something creative together, even if words are not always easy to remember.

Evaluations of the program confirm that use of medications has dropped dramatically on the unit, quality of life has improved, violent incidents have significantly decreased and workers, residents and families report greater satisfaction from their work and their days.

In addition, a formal music therapy program is offered to those who may benefit from one-on-one or small group sessions with a music therapist, and is said to extend and deepen the gains made through the music in everyday life.

**PROMISING PRACTICES:**

- *Stable, permanent employment.*
- *Good wages and working conditions contribute to staff morale and staff retention.*
- *High staff to resident ratio so staff have time to complete tasks and initiate new forms of care.*
- *Management who are responsive to and supportive of staff initiatives.*
- *Management who are interested in new programming and encourage staff to develop them.*
- *Staff who are encouraged to work as a team and try new things.*
- *Possibilities for skill development (music in everyday life program).*
- *Resources for new programs and projects.*
- *Innovative project and permanent program of music therapy and music in everyday life.*

## SWEDEN

### SWEDEN: BIG CITY

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#### **PROMISING PRACTICE: TIME FOR CARE**

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*Albert Banerjee and Susan Braedley*

There is much that is promising about nursing homes in Sweden but what was particularly striking about the home we visited was the time workers had to care. Workers were able to spend time with residents, to get to know them and their preferences, and their interactions were usually unhurried. They even had time to add special touches. When we arrived on the unit for our first research observation in the middle of the afternoon, one of the Assistant Nurses was baking a cake. The unit was filled with the delicious aroma of caramelizing sugar. Most of the residents were resting, the Assistant Nurse explained. When she has time, like today, she bakes something. The residents love it.

Good staffing levels help make the time for caring possible. For instance, each nine-resident unit had one Registered Nurse (RN) in charge and three Assistant Nurses working during the day. Because this is a non-profit nursing home with a charitable foundation attached, they are able to supplement the public funding they receive. They put this money into hiring more staff, so they are able to exceed the levels specified in their contract with the public funder. The home has also introduced a new staffing schedule to improve the consistency of care, making sure that residents see the same staff as much as possible. This builds familiarity and contributes to quality of care. However, not everyone is happy about this. Because it means more but shorter shifts, some nurses feel their lives now revolve around work more than they would like.

The design of the facility also helps create time for care. While the facility is large, it is divided into floors with two units of nine residents. This organization combines the benefits of smaller units with the economies of scale of a larger facility. As a result, they are able to

dedicate two Assistant Nurses to activity planning, spending 75% and 50% of their time organizing social activities for residents. Also, each unit has a fully functioning kitchen with a well-stocked fridge, stove, oven, microwave, coffeemaker, dishwasher and even a sparkling water tap. This allows nurses to provide snacks when residents are hungry. And breakfast is cooked on the unit by the Assistant Nurses, so waking and eating times can be flexibly organized around residents' preferences.

When we arrive the next morning at about 8 a.m., we find an Assistant Nurse setting breakfast out on a special stainless steel cold surface. She places slices of bakery-quality whole grain bread and slices of firm white cheese on the cold plate. Then she peels and slices an apple into paper thin crescents. A thermos of coffee, sugar and milk stand at the ready beside black pottery mugs. Next, she gets a carton of yogurt from the fridge, pours some into a small pitcher, and plunks it on the cold surface. From here breakfast can be served, eggs cooked and coffee poured. Residents are helped — sometimes a little, sometimes a lot — as their needs and desires dictate.

Importantly, there is time for staff to discuss residents' care with one another, to confer about problems that might have arisen, to brainstorm and to develop solutions together. This time for conversations about care is regularly scheduled in the form of meetings that happen throughout the day. Sometimes it happens in less frequent "reflection" sessions that bring the entire care team together. But mostly, we see these conversations happening on an ad hoc basis and often over the kitchen table.

During breakfast an Assistant Nurse comes into the kitchen, obviously concerned. She says that one of the resident's hair needs washing. The resident's daughter is likely to visit later that day. She gets upset if her mom's hair is not freshly washed. But her mother — the resident — hates having her hair washed. She is once again refusing to have it washed. But even more she hates to have her daughter wash her hair, which may happen. It has happened before. The nurses discuss how to deal with this issue. Perhaps if the two of them worked together to wash her hair — one to watch her eyes, talk with her and help her feel

comfortable, while the other washes? This might work. But they will have to wait until the third assistant nurse has arrived. They start work at staggered hours, and he is due soon. They discuss when this might be attempted. It must happen before noon, because the daughter usually comes at lunchtime. When the third nurse arrives, he is apprised of the hair washing dilemma. He suggests that they could attempt it after he assists the two residents who need help with eating, who are usually finished their breakfast by about 10. They also check with the RN about the plan, and she gives them the go-ahead.

**PROMISING PRACTICES:**

- *Non-profit ownership with a charitable foundation attached that supplements public funding, putting additional money into staffing.*
- *Good staff to resident ratios.*
- *Designated contact person (usually an Assistant Nurse) for each resident, who learns about their needs, plans and advocates for them. They also serve as a point of contact for family members.*
- *Time to confer with colleagues during formally scheduled meetings and reflection groups and plenty of opportunities for ad hoc discussions.*
- *Activity planners – two Assistant Nurses working 75% and 50% full-time hours.*
- *Food is of good quality, cooked in the facility, with breakfast prepared in the units' kitchen by Assistant Nurses.*
- *RNs do care as well as Assistant Nurses (and care aides at night). Care work is mixed, and also includes cooking breakfast and loading and unloading the dishwasher as well as light cleaning.*
- *Training levels are high, with some Assistant Nurses having specialized dementia care training and expected to model this expertise.*
- *Smart use of technology – vibrating alarms make for a peaceful environment; locked medical cabinets in each room get rid of medicine carts; functional kitchen in the unit supports flexible caring and adds home-like touches; and wheels on the front legs of chairs makes them easy to move reducing the strain on workers.*

## UNITED KINGDOM

UNITED KINGDOM: BIG CITY

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### PROMISING PRACTICE: A CONSISTENT GUIDING PHILOSOPHY OF CARE, WITH STRONG LEADERSHIP

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*Sally Chivers and Martha MacDonald*

This long-term care home is a 66-bed not-for-profit nursing home, built in 1997. It is part of a group that operates four care homes plus other services. There are three units, one of which is a locked dementia care unit. The Director has been there since 2006, and she implemented a major shift in the model of care about five years ago. Everything about this nursing home reflects the philosophy of dementia care advocated by David Sheard and implemented by an engaged, passionate director. The two key aspects to their approach are:

1. As cognitive abilities decline, the senses become more important
2. "Person-centred care"

The emphasis on the senses permeates the home in terms of physical space, programming and style of care. For example:

- **Visual** – colourful, decorations everywhere, including posters, artwork of residents, pictures of outings, old movie posters, flags, butterfly decals on the wall, staff dress colourfully; looks more like a day care than a nursing home
- **Tactile** – there is an abundance of what the British call "rummage," stuff everywhere, to be handled (stuffed animals, dolls, trinkets...); staff touch residents in frequent informal contacts
- **Smells** – baking on the unit, air freshener
- **Sounds** – birdsong and natural sound recordings, different types of music always playing; group singing; staff humming



This long-term care home's person-centred care is characterized by flexibility and a non-medical approach. The schedule is flexible (no set breakfast or bedtime) and there is no set seating in the dining room. Resident memorabilia is changed regularly and pictures of residents are kept current. Signs on walls say things like "you matter", "you are special", "knowing you matters", "make every moment matter". There are no uniforms and is no strict division of labour; staff are expected to pitch in as needed and "go with the flow". They take initiative, including spontaneous activities on units, and are encouraged to make suggestions. Staff follows the "Butterfly" approach, which encourages many short, personal interactions with residents. They are also encouraged to "live in their bubble" when dealing with dementia residents. Staff let residents take chances, even if they incur risk. A local doctor provides primary care and knows the residents. Physical changes that support the person-centred approach include removing the nursing station and keeping medications in each room (less hospital-like). Two care plans are maintained for each resident, one called "being with me", which focuses on overall well-being.

Staff engagement is reflected in low turnover. They also like the flexibility of shifts (six, eight, 12 hours). Most respond well to having a director who is "is passionate and expects you to be too." Typical comments were "very rewarding work;" "I want to give something back;" "this doesn't feel like work;" "I get paid to do this?" (referring to what feels like just a normal daily routine at home). However, one has to be careful that this does not result in voluntary overwork. Clearly a lot of staff "buy-in" is required and for the most part staff felt valued ("if treat staff well they will treat residents well").

Residents show many signs of positive engagement. During a fitness class, for example, "the atmosphere in the room was amazing — really jolly and lively, as people were having a great time." Residents enjoy a lot of independence and are free to wander and handle the many objects lying around. Many seem to enjoy the stimulating environment. The "star of the day" was implemented by a nurse: the chosen resident (each month) gets an assessment and care plan update, plus massage or nails done, pampering and special requests.

Families also feel involved and welcome at this long-term care home. Many family members remain volunteers after their family member dies. Family comments include “this is an oasis in a desert”; mother’s life “turned around — I never thought I’d see her like this”.

**PROMISING PRACTICES:**

- *Attention to relationships.*
- *Flexibility.*
- *Respecting residents’ views and engaging or attempting to engage them in decision-making processes.*
- *Promoting choice over day-to-day activities.*
- *Recognizing the importance of relatives and friends and engaging relatives in the day to day activities within the home.*
- *Privacy and the ability to come and go at will within the unit/area.*
- *Access to own bedroom at any time and locks on bedroom doors.*
- *A range of sitting areas — a quiet lounge, reminiscence area, television, garden, different eras of music.*
- *Differentiation between the corridors of the building to assist orientation.*
- *Appropriate activity and sensory stimulation.*
- *Opportunities to go out of the home.*
- *Design appropriate for people with dementia: sensory stimulation, picture cues for bedroom, toilet etc. Plain uncluttered floors, appropriate staff uniform.*

## UNITED STATES

### TEXAS: BIG CITY

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#### **PROMISING PRACTICES: HOME-LIKE FEEL, AND 'DISTRIBUTED LEADERSHIP'**

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*Hugh Armstrong*

Texas is perhaps an improbable site to encounter promising practices. According to an American advocacy organization, Families for Better Care, it ranks 51<sup>st</sup> or last among all the states and the District of Columbia. It fails on six of its eight criteria, concerning various measures of staff levels, as well as on inspections and verified complaints. It fares only slightly better on two measures of deficiencies. For the Executive Director of Families for Better Care, "Texas epitomizes what's dreadfully wrong with nursing home care and oversight in America".

If promising practices can be found in Texas, then they can be found anywhere. And our team did find them in a 60-bed skilled nursing facility in the Houston area. This facility is part of a non-profit continuing care retirement community (CCRC), in a large complex that also features independent living apartments and assisted living units. The latter include a 16-bed memory support or dementia unit for "low elopement risk" residents.

Together, the community's services provide integrated care for those who can afford it. Its skilled nursing facility accepts elderly Medicare recipients for short rehab (100 days or less) placements, but does not accept Medicaid recipients, who are generally poor and/or severely disabled and for whom public funding is poor, especially in Texas. The fees of most residents are covered by a private insurance scheme, are paid out-of-pocket or are met from a combination of sources.

The non-profit feature of the community is qualified by the fact that it was developed and its land and buildings owned by a for-profit firm

and it is managed by another for-profit firm, while a third such firm is responsible for its management payroll.

Within the skilled nursing facility are four, 14 or 16 bed units, two of which are locked, for “elopement risk” residents. These units have quite a home-like feel to them. The corridors are wide, with carpeting, ceiling pot lighting, and side rails that blend into the tasteful decor. At the end of each of the two corridors is a TV lounge that looks like a comfortable living room, with a couch and luxurious wooden end tables, desk and cabinet. There are no laundry bins in sight, as each unit has a washer/dryer room on the floor. Medication trolleys are made to look like tea trolleys. The nursing stations are recessed and largely out of view. Although regulations require the presence of a shower room or ‘spa’ on each unit, it is used for storage. Each large, single private room has its own fully equipped en-suite bathroom, as well as some furnishings brought in by the resident. Spouses of facility residents who live in independent or assisted living in the CCRC are welcome to visit at will, and to share meals with their partners.

A second promising practice exemplifies distributive leadership. This is an integral component of each of the facility manager’s job descriptions. In addition to responsibility for food and transport, building cleaning and maintenance, laundry, social work, activities, or an aspect of nursing care, each of the 12 managers is assigned on a rotational basis every few months to five residents. The managers are frequently to be found ‘on the floor’ as they spend time getting to know their assigned residents as individuals. They meet with their residents at least five times a week, and are required to document these meetings. They also report back to the brief meetings of all managers on any challenges and successes they learn about. (These weekday morning meetings concentrate, however, on ensuring that residents can continue to pay for their stays, whether by means of out-of-pocket, private insurance or in particular Medicare payments, with Medicare’s 100-day limit.) Managers report that this resident assignment activity is not just another duty, but a source of satisfaction as they advocate for and feel connected with specific residents and their concerns. To be effective, the system of course requires a large group of managers with sufficient time. Few of the 12 managers had responsibilities beyond the 60-bed skilled nursing facility.

**PROMISING PRACTICES:**

- *Home-like feel, calm atmosphere.*
- *Distributed leadership system.*
- *Unit size: 14 to 16 residents, all with single private rooms and en-suite bathrooms.*
- *Skilled nursing facility integrated with independent and assisted living.*
- *Resident council, with managers excluded except by invitation.*
- *Fruit, cheese, coffee, tea and water always readily available in unit lounges.*
- *Popular (male) activity facilitator, adept at nail polishing.*
- *Staff development supported and hiring from within practiced by management.*

## TEXAS: BIG CITY

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**PROMISING PRACTICE: THOUGHT FOR FOOD**

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*Tamara Daly and Ruth Lowndes*

Located in urban Texas, the care home is an affluent resort-style long-term care complex. The entrance of care home has a security station on one side, is flanked by imposing pillars, and opens to a circular staircase and a large lobby with marble and a fountain. Like many American facilities, it houses a continuum of residential care including independent living, assisted living with a memory unit, and two nursing units within the same complex. There is shared management and resources including its central kitchen. The thoughtful attention paid by the facility to food and dining constitutes a promising practice. Below, we detail the home-like layout of the dining spaces, the organization of the residents' dining experience, and the choice of food available to residents.

The complex is sub-divided into sections based on the level of care required, and the design of the dining spaces varies according to each of the sections. On the independent side, there are individual apartments with a private kitchen, living and sleeping facilities in each unit. For congregate dining, there is a casual bistro/bar dining room, an elegant dining room, an assisted living dining room, and a private dining room for eating with family and friends. If spouses or friends are in different levels of care, they can go to eat together in the various dining rooms in the complex. People can also order meals catered from the central kitchen, and during the holidays the congregate meals are more elaborate. In the nursing home part of the complex, there were 60 skilled nursing beds on two units. The dining rooms were small with intimate tables but the space was bright and welcoming. The main dining rooms all looked more restaurant-like, than institutional-style.

Within the assisted living "memory unit", attention had been paid to making the space appear less institutional and much more like a home environment. There were 16 private rooms located in a separate

locked area. The entrance opened into the dining space, which had an open-concept design. As in a high-end kitchen, the counters were granite. They were positioned at just above table height and behind the counter one could see tasteful kitchen cabinets, a stove and fridge. The tables were dining room style wood and the chairs were wood with fabric covered, comfortable seats. There was an outdoor walled garden space just to the left of the kitchen, and the dining space was flanked by sitting chairs.

Unlike in many long-term care homes with fixed and inflexible dining hours, mealtimes were spread over a significant period, allowing residents to talk and take time eating. Should someone miss a meal, or desire different food, there was an à la carte menu that sat outside of the dining space from which food could be ordered 24 hours per day; it included high quality selections such as steaks and other choice cuts of meats. The steaks reflected its Texas location. Food was served by wait staff in the dining rooms. In the memory unit, when the food arrived from the central kitchen, it was served from dishes placed along the top of the counter; staff portioned individual plates of food from the dishes, giving a family-like feel rather than that of an institutional buffet.

High quality food was shared across the community complex. All three meals were chef-prepared daily, with an executive chef in charge of the kitchen. The menu included a variety of foods such as fresh vegetables; in addition, fresh fruit was always available. There were snacks that remain out and available on each floor. On the memory unit there was a large closed pitcher with water. On the nursing side, there was hot coffee available from an urn. The fridge was also stocked with fruit juices and water, and staff and private companions were able to get drinks whenever they needed to. In addition, when visitors came to the complex, there was lemonade and cookies available in the front foyer. The memory unit had an old-fashioned looking popcorn cart that created a wonderful smell according to families. Residents could customize their own omelets periodically cooked on the units. Special holiday treats such as pumpkin pies were also baked on the units so residents could enjoy the aromas before eating. The quality of the food items was a reflection of the \$24 per day per resident food budget, which was about three times higher than it is in most Canadian

provinces. In terms of ensuring the quality, dietary staff walked around to check-in directly with residents to ensure their satisfaction.

As part of our observations in facilities, the researchers tour the kitchen, the store rooms, fridge and freezer, interview kitchen staff and management and taste the food. At the care home, we noted the selection and cuts of meats, fresh foods, and the variety of the ingredients that were used to make food from scratch. We peered into the ice cream cooler, watched a meal being made, and tasted the food in its regular, minced and purée format. At this site we were served what was on the menu for that evening: peppercorn steak. This was not a choice typically found on long-term care menus. Sampling the steak, we noted it was not overcooked, remained pinkish in the centre and was tender to chew. The potatoes were cooked from fresh potatoes, not powdered, and the red skins were incorporated into the minced and purée formats. The vegetables were not overcooked, were freshly cut, retained a slight crunch though steamed, and were served without oil. We found that the meal, in all its forms, was flavourful, appetizing and easy to swallow.

In short, the well-appointed and home-like dining spaces, the flexibility of the dining experience, the chef-created and prepared food, and the customizable dining choices make their approach to food one that deserves thought for other settings.

**PROMISING PRACTICES:**

- *Well-appointed, comfortable and very home-like, smaller size dining spaces.*
- *Slow and relaxed dining experience.*
- *On-site food preparation using high quality ingredients and food that tasted good in regular, minced and purée formats.*
- *Choice in dining options and the capacity to order food à la carte 24/7.*





# CONCLUSION: WHERE DO WE GO FROM HERE?

*Pat Armstrong*

Our visits to 25 long-term residential care homes in 10 different jurisdictions confirmed for us that it is necessary to begin by understanding that *care relationships* are central to treating residents, staff and families with dignity and respect. An emphasis on care relationships is especially important given that residents stay for months and even years. And our extensive research in those sites confirmed that there are ingredients essential to ensuring the conditions necessary to allow care relationships to be developed and maintained.

## **1. Promoting care as a relationship requires adequate staff and an appropriate staff mix.**

Over and over again in Canada especially we heard “there are not enough hands”. In Sweden we saw almost one staff member for each resident compared to one staff member for five residents in Canada. Staff had more time to respond, to take residents to the toilet and to help them eat, more time to chat and to sing. As a result, levels of violence and of drug use were significantly lower, providing just two indicators of how staffing levels influence workers and residents.

We saw many different ways of dividing up the work and did not come to any firm conclusions about which approaches worked well for whom under what conditions, but we saw plenty of evidence to support the conclusion that direct care staffing should be set at a minimum of 4.1 hours per resident per day. It should be noted, though, both

that these numbers are minimums and that they apply to direct care, thus excluding housekeeping and laundry, clerical and maintenance workers. If direct care hours are filled at the expense of these other workers, there may be an overall reduction in staff and an increase in workload for those who remain. Multiple studies have shown that staffing is lower in corporate-owned residences than it is in not-for-profit ones, indicating that ensuring adequate staff means removing profits from care.

## **2. Promoting care as a relationship requires a stable workforce.**

It is hard to form care relationships if workers constantly change as a result of a reliance on agency staff, and/or on casual and part-time variable staff. There is plenty of research showing that job security promotes worker health and that especially residents with dementia need to know those who are providing care. Residents and families told us they appreciate workers who have the opportunity to understand individual histories and workers find work more rewarding when they know the families as well as the residents. Moreover, teamwork is much easier when staff know each other and difficult when they never know who will be at work. Although for-profit strategies promote a flexible, just-in-time labour force, there are long-term costs in work absences and care quality. We saw places where managers worked hard to ensure stability, hiring most staff full-time, employing regular part-time staff and hiring from their part-time workforce when temporary needs for staff arise.

## **3. Promoting care as a relationship requires time, which is not the same as staffing levels.**

How care is distributed over time and what tasks are understood as necessary matters. In many places in North America, we saw too much time spent on paperwork, on reporting what has been done rather than on doing it. We witnessed workers sitting at meals not communicating with residents or helping them eat because they were required to fill out forms on how much the residents were drinking or eating. There was too little time to care, to respond, to talk, to find out about a person. Moreover, the time spent on paperwork that could

only be done by nurses in several Canadian jurisdictions reinforced hierarchies and took these nurses away from providing much needed direct care.

Conversely, in Norway and Germany we saw care providers sitting and talking at mealtimes, responding to individual needs. In North America, work tended to focus on clinical interventions, symbolized by medical carts blocking hallways and large signs saying "do not talk to the nurse distributing meds". By contrast, medications were kept in individual rooms in the places we visited in the U.K. and Sweden, nursing stations were removed and replaced by lounges and free meals encouraged workers to eat with residents without jeopardizing their break times.

We saw teams that included everyone from kitchen staff and receptionists to managers and nurse practitioners. In the U.K. and Manitoba places we visited, care providers stopped to respond, regardless of their status or scope of practice even if they then had to fetch a person with the appropriate skills. The RNs in the U.K. home helped with eating on more than one occasion and in Manitoba we saw the receptionist visit each resident every day. This flexibility reflected a focus on more social care and less on medical care. It required more autonomy for workers, as well as more time for care.

#### **4. Promoting care as a relationship requires standards, effectively enforced.**

There is a significant difference between standards and standardization. Standards establish principles, the basis on which individual care providers can make decisions in an equitable and evidence-informed manner. Standardization means one right way, ignoring the individual needs of residents and removing the right to decide from care providers. In Canada, we saw a move towards standardization with detailed rules governing how workers provide care. Residents, families and staff all complained about these rules. They reported that such standardization meant, for example, that diapers could be changed only when the blue line indicated saturation rather than when the resident wanted them changed or when the worker or family thought they should be changed. By contrast, in Germany, Sweden, and

Norway, governing bodies established principles and left their specific interpretation up to those in the nursing home. In all countries, we visited at least one home where we saw workers serving residents as much food as the resident wanted and as much as the worker understood as sufficient for that person; we saw dietary staff preparing food based on their contacts with local sources and their knowledge of resident preferences; we saw workers getting people up for breakfast when the resident woke up and the worker judged the timing was appropriate; and we saw workers stopping to chat or listen when they thought the resident needed support.

### **5. Promoting care as a relationship requires appropriate training and education.**

Training was an issue raised frequently by both staff and families who asked for more training for themselves. And we heard about the need for training that is relevant to developing care relationships, training that is not based primarily on a computer module, training that is a part of paid time involving face-to-face interactions, and training that is frequent enough to keep up with changing populations and demands. In one Ontario home, the woman newly hired to work in recreation found she had to help residents eat and was told to watch a video because she had no training for this work. She said all the video did was scare her about feeding people rather than providing the skills necessary to make eating not only enjoyable but also safe.

Manitoba provided a more positive example. The home we visited provides training that includes staff members experiencing a lift and being bathed by others. A care worker we interviewed talked about how vulnerable he felt being bathed, even though they let him wear a bathing suit. The experience taught him to understand what vulnerability feels like, something he could not understand from the videos that are so often used as a substitute for other forms of education. And in Norway we saw workers teaching others language skills to help immigrants understand local meanings, a process that promoted solidarity, built on workers' skills and helped ensure appropriate communication.

## **6. Promoting care as a relationship requires appropriate working conditions.**

Our project assumes that the *conditions of work are the conditions of care* and our research confirmed this assumption. Worker after worker in Canada told us that their training was not useful if the conditions did not allow them to use their judgements or if conditions did not allow them time to provide the care their training taught them was correct.

Conditions also had a more direct influence on the health of both workers and residents. The workers we talked to in the U.S. had no union protection, no paid sick leave, earned minimum wages and had no pensions at their workplace. The result was workers went to work sick, became sicker, too often shared their illness with the vulnerable residents and too often continued working well past age 65, even though the work is physically and mentally demanding.

In the U.K., we talked with workers who were on zero hours contracts, meaning they had no guarantee of minimum hours or indeed of any work at all, creating high turnover and little continuity in care. Workers in Sweden and Norway were much better paid in comparison, had more autonomy in decision-making, had pensions and sick leave as well as a more stable workforce. Even in these countries, there is significant room for improvement. When we asked a Human Resources manager in Norway what she would change if she were in charge, she said she would pay the women working in nursing homes what the men working in the oil rigs are paid because these women work at least as hard under conditions that are at least as bad. Like the approaches to continuity and standards, ensuring decent working conditions requires government intervention and public support.

## **7. Promoting care as a relationship requires an integrated system.**

Our system is fragmented not only across Canada but also within Canada. The fragmentation is promoted not only by the division of responsibility for health care among the federal, provincial, local governments and individuals but also by privatization that promotes contracting out and corporate ownership. In British Columbia (B.C.),

we were told the provincial government promoted the contracting-out of services. A housekeeper told us she had lots of interaction with residents in one area, interactions which were rewarding for her and the residents. But when the work was contracted-out, she was required to focus on a few tasks done throughout the home and told not to waste time talking with residents. This company had just lost the contract and she worried that she would either lose her job or be moved elsewhere. In the same home, large signs said "do not talk to the dietary staff", who were employees of a large, international corporation and always pressured to work faster to get the job done with minimal staff.

Homes were also often physically as well as bureaucratically separated from other health care services and public facilities. By contrast, a Norwegian home was physically part of the building that housed a day care and an arts program, the town cinema, a climbing wall and a cafeteria. Residents and workers could visit all these places "with their indoor shoes" and those using these services could visit residents. Workers in the nursing home moved back and forth between homecare and nursing home work, providing continuity for those needing care and variety for workers as well as ensuring care relationships.

### **8. Promoting care as a relationship means tolerating some risks.**

In our research, we have become increasingly convinced it is important to take some risks rather than focus solely on safety. In one Canadian site we saw those being admitted to the nursing home, put directly in wheelchairs to ensure they would not fall. As a result, they quickly end up being unable to walk. A nurse told us this was required because there were not enough staff to support residents walking and any falls meant penalties for the nursing home. In Germany, in contrast, the first thing we saw was a woman with dementia competently cutting onions, getting advice from other residents. This contrasts with a Canadian site which does not provide soya sauce because salt is a hazard, even though half the population is Asian and has been eating soya for more than 80 years. As Dr. Gwande makes clear in his book *Being Mortal*, it is important to support joy and it may come in the form of chocolate ice cream more than once a day. Such joy can give pleasure to both workers and residents. And avoiding all risk is not only impossible. It is boring.

In sum, we saw alternatives big and small but all require some basic ingredients. They all require public intervention and an end to privatization in all its forms, and they all pivot on the concept of care as a relationship that can be fostered and supported between well-trained, well-supported staff and residents, or lost in a sea of paperwork and restrictions.





## **ADDITIONAL RESOURCES**

**AdvantAge Ontario**

<https://www.advantageontario.ca>

**Advocacy Centre for the Elderly**

<http://www.advocacycentreelderly.org>

**Alzheimer Society of Canada**

<https://www.alzheimer.ca/en>

**Canadian Association on Gerontology**

<https://cagacg.ca>

**Canadian Centre for Policy Alternatives**

<https://www.policyalternatives.ca>

**Canadian Federation of Nurses Unions**

<https://www.nursesunions.ca>

**Canadian Frailty Network**

<https://www.cfn-nce.ca>

**Canadian Health Coalition**

<http://healthcoalition.ca>

**Canadian Institute for Health Information**

<https://www.cihi.ca/en>

**Canadian Union of Public Employees**

<https://cupe.ca>

**Canadian Women's Health Network**

<http://www.cwhn.ca>

**Centre for Ageing Research and Development in Ireland**

<https://www.cardi.ie>

**Concerned Friends of Ontario Citizens in Care Facilities**

<https://www.concernedfriends.ca>

**Council on Aging of Ottawa**

<https://www.coaottawa.ca>

**Gilbrea Centre for Studies in Aging**

<https://gilbrea.mcmaster.ca>

**Health Quality Ontario: Quality Improvement in Long-Term Care**

<https://www.hqontario.ca/Quality-Improvement/Quality-Improvement-in-Action/quality-improvement-in-long-term-care>

**Institute on Aging & Lifelong Health**

<https://www.uvic.ca/research/centres/aging>

**Institute for Life Course & Aging**

<http://www.grandparentfamily.com>

**Institute for Research on Public Policy: Faces of Aging**

<https://irpp.org/research/faces-of-aging>

**International Federation on Ageing**

<https://www.ifa-fiv.org>

**McMaster Optimal Aging Portal**

<https://www.mcmasteroptimalaging.org>

**National Initiative for the Care of the Elderly**

<http://www.nicenet.ca>

**National Institute on Ageing**

<https://www.nia-ryerson.ca>

**National Institute on Aging**

<https://www.nia.nih.gov>

**National Union of Public & General Employees**

<https://nupge.ca>

**New Dynamics of Ageing**

<http://www.newdynamics.group.shef.ac.uk>

**Nova Scotia Centre on Aging**

<https://www.msvu.ca/en/home/research/chairs/centresandinstitutes/centreonaging/default.aspx>

**Older Women's Network (Ontario)**

<http://olderwomensnetwork.org>

**Ontario Health Coalition**

<https://www.ontariohealthcoalition.ca>

**Ontario Long Term Care Association**

<https://www.oltca.com/OLTCA>

**Ontario Nurses Association**

<https://www.ona.org>

**Parkland Institute**

<https://parklandinstitute.ca>

**Quality Palliative Care in Long Term Care**

<http://www.palliativealliance.ca>

**Re-imagining Long-term Residential Care: An international study of promising practices**

<http://reltc.apps01.yorku.ca>

**Research Institute for Aging**

<https://the-ria.ca>

**Service Employees International Union Healthcare**

<https://seiuhealthcare.ca>

**Statistics Canada**

<https://www.statcan.gc.ca>

**Toronto Long-Term Care Homes**

<https://www.toronto.ca/community-people/housing-shelter/long-term-care-homes>

**Trent Centre for Aging and Society**

<https://www.trentu.ca/aging>

**Unifor**

<https://www.unifor.org>

**Wellesley Institute**

<https://www.wellesleyinstitute.com>

**York University Centre for Aging Research and Education**

<http://yucare.info.yorku.ca>

***Promising Practices in Long-term Care: Ideas Worth Sharing***

reports on the findings of an international team of 26 researchers and more than 50 graduate students who went to six countries in a search for promising practices in long-term residential care for the elderly. The book presents concrete examples of how long-term care might be organized and undertaken in more promising ways that respect the needs of residents, families, workers and managers. The book also presents statistical data that confirm that Canada can afford the same promising care found in other countries. In short, the book provides ideas on how we might re-imagine long-term care in promising and hopeful ways.

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