Relational Care and Long-Term Care Home Transitions: Enabling and Constraining Practices

Martha Cope

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Abstract

Care planning in long-term residential care is currently determined mostly by institutional practices whereby decisions about staffing, care delivery, and accountability are made using traditional biomedically focused models. These structures also reflect the influences of neoliberal health care reforms, which began to dominate health care delivery and practices starting in the mid-1990s, creating tensions for nurses between quality of care and the corporatization of health care. A consequence is that long-term care (LTC) care planning and delivery does not emphasize relationships between residents, their family members, and staff as much as it does the biomedical (physical, clinical) aspects of care. Highlighting “care as a relationship” promotes the uniqueness of individuals. The concern, then, is that relational care (also referred to as *relationship-centered care* or *relationship-focused care*) is not being enabled for staff, families, and residents, particularly during transitions.

Person-centered (resident-centered) initiatives in LTC have been underway for many years with the intent to improve quality of life and care of residents. In spite of this person-centered notion, long-term residential care homes (LTCHs) are challenged to deliver care that is relational. Transitioning into LTC has been shown to be a stressful and uncertain time for residents and families and a demanding time for staff. Current research lacks experiential data from residents themselves and also about how staff experience this process. Therefore, looking more closely at the specific ways that residents, families, and staff experience transitions will aid in identifying what is currently happening in this area and what could make it better.

A qualitative case study design, using purposeful sampling with semi-structured interviews, was used to gather data from various stakeholders in one LTCH. In this thesis I use a critical paradigm and feminist political economy approach to explore what residents, families,

and staff identify as the current challenges during transitions into LTC and what would improve this process to further reinforce care as a relationship.

This research will contribute to nursing by acknowledging the importance of the nexus of relationships involved in LTCHs and how relational care can offer constructive strategies to address the tensions involved in care quality, accountability, and work conditions so often experienced during transitions.

Dedication

I dedicate this thesis first to my husband, who has not only put up with me during this process but provided unwavering support every page along the way. I could not have achieved this goal without your love and encouragement. Next, I must thank my children, Quinn, Mimi, Rilynn, and Ruby, who love seeing me reach my goals and live my best life. Lastly, to my mom, dad, sister Melissa, and close friend Connie: I cannot comprehend putting all the hours into this without you holding up the fort, it truly does take a village.

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Chapter One: Introduction

Ontarians have been shocked by long-term residential care home (LTCH) horror stories as of late. In Ottawa, a woman was found with maggots in a festering wound (Ottawa Citizen Editorial Board, 2016). Elsewhere, three brothers have launched a lawsuit after their mother died, allegedly falling through a sling that had been used to transfer her back to bed (Ottawa Citizen Editorial Board, 2016). These events, and others, continue to raise questions about LTCH and the care of their residents.

When the Liberals came to power in Ontario in 2003, it was amid reports of increased violence happening in LTCHs and calls to address understaffing in long-term care (LTC) (Helvick, 2016). For example, the inquest into the killing of two residents at the hands of another resident at Casa Verde Nursing Home in Toronto in 2001 led to 85 recommendations to improve LTC (CBC News, 2005). Government response has been to create new rules and regulations, captured in the revising of the *Long-Term Care Homes Act* in 2007 (effective in 2010) plus increased oversight of facilities that offer nursing home beds (Ministry of Health and Long-Term Care [MOHLTC], 2012). According to the Ontario Long-Term Care Association (OLTCA) (2018), older adults are moving into LTC when they are older, more frail, and requiring complex care, and over half of those living in LTC (64%) have some form of dementia or Alzheimer's disease (OLTCA, 2018). LTCHs, also referred to as nursing homes or long-term care homes, provide care services for both acute and chronic conditions for residents with varying degrees of cognitive and physical impairments on a 24 hour basis, thus distinguishing them from retirement homes or assisted living facilities (Banerjee et al., 2012).

Long-Term Care Homes

Canada-wide, a majority of seniors (aged 65 or older) living in residential care homes have a diagnosis of dementia, making planning and caring for this growing cohort a high priority from both a financial and social perspective (Canadian Institute for Health Information [CIHI], 2010). Today, 564,000 Canadians are living with dementia, with projections placing this number at 937,000 in the next 15 years (Alzheimer Society Canada, 2018).

The needs of residents in LTC are becoming more intensive in terms of workload and support, with one in three “highly or entirely dependent” on staff for such things as toilet use and personal hygiene (OLTCA, 2018). Since 2008, and in response to these trends, the Alzheimer Society of Canada (2017) has highlighted the importance of person-centred/resident-centred care through the “culture change initiative” for those living with dementia in LTC. The goal of this culture change initiative is to promote relationships and partnerships via person-centred care in order to improve the quality of life and care of residents living with dementia in LTC. In spite of this person-centred approach and the priority on relationships, many argue that the system has instead turned toward more measurable, standardized, and clinically focused approaches to care. Furthermore, there are growing critiques linking these latter approaches to neoliberal assumptions that actually devalue the relational aspects of care (Adams & Nelson, 2009; Banerjee & Armstrong, 2015).

The focus in caring for Ontario’s older population should be on the levels of care required and the mix of care providers available in LTC. In fact, in the US, current recommendations concerning minimum nursing and personal time allotted per resident for care have been increased to 4.1 hours, reflecting growing acuity levels in this sector (Harrington, Schnelle, McGregor, & Simmons, 2016). The consequence of minimums is that they are just that, minimums. They do not address the resources (staffing and programs) required to facilitate meaningful relationships between care providers, residents, and families that go beyond "hands-on" care (Greenwood, Loeventhal, & Rose, 2001). Highlighting care as a relationship promotes the support, inclusivity, and personhood missed in an otherwise task-oriented LTC system (Latchem & Kitzinger, 2015). Indeed, according to the College of Nurses of Ontario's (CNO) *Ethics Practice Standard* (2009), it is a nurse's obligation to establish and maintain these types of meaningful relationships in order to meet the needs, and promote the health, of each client (CNO, 2009).

Currently, LTCHs work in a way that can depersonalize residents and impose inflexible routines, disregarding the uniqueness of residents' and families' lived experiences (Banerjee & Armstrong, 2015; Reed & Payton, 1997). The concept of personhood, which is a product of being in relationship with others, places residents at the centre of individualized care that promotes advocacy, autonomy, and staff and family involvement (Chenoweth et al., 2009; Reed & Payton, 1997). This type of care can be nurtured when partnerships are valued and respected, creating strong ties and mutually beneficial relationships between staff, residents and families (Chenoweth et al., 2009).

When LTCHs comply only with government regulatory requirements, nursing priorities and interventions are often focused on measuring clinical outcomes. This quantifiable measuring is in stark contrast to the ideals of resident-centred care, rooted in a person-centred approach that the RNAO and the Alzheimer Society of Canada recommend as a central tenet of LTC delivery (Alzheimer Society of Canada, 2017; McGilton et al., 2012; RNAO, 2008). These ideals include respecting and acknowledging that residents are the experts of their own lives, empowering residents to advocate and make decision for themselves, and putting residents at the centre of their own care (RNAO, 2008). The challenge for LTCHs is to apply the ideals of resident-centred care, within a standardized regulated structure and create care delivery models that residents, families and staff recognize and experience as relational.

Neoliberal Context

In Canada, neoliberalism has become a dominant force, narrowing the discourse of social, economic, and political debates and changing how we define rights, privilege, and service (Stanford, 2014). As these social and historical contexts fluctuate over time, within and among varying populations, neoliberalism leads to transformation and change in a process rife with tensions, resistance, and struggle, often with contradictory and competing interests (Coburn, 2001).

Neoliberalism is not specific to Canada but is a global phenomenon, an ideology and policy model for how best to structure economies (Smith, 2017). This section focuses on the Canadian reforms which reflect specific interests that have, over the past several decades, guided health care reform and the development of policies that prioritize profits and cost efficiencies. Reform changes began in Canada under the federal and provincial governments starting in the late 1980s and continued to gain momentum and strength under the Harper government, which since 2006, has overhauled social and health programs for Canadians using market-led economic and social restructuring (Dunlop, 2006).

These reforms include a strong focus on cost savings “above all else” through the development, use, and implementation of so-called efficiencies and innovations. These include applying market-based solutions to social problems, encouraging public-private partnerships and privatization (Dunlop, 2006). LTC, primarily a provincial responsibility, reflects upstream neoliberal forces in the approaches to funding, structuring, and organizing care, including an increased reliance on a casual workforce, privatization, and regulatory oversight (Daly, 2015; RNAO, 2018a; Williams, Barnsley, Leggat, Deber, & Baranek, 1999).

Under neoliberal influences, care is measured and tracked with far-reaching consequences for both receivers and providers of care. For-profit approaches shift the health care focus from an emphasis on human rights and equity to one of cost-containment and efficacy (Berta, Laporte, & Wodchis, 2014). Care commodification under a market-based regime equates quality and efficiency with health care practices that are standardized, observed, measured, and counted. A basic assumption of neoliberalism is that markets reflect the best and most efficient allocation of resources and within health care the effect has been to prioritize cost savings in care delivery (Coburn, 2001).

Relational Care

In contrast to a neoliberal approach, what some have identified as a philosophy of “relational care” also known as “relationship-centred care” assists in fostering the creation and development of care within LTCHs that focuses on the individualized care needs of both residents and their families (Latchem & Kitzinger, 2015). When a LTCH incorporates a relational care approach, responding to a resident’s and family’s needs goes beyond the instrumental interactions of institutionalized care to include personal preferences, values and beliefs, directly linking relationships with quality care (Latchem & Kitzinger, 2015). Although relational care is not a fix-all for current problems in LTC, there is evidence from research and nursing professional associations that there is a better chance of improving the landscape within LTC when relationship-centred care is supported, funded, and prioritized (Alzheimer Society Canada, 2017; Banerjee & Armstrong, 2015; McGilton et al., 2012; RNAO, 2008).

Those who work in LTC play a pivotal role in caring for residents and interacting with their families. In Ontario, personal support workers (PSWs) provide almost all of the direct physical care of residents, while Registered Practical Nurses (RPNs) and Registered Nurses (RNs) administer daily medications, perform wound care and assessments, and document that care.[1] Depending on the LTCH, on a day-to-day basis the RN may have very limited interactions with residents and family members, instead processing orders, updating care plans, and ensuring ministry documentation standards are met. The role of health care professionals (HCPs) in LTC is extremely structured and tends to be more task-oriented. This means the allocation of tasks is divided among staff on the basis of education, skill, or job classification (Syed et al., 2016). RNs, RPNs and PSWs may also develop strong relationships with residents and families in the course of their repeated interactions, but what is being highlighted here is that the time spent outside of task-based care (toileting, feeding, transferring) is just as valuable (in terms of funding and planning) as hands-on care.

A problem that has been identified in the research on those working in the long-term care sector is that as policies (such as the *LTCH Act* [2007]) continue to influence care using biomedical and market-based approaches, new residents and their families often end up being left out of the care planning process, with limited or no platform to express and share their needs (Banerjee & Armstrong, 2015; Doleweerd & Berezny, 2009; Eika, Espnes & Hvalvik, 2014; Levine & Feinberg, 2012). This, in turn, reduces the opportunity for staff to engage with residents and family members in a way that prioritizes getting to know one another.

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[1] The Ontario health care system refers to Registered Practical Nurse (RPN) while in other provinces the term Licensed Practical Nurse (LPN) is used.

Soklaridis, Ravitz, Nevo, and Lieff (2016) conducted a 20-year scoping review looking at relationship-centred care in health care and concluded that it is important as a framework toward improving processes and outcomes of health care. Relationship-centred care has many definitions, but at its core has a focus on the central role of relationships between and among practitioners and their patients, clients or residents (dependent on setting), the community, family, and other practitioners in providing quality care and improving health outcomes (Soklaridis et al., 2016). It is founded on four main principles:

1) That relationships in health care ought to include the personhood of the participants,
2) That affect and emotion are important components of these relationships,
3) That all health care relationships occur in the context of reciprocal influence, and
4) That the formation and maintenance of genuine relationships in health care is morally valuable (Beach & Inui, 2006, S3).

These four principles of relationship-centred care encompass the ideals of relational care in that they centre around the uniqueness of each individual while maintaining a focus on the building and maintaining of reciprocal, caring relationships between staff, residents, and family members.

Transitions

For some, a move into LTC is one of the most feared transitions in their lifetime. Transitions into LTC are critical times to focus on the relations of care; problems often occur as new residents and families are anxious about the unknown, and staff members have to facilitate the move-in process during an already busy day. Transitions (crisis or non-crisis) from home (with or without home care), assisted living, or another institution (another LTCH or hospital) is the primary type of transition into LTC that is the focus of this thesis, because there are many other types of transitions as well (for example, to hospital and back again). Crisis placements into LTC are initiated by the Local Health Integration Network (LHIN) case manager if the living arrangement or condition of the resident poses significant risk to the health and safety of the individual.

In Ontario, the process of moving into LTC used to start with a family member or by residents themselves calling their local Community Care Access Centre (CCAC). These centralized services were responsible for all LTCH wait lists and placements in Ontario. This service was restructured in 2016 under Ontario's *Patients First Act* in order to provide a more integrated health care model (MOHLTC, 2017). As a result, CCACs and the services they provide now come under the umbrella of LHINs. Prior to this Act, the LHINs were responsible for regional administration of public health care services and distributing provincial funding to the CCACs (MOHLTC, 2017).

In spite of these service changes, the process of transitioning into a LTC bed remains basically the same: Once a bed offer has been made from any of the (up to) five homes a person is allowed to apply to, the potential resident and their family have 1 day (24 hours) to accept or reject the bed offer. If the person accepts the offer, they have up to 5 days to move in (Government of Ontario, 2018). If they reject the offer, they are taken off all LTCH wait lists and must wait 12 weeks before reapplying (or if the person's health status changes before the 12 weeks is over) (Government of Ontario, 2018). This type of timeline invariably aligns itself with terms such as *rushed* and *pressured*, even when a move into LTC is planned and anticipated. In turn, transitioning into LTC starts from a place of hurried preparation and rapid planning by new residents and their families.

Transitions as just described are occurring at the same time as the discourse of resident-centred care is growing, creating tensions in how staff as well as residents and their families experience transitions. The ideals of resident-centred care in LTC (aligned with person-centred care), which promote care as a relationship and centre around the resident as the expert in their own lives, occur within a system caring for more, and more higher-needs residents without a corresponding increase in institutional support (RNAO, 2018b). Looking at nursing transitional research and accounting for current reform directions, including recent regulatory initiatives, the question remains: What is occurring during transitions and what could make it better?

Long-Term Care Homes and Neoliberal Tensions

It is important to explore LTC transitions within a subtext of care quality. It is also important to understand that the move toward standardized, measurable indicators as the road to quality reflects growing neoliberal influences. Over the past three decades, these neoliberal reforms have encouraged the linking of care quality to cost savings, achieved through the careful documenting and reporting of measurable indicators. This focus has challenged the ability of nurses and other care providers to create meaningful relationships with both residents and families (Choiniere, 2011). The literature suggests that this drive (from the organization to meet imposed Ministry standards) to promote care standardization can create tension between the priorities of the administrators within the organization and LTC staff, residents, and families (Adams & Nelson, 2009; Choiniere, 2011; Rockwell, 2012).

These neoliberal forces that influence Ontario LTC can also be understood as reflecting the corporatization of health care. Regardless of whether the LTCH is for-profit or not-for-profit, efficiency and cost savings and adopting business-like management approaches are priorities (Banerjee & Armstrong, 2015). Since 2005, administrators in LTCHs in Ontario have had to justify funding levels by documenting and reporting on a growing number of resident clinical indicators using the Resident Assessment Instrument-Minimum Data Set (RAI-MDS) (Burns, 2007). The argument made by those who support regulating the assessment and recording of these detailed indicators is that it will not only improve the quality of care but also be more efficiently managed. As a result of RAI-MDS implementation, LTCHs are reimbursed according to resident acuity levels, physical care, and medical treatment indicators, giving them a higher priority (financially) than relational care aspects (Choiniere, MacDonnell, & Shamonda, 2010; Rockwell, 2012). This shift in focus toward medical care or clinical needs, over care that is rooted in relationships, also reflects gendered assumptions, with nursing and “caring” devalued and seen as primarily women’s work. These assumptions ignore the critical and vital nature of nursing knowledge amidst what critical researchers have identified as an often overarching paternalistic biomedical context in health care (Adams & Nelson, 2009).

Staffing models in LTCHs have also been influenced by neoliberal forces, evident in 1996 when the Harris government set about removing regulations setting minimum standards for staffing and other quality standards, and creating a fragmented system whereby some aspects of RN practice have become highly standardized (Braedley & Martel, 2015). What does this look like in today’s LTC climate? Despite RNs’ professional commitments to focus on client-centred care and developing therapeutic relationships, the main focus of RN work in LTC has strayed into more administrative roles. These activities can be understood as a regulatory push for standardized reporting to provide very detailed facets of resident care in the face of an intense compliance and enforcement system (Braedley & Martel, 2015; Choiniere, 2011).

Research that uses a critical lens is valuable to examine dynamics of power such as neoliberal influences related to groups or individuals. A critical feminist approach is important to highlight gender dynamics and how this impacts inequality and discrimination. A feminist political economy (FPE) perspective critiques the intersection between market forces and gender to focus on division of labour, societal organization, and provision of services (Riley, 2008).

In summary, based on the literature review that I have undertaken, detailed in Chapter 2, it is clear that reforms have contributed to LTC delivery models that often overlook care as a relationship, ignoring the time and resources it takes to build and maintain relationships among staff, families, and residents. Given the current gap in the literature regarding relational care, transitions in this thesis are used as a mirror to critique market-based reform and current dominant neoliberal assumptions, which continue to shape the conditions of work and care in LTC (Choiniere, 2011). Thus I will undertake a qualitative exploratory study to examine transitions into LTC in Ontario using a critical FPE lens. The purpose of this research is to explore and understand how transitions are experienced by staff, family, and residents, and how these experiences are rooted in institutional, organizational, and financial tensions. As an RN myself, and having experience working in multiple LTCHs, I feel compelled to explore what is happening in Canadian LTC, to add to the body of research critiquing constraining forces in LTC and identify promising practices to make it better. The study design chosen is a case study design with multiple sets of data points. This particular qualitative study is important for nursing because it adds to the body of literature that recognizes the importance of relational care and also highlights that more research is needed to understand what support nurses and other care providers need in terms of time and staffing in order to take part and engage others in creating relationships.

Chapter 2: Literature Review—Transitions

In this chapter, I detail the relevant literature on LTC-related transitions that provides a rationale for undertaking this study. This includes presenting a thorough review of transitions research, highlighting key contributions and findings. I also identify gaps in the literature and how my study addresses these gaps. For this review, I examined sociological, nursing, and health policy research on LTC from an international and national perspective, then focused more specifically on transitions. My research on transitions included Canadian, US, and European studies using qualitative, case study, and ethnographic designs. FPE research in LTC highlights a gendered approach to care and how this is exacerbated by neoliberal social and economic forces. Research in LTC using FPE as a theoretical approach is extensive and critiques the hierarchical structures and regulatory policies that influence care and care work in LTC (Adams & Nelson, 2009; Armstrong et al., 2012; Brassolotto, Daly, Armstrong, & Naidoo, 2017; Choiniere, 2011; Lowndes, Daly, & Armstrong, 2018). The importance of this body of work is to point out the intersections between the broader context of market forces and who provides care, how care work is valued (or devalued), and the conditions of work.

Armstrong, Armstrong, and Choiniere (2015) highlight the fundamental importance of care as a relationship and the advantages of care continuity for older adults' health and safety, including the need for a stable and adequate health care workforce and an integrated health care system with appropriate working conditions. In the LTC sector, these recommendations challenge care delivery priorities and address the tensions between biomedical (focused on biological factors leading current health care delivery), mechanistic (a person being viewed as consisting of separate systems, each treated separately), and reductionistic (narrowing or ignoring the complexity of social and biological processes) approaches on the one hand and relational care on the other hand (Armstrong et al., 2015). Tensions such as those described above have led to workload increases, unsustainable work intensification, and worker injuries in LTC, as care for older adults is more intense than ever, with no extra resources available to support these additional care needs (Choiniere, 2011; Choiniere et al., 2010). These forces and tensions can be very relevant to the process of transitions. Of particular interest is how staff workload and intensity are impacted when a new resident is moved into LTC, and how families and new residents experience the transition.

A Canadian study looked at the usefulness of training LTCH caregivers using a person-centred care model called "relationship-based care" (RBC) and how RBC learning was implemented and retained by staff (Viau-Guay et al., 2013). Study participants reported that RBC was generally helpful, with their support based on the RBC values of dignity and maintaining autonomy, which were consistent with staff members' personal and professional identities (Viau-Guay et al., 2013). Although this study did not look at transitions in particular, the findings suggest that in order to change care practices in a sustainable way, the approach to care (in this study RBC) must be consistent with the needs and preferences of both staff and residents while being supported by flexibility within the organization (Viau-Guay et al., 2013).

A philosophical foundation of nursing is meeting the needs of patients and their families through meaningful and empowering relationships (RNAO, 2015). Person- and family-centred care reflects this philosophy, its goal being to create partnerships in care and recognize the impact and importance of those partnerships. The RNAO recognizes the importance and benefits of such partnerships, as evidenced in their move to replace the Best Practice Guideline *Client-Centred Care* (RNAO, 2006) with *Person- and Family-Centred Care*, in 2015. This new guideline focuses on creating relationships with people and their families, inviting them to be active participants in care while respecting their autonomy and decision-making (RNAO, 2015).

Currently, LTCH policies espouse a resident-centred care philosophy, with clients having a right to self-determination and to having their values and preferences supported (Rockwell, 2012). Yet, resident-centred care in LTC is argued to be disconnected from what the resident actually wants or requests (Rockwell, 2012). Current research has found that residents' quality-of-life indicators, such as autonomy and personal choice, may suffer from disempowering processes in which one's voice is either ignored or hushed by LTC staff and management (Boisaubin, Chu, & Catalano, 2007; Iris, DeBacker, Benner, Hammerman, & Ridings, 2012; Wulff et al., 2013). Often, residents cannot communicate effectively due to illness, necessitating even more specialized advocates (family or resident representatives) who have an ongoing relationship with the resident and who can speak on their behalf. In a systematic review, Graneheim, Johansson, and Lindgren (2014) found that family caregivers have unique and important life-story knowledge about their family members who are suffering from dementia. Furthermore, their findings suggest that this information should be acknowledged in care planning activities in LTC.

Difficulties arise when care and the relations of care are not given priority, with care reduced to functional processes and tasks (Greenwood et al., 2001). This translates into interactions between staff and residents that are primarily task focused, without any time dedicated to growing relationships. Studies show that this disparity between residents' needs (the need to be loved, cared for, in relationship with others) and available resources (time, skill, and space) are tied to the push for efficiency, and the "deskilling" of staff, including the removal of the RN to administrative duties (Choiniere, 2011).

While McGilton and Boscart (2007) did not specifically explore LTC-related transitions, they analyzed the perceptions of residents, family members, and care providers in LTC with regard to close resident–care provider relationships. They found that although all groups spoke of the need for connectedness in LTC, inadequate staffing and workload were barriers to care providers being able to create time for meaningful one-on-one relationships (McGilton & Boscart, 2007). With the large number of persons in LTC suffering from some form of cognitive impairment, relationships take even more time to develop between staff and residents.

A Canada-wide study by Kehyayan, Hirdes, Tyas, and Stolee (2015) used a survey measuring self-reported quality-of-life indicators for residents with mild to moderate cognitive impairment. According to this survey, only 59% of respondents reported that the LTCH felt like home, even when most homes adopted a resident-centred care philosophy (Kehyayan et al., 2015). Further results showed that only 35% responded positively to having a bath or shower as often as they wanted (Kehyayan et al., 2015). These findings suggest that gaps continue in translating well-intended philosophies of care into practice. While quality care is a goal in LTC, many residents still do not experience it (Edelman, Fulton, Kuhn, & Chang, 2005). This disconnect is argued to be strengthened by neoliberal forces in health care, including the assumption that what is closely "managed" is of better quality. The impact of these forces is a turn toward increased standardization (and a turning away from individualized and relationship-based care), which is also reflected in the classifying and standardizing of care (Rankin & Campbell, 2009).

The RAI-MDS, a tool developed by interRAI, a not-for-profit international research network, is designed to collect the minimum amount of data (about a resident) to guide care planning and monitoring of older adults living in LTCHs (Hutchinson et al., 2010). It is a tool in widespread use in Canada and internationally. In Ontario, this tool generates data that policymakers and service providers can use to determine resource requirements and the particular needs of persons living in LTC (Glenny & Stolee, 2009). Over 300 items are captured using this tool, which creates performance scales on such things as activities of daily living (ADLs), cognitive impairment, and medical conditions (Glenny & Stolee, 2009). Both physical and psychosocial documentation in the RAI-MDS follows an assessment, care planning, and intervention workflow for staff, creating care plans that can be implemented and followed by staff. Standardizing psychosocial documentation in the RAI-MDS (emotional and psychological health or behaviours) bypasses the unique social and relational needs or outcomes of each resident (MOHLTC, 2012).

The research presented in this section provides background for understanding current LTC transitions as it highlights how regulatory oversight impacts care and care work in LTC, and how institutional challenges (staffing and time) limit opportunities for relational care between staff, residents, and family members. This section also shows that while the nursing profession has been engaged in relevant LTC research for some time, the literature on transitions is lacking. In the next section I present transitions research and how my qualitative transitions study adds to this body of work.

Transition Research

There are very few studies that focus on the perspective of the resident during transitions, an absence in the literature that further devalues an already vulnerable population. The importance of capturing events from residents' point of view was noted in Murphy, McCarthy, and Cornally's (2013) qualitative study exploring residents' perceptions of relocating from one LTCH to another (inter-institutional transition). The researchers found that workers could take a more person-centred approach in order to reduce the negative impact of transitioning. The researchers studied a "planned" inter-institutional relocation of 27 residents, looking closely at 8, and therefore did not capture the often short notice and hectic turnaround time for those awaiting LTC placement (often less than 5 days between a bed opening up in an LTCH and the new resident's move-in day).

Heliker and Scholler-Jaquish's (2006) interpretive study did include the perspective of the resident at 1 week post-transition and then again periodically during the next 3 months. This US study focused on the events that occurred after move-in day; the act of storytelling was proposed as a way to ease transitions and familiarize new residents with their surroundings (Heliker & Scholler-Jaquish, 2006). Although the authors identified the importance of sharing stories to co-create new meanings, they neglected to address the actual transition on move-in day and how that was experienced. Instead, the study focuses more on the process of how new residents settle in and deal with the loss of their homes. My study adds to this research by using the views and experiences of the residents themselves as important indicators of how well the current system meets the needs of residents during transitions into LTC, including those that are not planned or anticipated. My qualitative transitions study explores the events occurring on the day of transitioning as well as during the weeks and months thereafter. Such events include settling in and loss of independence, both of which are well represented in the literature.

Social work transitions research does not always adequately capture the voices of LTC nursing staff in a consistent way (Koenig, Lee, Macmillan, & Fields, 2014; Reuss, Dupuis, & Whitfield, 2005). For example, Koenig and colleagues (2014) looked at the perspectives of family members and older adults (same family), focusing on disagreements regarding the decision to move into assisted living. The authors describe transitions as a "process" (not a one-time event) taking place over many months in which social workers can be involved to ease the emotions and fear surrounding a decision to move into assisted living. This study helps promote the idea that the transitional process is more than just move-in day; it lasts for many days, weeks, and possibly months, and identifying ongoing support is important to a successful transition. Koenig et al. (2014) do not present specific social work interventions but rather recognize transitioning is a complex and unique process requiring further research. Although this study is US based, and large differences exist between the US system and Ontario's structure and funding, the notion of transition as a process is useful. Picking up on this view, my qualitative transitions study explores, with residents, family members, and staff, what would have improved the process of moving in, linking suggested practices to proposed policy reform and nursing implications in Ontario.

Reuss, Dupuis, and Whitfield (2005) researched how family members experience moving a loved one into LTC and how the facility can help ease this process. The authors in this Ontario-based study recommend that better preparation and support from facilities and community services (such as LHINs, which coordinate LTC placement in Ontario) could help ease the difficult aspects of moving a loved one into LTC. However, they recognize that in order to develop a more comprehensive model of the transition experience, older adults and staff should be included in the sample as well as family members. My qualitative transitions study addresses this gap in the literature by including all three key participants during a transition (family members, residents, and staff), in order to understand better how these experiences intersect within current LTC institutions and how facilities can respond to everyone's needs.

Outside of social work research, much of the transition research focuses on applying tools to avoid negative transitional outcomes. For example, considerable research has focused on quantifiable and measureable outcomes, based on communication sheets, medication reconciliation accuracy, and the lack of adverse clinical events (Caruso, Soe, & Brandeis, 2014; Gruneir et al., 2012; Herndon, Bones, Bradke, & Rutherford, 2013; McGilton et al., 2012; Swann, 2006). “Adverse clinical events” are measured and prioritized as physical and medical, such as medication errors, falls, and exacerbation of chronic illnesses, negating residents’ experiences of fear, discomfort, or disorientation. Yet considering the research on the “management” of transitions, very little is known about how residents and families transition, from their perspectives (Caruso et al., 2014; Gruneir et al., 2012; Herndon et al., 2013; Swann, 2006). My qualitative transitions research aims to look past the “tools” and tick-sheet questionnaires proposed by transitional research to explore how transitions are experienced and whether these experiences reflect a need for more information sharing to allow staff, residents, and families to get to know each other better.

Research has shown that transitions into and between LTCHs are often plagued by uncertainty, in part because of a lack of knowledge among incoming residents and their families, and inadequate information-sharing between facilities, but also because of ineffective psychosocial supports and resources to address the emotional transition that families and caregivers experience (Davies, 2005, Glasby, 2004; Glasby, Littlechild, & Pryce, 2006). As discussed previously, moving into LTC can take days, several weeks, or even months. This depends on the location of the LTCH, the health status of the resident, and bed availability. Shortfalls in transitional care have been linked to unmet expectations of family members and reduced satisfaction with care (Naylor, Kurtzman, & Pauly, 2009).

Even after the initial transition into LTC, older adults continue to experience multiple and simultaneous care transitions, such as to and from hospital, between other LTCHs, and internal transitions between rooms and floors. Research has shown that the majority of these transitions are deemed “unsuccessful” by residents and families and marked by inconsistent information for families and new residents during the move-in or transfer process. There is also a lack of support to address the psychological and emotional impact on families and new residents (Cummings et al., 2012; Doleweerd & Berezny, 2009; Kydd, 2008). My qualitative transitions study explores how inaccuracies and miscommunication can occur during transitions and considers how families and residents try to mitigate this lack of continuity during the few days and weeks of moving into a new LTCH. My study also adds to the literature by exploring the impact of uncertainty on the well-being of residents, staff members, and family members.

Boockvar and Burack (2007) looked at whether the effectiveness of management-level relationships between nursing homes and hospitals improved the transfer of care for older adults moving into LTC. They found no correlation between management relationships with hospitals and improved transition outcomes. Other research supports the finding that creating working relationships with hospitals or other LTCHs has no improved outcomes (such as communication or consistency of information) for older adults during transitions, as there is little trickle-down effect to front-line workers who actually coordinate the transfer process (Lester, Stefanacci, & Chen, 2009). Yet other research proposes that a re-engineering of staff and/or staffing mix for better transitions is more effective than cross-organizational coordination (Eika et al., 2014; Toles, Young, & Ouslander, 2012). Such staff changes include “up-staffing” (increasing the number of staff) on move-in day, or creating a transitions team or coordinator (Toles et al., 2012). If and how staffing levels are impacted and perpetuated by recent restructuring is explored in my research, with the intent of adding to current understanding of how relationships, beyond management and institutional, influence the transition process.

There is relatively little available information concerning the practices for staff, residents, and families to ease transitioning into an LTCH using a relational model of care. Much of the research exploring the experiences of family and residents during transitions uses mid-range theories and transition models to provide strategies for families that will help support residents as they move into LTC (Davies, 2005; Davies & Nolan, 2004; McNamara, 2011). Strategies include inviting family to be involved with staff, attend social events, being introduced to other residents and staff, and making sure the room is ready on move-in day (Davies, 2005). While important, these strategies are entirely dependent on individual homes to implement. The concern is that if, as the literature suggests, LTCHs are de-emphasizing relationships and focusing primarily on physical care tasks, other transition strategies will not be as successful as they could be.

In Ontario, there are no regulatory mandates instructing LTCHs how to handle transitions and/or the move-in process into their facility. What is regulated in Ontario is the admission assessment and documentation process, using the RAI-MDS to capture such things as clinical conditions and physical care needs. For example, an admission care plan must be completed and shared with the team within the first 24 hours of admission (completed by the nurse). Within 14 days the assessments must be performed for the “initial plan of care” and by day 21 the initial plan of care must be completed (MOHLTC, 2012).[2] In spite of the discourse of “culture change” and resident-centred/person-centred care, the literature suggests that this is not happening, which has prompted me to look more closely at what is actually happening during transitions (Boockvar & Burack, 2007; Caruso et al., 2014; Eika et al., 2014; Heliker & Scholler-Jaquish, 2006).

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[2] The admission care plan can include any number of documents, such as a Kardex, medication administration records, and bath or snack lists. Once created, the initial plan of care replaces the admission care plan and is based on interdisciplinary assessments of all specified care domains.

Levine and Feinberg (2012) used a person-plus family-centred approach to propose that families are not merely “informal caregivers” but vital “care partners” during transitions, as they are able to provide information, assistance, and support for their loved ones. Levine and Feinberg suggest that this approach shifts the power, control, and decision-making out of the hands of nurses and support staff and into the hands of residents and families. They also note that during transitions, family and residents considered interpersonal interactions, individualization, and flexibility as most important for quality and safety of care (Levine & Feinberg, 2012). While these findings are important in showing that the expectations and needs of residents and families are not the same as the priorities of the organization during transitions, they fail to address how this tension can be addressed within current LTC systems.

Transitions research encompasses work from a variety of disciplines using varied theoretical and study approaches. This section has highlighted current research on transitions, which, while limited, is expanding. Although some Canadian studies are underway, my study is part of a larger transitions study and research group and seeks to highlight the intersection of transitions and policy using FPE to critique what is currently happening in LTC. In the next section, I present my theoretical perspective. By applying a critical lens, I will highlight the tensions in LTC that have an impact on care work and care quality.

Chapter 3: Theoretical Perspective

A Feminist Political Economy Framework

FPE is a critical method of inquiry that has grown out of a feminist critique of shortcomings in the political economy approach to professions, institutions, and labour (Vosko, 2002). Early political economy analysis focused on inequality from a perspective of class within a formal "paid" work economy, institutional development within a for-profit sector, and power differences embedded in health care structures (Luxton, 2006). Women, like men, were drawn to political economy's class-based critiques and the challenge it offered to a "progress-as-profit" perspective (Armstrong, 2001, p. 124). Yet, there was considerable concern among feminists with the narrow political economy focus on the "formal economy" and how it did not include reproduction and other gender issues into its theory (Armstrong, 2001 p. 129).

Hence feminists felt compelled to develop a lens, albeit still critical, that included a gendered analysis of how men and women experience the world and how power structures (political, social, and economic) reflect the current tensions between the formal economy and unpaid care work (Armstrong, 2001, p. 131). The aim of this FPE perspective was to challenge and question conventional ways of framing issues in order to investigate how social relations are shaped by powerful interconnections between politics, economics, and ideology within gendered constructs (Vosko, 2002). This type of approach is useful for understanding how economic and political changes affect current events in Canadian health care as influenced by the rise of globalization and neo-liberalism in the mid- to late 20th century (Coburn, 2001).

FPE research in LTC suggests that policy ideals, such as creating "home-like settings" in LTC and the philosophy of resident-centred care, have not ensured respectful and equitable care for residents and working conditions for staff (Braedley & Martel, 2015). This is argued to be a result of highly structured routines in LTC, rigid division of labour among staff, and a focus on biomedical care, all of which create barriers for residents in being able to experience LTC as a home-like setting. Feminist political economists argue that instead of creating the opportunity for residents to make their own decisions about such things as when they bathe or what they eat, LTC regulations and policies restrict these decisions (Braedley & Martel, 2015). In terms of transitions, LTCHs use phrases like “we work in their home,” to communicate to staff, potential residents, and their families that the move into the LTCH will have the familiarity and feeling of home. Applying an FPE critique, the reality of what is possible in LTC is determined by forces (federal and provincial governments) outside of LTC institutions, which in turn create the conditions for managing care from a distance (Banerjee & Armstrong, 2015).

Braedley and Martel’s (2015) research goes on to suggest that old age care continues to be highly feminized work “associated with the unequal gendered division of labour that assigns domestic labour and familial and community caring to women” (p. 60). Feminist political economists argue that as this labour continues to be tied to a women’s biological instincts to care for and nurture others, it devalues not just the work but the predominantly female workforce in LTC (Braedley & Martel, 2015). One must look at the much broader historical landscape of medicine, which privileges a biomedical paternalistic model of care, in order to understand how gendered work is relegated to the bottom of the skills hierarchy (Braedley & Martel, 2015). When looking at transitions into LTC, research suggests that these disempowering hierarchical structures create work environments that are understaffed, stressful, and with heavy workloads (Armstrong et al., 2015; Canadian Federation of Nurses Unions [CFNU], 2017).

Lowndes, Daly, and Armstrong (2018) used an FPE view to look at how mealtimes in LTC were impacted by budgetary constraints. They found that cost efficiencies created low staffing levels during mealtimes, forcing staff to rush. There are just too many residents needing help with eating, and these needs can fluctuate from meal to meal (Lowndes et al., 2018). Although this study did not look at transitions in care, the authors highlight the reliance on unpaid care workers (volunteers, family members, students) during mealtimes to “get the job done.” This suggests not only that there is not enough staff to meet the individual needs of each resident but also that staff do not have enough time to do this type of labour-intensive and unpredictable work. These considerations are particularly important when it comes to transitions in LTC, because moving a new resident in (and getting to know the person and meeting the family) takes time. The time needed to do the work of transitioning is only available if there is enough staff to cover the workload and care of the other residents.

Adams and Nelson’s (2009) work highlights how the “virtue script” of nursing (nursing as altruistic in nature) and the invisibility of nurses’ work in an otherwise paternalistic medical system, along with health care reforms focused on cost efficiencies, have contributed to a devaluing of skilled nursing work. In terms of LTC, this systematic devaluing has meant that care that can be counted and measured (cost-driven and manageable) is funded more heavily than what the authors term “body and relationality gained knowledge” (Adams & Nelson, 2009, p. 16). They argue that relationality and body knowledge are individualized and can only come from repeated interactions (Adams & Nelson, 2009). Their findings highlight that, for nurses, restructuring has meant less time spent in personal contact with the people they care for (Adams & Nelson, 2009). During transitions into LTC, staff and residents have fewer opportunities to get to know one another, and the individual and unique aspects of each new person moving in are devalued.

Adams and Nelson (2009) also discuss the care–cure dichotomy and how this connects with the dualism of female versus male and nursing versus physician. Feminist economists have explored how these dualisms have gendered undertones and can be linked further to private (home) versus public (health care marketization) and relational versus biomedical (Adams & Nelson, 2009). In this type of dualistic structure, one is viewed as superior to the other, and in terms of care work nursing work is taken to be non-curative and sentimental in nature (or in other words, *care* is unrecognized in the *cure* of individuals) (Adams & Nelson, 2009). Understanding this dualism within the current state of LTC delivery makes it clear that funding, care work, and quality continue to be challenged by fundamental biases against women's work (Adams & Nelson, 2009).

My work is informed by an FPE approach that emphasizes the importance of exploring and addressing the context, gender inequities, power structures, and tensions inherent in health care delivery (Choiniere, 2011). In this framework, particular attention is paid to whose interests are being served and whose are not, by connecting the processes involved in the production and reproduction of care and care work. For example, analysis from an FPE perspective identifies that current market or neoliberal forces support the notion that what is defined as "productive" is possible only through standardization, privatization, and categorization. An FPE approach also challenges the dominant medical-model framework of the Canadian health care system, arguing that care must also be equitable and seen as social and relational. Use of an FPE lens has led me to reflect on neoliberal and market-based reforms within the health care sector, looking critically at how marketization intersects with gendered forces to prioritize, define, and regulate care and how the quality of that care is understood and measured (Banerjee & Armstrong, 2015).

I have found an FPE approach helpful for critiquing Canada's health care system, which has seen the transformation of care into a commodity, and to explore how the intersection of gender and neoliberal reforms perpetuate the devaluing of women's work and the care work they provide (Choiniere, 2011). In the following sections I give an overview and explain how government reforms reflecting a market-based approach intersect with gendered assumptions to influence quality of care; the focus here is on long-term residential care. I then discuss how these reforms have perpetuated the devaluing of women's work in general, and their care work in particular, and critically analyze the processes that undervalue the importance of relationships in health care and under-prioritize the less measurable aspects of care.

Situating these tensions within the study setting, my critical lens identifies that within LTCHs there are market and gendered forces at work that regulate how care quality is understood and how it is delivered. The result in LTC has been an overemphasis on care that can be observed, measured, and more easily managed, giving the less measurable aspects of care, such as quality of life, comfort, having someone to spend time with, and building relationships, less importance (Choiniere, 2011). The intersections between gender and market are reflected as tensions and contradictions in the experience of staff, residents, and families during transitions into and between LTCHs, a time well documented as challenging and filled with stress for new residents, family members, and staff (Davies, 2005, Glasby, 2004; Glasby et al., 2006). Based on this understanding of transitions, my study explores the points of view of those who are transitioning, their families, and those who do the work of transitions; my critical lens has led me to understand that these are important voices to capture.

Capturing the views of these specific groups will offer insights and greater understanding regarding LTC transitions, and contribute to a redefined conceptualization of care that focuses more on the relational aspects of health care work, in sharp contrast to the dominant medicalized, task-based system currently in use. By reframing concepts of care and care work using relationality and then understanding how these relationships occur within the context of transitions, an FPE approach provides a foundation for interpreting differences within work organizations, across settings and between HCPs.

Market Forces in Health Care: Constrained Work

When care staff are unable to provide the type and quality of care they deem necessary for some of the most vulnerable individuals in our society (persons in LTC with cognitive or physical impairment), HCPs may engage in unpaid overtime to make up for the deficits (Baines, 2004). This means that when staff spend time with residents to bathe, dress, and toilet them and then recognize that more time is needed, they employ a few different strategies to make up for the lack of time they can spend with each resident. They may work through their breaks in order to "get the job done," or rush through the rest of their care work in order to stay on task. Tensions arise when gendered and market forces promote a health care culture where providers are pressured to skimp on the "softer" aspects of care in order to provide those clinical aspects of care considered to be most important (those that have greater relevance for costs and or profits) (Williams et al., 1999). Additional tension is experienced in the conflict between the values linked to relational care (time spent with the resident, resident autonomy) and the professional ethics linked to a "job well done" (residents all up and washed before breakfast, medications given on time) (Viau-Guay et al., 2013).

It used to be that LTCHs provided care for a variety of residents with both low and high care needs (OLTCA, 2018). With the recent push toward community-based LTC and a provincial “aging in place” strategy, the admission criteria for entering LTC have become stricter. The result is that older adults are entering LTC when they are older and frailer and require more complex medical and personal care (OLTCA, 2018). With over half of those living in LTC having some form of dementia (64%), the vulnerability of this population is multiplied (OLTCA, 2018).

The majority of LTCHs in Ontario are private, for-profit agencies. However, these homes receive the same provincial funding as public or not-for-profit homes. Thus, the drive to be profitable among for-profit homes is approximated within the not-for-profit homes’ drive for cost efficiencies. These pressures continue, even though nursing homes are caring for more high-needs residents. This push for efficiency also plays a critical role in placing a priority on care work that is not only efficient but also accounted for and thus easier to monitor and control (Banerjee & Armstrong, 2015).

Types of cost-saving strategies implemented by employers include using a larger proportion of less educated and less expensive personnel; having RNs perform primarily coordinating functions and act as managers; and moving toward multi-skilling (cross-training staff to perform multiple roles within a home) or deskilling (moving work onto the lowest skilled staff) (Choiniere, 2011). These changes pull nurses away from front-line patient contact and into administrative tasks, managing the accurate measurement and documentation of care. Staff members continue to be pressured to deliver high-quality, competent, and safe care for each resident, with few additional resources available to support that care.

As mentioned previously, an important assumption of neoliberalism is that care is more efficiently and effectively provided through the managing and measuring of that care. It is an assumption that also appears in decisions about how LTCHs are regulated and funded (Banerjee & Armstrong, 2015). At the same time, increased regulation is tied to the vulnerability of residents (Berta et al., 2014). Residents with decreasing mental and physical health may not be able to voice concerns over the quality of care they receive, hence regulatory oversight is needed to protect these very vulnerable individuals (Berta et al., 2014). However, it is the ways in which care is organized and homes are regulated that raise questions about whether this is the best approach to protect residents. LTCHs are encouraged to organize and prioritize care on the basis of assessments, tasks, and care that have the highest financial remuneration (for example, physical care and medical conditions). Care funding and planning in LTC involve measuring and documenting the care priorities as laid out in the RAI-MDS system, which uses algorithms by weighting categories such as physical functioning, continence, and skin condition (CIHI, 2012). The scores are then statistically amalgamated into a Case Mix Index (CMI), which determines the level of funding received from the province. The higher the CMI, the more funding a home receives for the nursing and personal care of its residents. What this funding structure does is place pressure on LTCHs to focus on particular aspects of care, as well as exaggerate the intensity of care (Bevan & Hood, 2006).

It is important to note here that LTCHs create and manage efficiencies in all areas of the organization and across varying departments. What is being highlighted here is the way in which regulation is carried out and the stringency of provincial funding that prompt homes to exaggerate the intensity of care in order to secure maximum funding (Bevan & Hood, 2006). My thesis explores whether strict regulatory practices and government oversight influence the quality of transitions for residents, families, and staff.

Long-Term Residential Care Priorities: Defining and Measuring Care Work

Women, who provide the majority of unpaid and paid health care labour, or care work, are most affected by Ontario's health care reforms, and what affects their labour also affects care quality (Seeley, 2012). There are issues in how care work is valued, with skills viewed as inherently female being less valuable in terms of production and the economic market (Seeley, 2012). Conversely, funding is more dependent on capturing the clinical aspects of care work. The assumption that the care of residents can be quantified into task-based care moments that are predictable and standardized fits with the assumption that the cost of caring for residents can also be controlled and "managed" and, further, that this can be obtained through enhanced oversight (Kontos, Miller, & Mitchell, 2010). When care work, performed by mostly female staff, is viewed as less important in terms of funding, the job that gets done comes at significant personal and professional cost to HCPs (Syed et al., 2016).

Research suggests that given these pressures, and as HCPs try to balance the demands of work constraints with more intense workloads in practice settings, relational care work is often dramatically reduced. This means that as health care workers continue to work in a system with the constant stress of scarce resources and conditions of work that challenge care quality (the majority of their time given to activities mandated by the institution), this leaves little opportunity for spending time getting to know residents, including their likes and dislikes. This in turn creates contradictions and tensions between how staff would like to work and the way in which they are pressured to work (Viau-Guay et al., 2013). In my thesis, I explore if and how transition work in the LTC sector is influenced by similar market and gendered forces.

Transitions: Articulating Care as a Relationship

Current research emphasizes that relational care (recognizing the importance of establishing and maintaining relationships in care settings and emphasizing the importance of getting to know what is most important to a person and family at a particular time and in a particular setting) is necessary for effective and therapeutically successful transitions into LTC (Eika et al., 2014). Transitions are often a time of great stress for new residents and their families (Eika et al., 2014). Staff also experience an increase in workload and intensity around the time a new resident arrives (Eika et al., 2014). The ability to spend time with incoming residents and families provides staff (as well as residents and families) the opportunity to create and take part in new patterns of interactions and ways of being with one another as the process of transitioning unfolds (Eika et al., 2014).

Front-line health care workers, and those who work in LTCHs in particular, are constrained by management and institutional policies that pit delivering relational care that is focused on human needs and quality against resource utilization and efficiencies. For example, a staff member may not have the time required to provide morning care for a resident with dementia who is at times combative and often aggressive when rushed, knowing there are six to seven other residents who all must be up and washed prior to breakfast. Care becomes fragmented as certain care activities, including those during transitions, are prioritized. This approach does not enhance human connectedness, allow for caring relationships to flourish, or focus on the wants and needs of each individual person as innately unique and autonomous (Braedley & Martel, 2015).

It is important to note that person-centred care was introduced during the 1990s in Canada (Morhardt & Spira, 2013). Its adoption and implementation was widespread in Ontario and held important caring elements (placing the person at the centre of care and care decisions) but was often misunderstood and misrepresented. This has been argued as being due in part to its generality but also to everyone from administrators to policymakers being free to "justify" care cutbacks and choices based on the premise of their own interpretation of person-centred care (Berta et al., 2014). As an approach to care, it is often ambiguous to define; it is contingent on who you are and what your perspective is. Updated models such as resident-centred care, client-centred care, and person- and family-centred care have grown out of the principles of person-centred care and continue to offer strategies for how the interprofessional health care team can enhance the quality of their partnerships with individuals and families. While the discourse remains, person-centered care and its focus on the person can only be realized if the structures that regulate that care align with the same framework.

Resident-centred care is a theoretical approach to care that promotes residents' autonomy, empowerment, uniqueness, and self-determination; in other words, residents being "experts" of their own lives (RNAO, 2008). Relational care is also resident focused and highlights the importance of care as a relationship. Both approaches allude to a partnership model in which the health care teams' care activities are driven by the resident's goals and choices within a flexible and collaborative working space (RNAO, 2008). Relational care goes further to act not only as a theoretical approach but as a framework to organize and plan care that is inclusive and respectful of all care partners (family and support staff) while maintaining the dignity and autonomy of residents (Nundy & Oswald, 2014).

Shura, Sliders, and Dannefer (2011) critiqued resident-centred care as also being used as an "appeal to the public," a catch phrase that LTCHs align themselves with in order to promote the idea they are providing individualized, person-centred and holistic care. While LTCHs consider themselves to be resident centred when they do such things as involve residents on committees and use satisfaction surveys to inform decisions, these activities, when occurring under disempowering hierarchical processes and within settings that are constrained, limit the ability to enact any real change (Shura et al., 2011).

Unfortunately, rather than achieving the intended goals of resident-centred care, research suggests that residents and staff continue to report work intensification and staff time pressures and a decreased quality of life among residents (Morhardt & Spira, 2013). As such, the ideology of resident-centred care is failing to result in the conditions that underpin caring and reciprocal relationships, which are necessary to improve the quality of lives in LTC (Morhardt & Spira, 2013). Relationship-centred care (or relational care) in LTCHs takes a holistic approach toward the interactions between staff, families, and residents, with an emphasis on the social definitions of what it means to be a person.

FPE intersections with Transitions

Using an FPE lens has led me to understand that the direction of regulation in Ontario LTCHs can work against framing care as a relationship (Armstrong, 2001, p. 127). This is especially evident when HCPs who work within these systems report feeling pulled between providing care that is viewed as relational and upholding the care priorities of the organization (Raphael, Bryant, & Rioux, 2010). These priorities also take up much of HCP time and energy, including charting and documentation. Therefore, the ability of HCPs to uphold residents' autonomy, choices, and preferences is often not supported within the home in terms of time and staffing.

Care that is based on social relationships can only exist within a system that values relationality over cost savings. In other words, as LTCHs continue to be organized in ways that focus on cost containment and work efficiencies, the possibility of introducing and taking up relational care as a model is more difficult to achieve. Arguably, a widespread and systematic culture change would be required from the bottom up and top down to reorganize care that is aligned with relationality. In short, resident-centred care is subject to the same neoliberal reforms and gendered pressures that are evident throughout the health care sector.

It is important to assess how these gendered and neoliberal forces are influencing the goals of resident-centred care when it comes to the transition into LTRC from the hospital or home. These transitional experiences encompass months of waiting and sometimes only days of planning for the family/caregiver and new resident (Doleweerd & Berezny, 2009). Few transition studies explore how staff, families, and residents experience transitions, or what the perceived and actual needs are.

During transitions, it is imperative that relationships between residents, staff, and families remain central, as this will set the stage for future interactions and collaboration. In using a critical lens to examine LTC transitions and relational care, I emphasize the importance of capturing the voices of those who experience transitions and the staff who do the work of transitions. This has led me to explore the process of transitions into LTCHs in order to understand if and how neoliberal and gendered forces and regulatory oversight impact care and care work during this time. My goal is to examine how resident and family needs are met during transitions and how staff members are able to deliver quality, relational care from the perspective of residents, families, and staff themselves.

In my thesis, I focus on staff experiences in delivering transitional care with the resources and expectations of the LTCH, and also how that care is experienced by new residents and family members. My goal is to identify what is currently happening, what is being overlooked, and what could make it better. Overall, a main research objective is to understand how transitions into LTCHs can be more successful for residents, families, and staff, to better understand the work and care needs of all involved and how these can be prioritized during the transition process.

Chapter 4: Methodology

The purpose of this study is 1) to explore what is currently happening during transitions into LTC, 2) identify promising practices which could improve the process, and 3) highlight the enabling and constraining influences that reinforce care as a relationship during LTC transitions. My thesis makes use of a subset of data collected during a much broader project titled "Transitions: Examining Promising Practices for Older Adults Transitioning into and between Long-Term Care Facilities in Ontario" (hereafter shortened to *Transitions*). I will first describe the larger *Transitions* project, making clear my role as a student researcher and team member, then how it informed my research study.

Transitions acknowledges that older adults have the "right to live in dignity . . . this means facilitating a transition that respects their independence, yet responds to their needs in a manner that considers their vulnerabilities" (Choiniere & Daly, 2014). The research design was set up to be a cross-comparative study between four provinces (British Columbia, Manitoba, Nova Scotia, and Ontario) with the goal of identifying promising practices during transitions while highlighting work flow and process maps between LTC transfer, admission, and assessment. Inclusion criteria for the *Transitions* study were those who work in LTC homes, families of residents, and residents who were able to speak to the research team (and sign consent) based on family and staff input. At the time of this study's data collection, *Transitions* was in its first year and had received funding to begin with a pilot study in Ontario.

Research Design

This is a qualitative research design using semi-structured interviews to gather data in one urban LTCH. I began work on *Transitions* as a graduate student in the fall of 2014. My

Master's thesis supervisor and principal investigator (PI) on *Transitions*, Dr. Jacqueline Choiniere, provided me the opportunity to be a research assistant (RA) on *Transitions*, which was in alignment with my own research interests concerning care work and care quality in the LTC setting. My work began by generating a list of key transition words and phrases (see Appendix C) that served as search terms for the literature review. In the spring of 2015, I drew on this initial work as part of the literature review for this thesis. It is important to note here that the FPE approach used in the larger *Transitions* study helped me to explore how political power, such as neoliberalism, and economic controls in terms of the RAI-MDS have influenced the care work and care quality in LTC.

My initial engagement with the literature included studies on transitions into and between LTCHs, health care reform in Canada, and relational care, and previous research highlighting promising practices related to transitions and LTCH organizational structures. This literature drove my study's research questions as it led me to question how heath care reform has impacted work structure and care quality in LTC and what that means for transitions. Based on this line of inquiry and review process, the research questions for this study are as follows:

1) What are the experiences and current challenges during transitions into LTC for residents, families, and staff?
2) How is relational care reflected in the narratives, which are used to inform promising practices that guide improvements in transitions for residents, caregivers, and staff?

It is important to note here what my role consisted of during the site visit for *Transitions* and how this resulted in the opportunity to generate and access data for my thesis. The site visit occurred over a 1-week period in June 2015 after my thesis had successfully gone through both committee and ethics approval (to be discussed in more detail in subsequent sections). The research team I was a part of consisted of two PIs, postdoctoral fellows, and graduate student researchers, who were working on the *Transition* project plus another research project entitled "Invisible Women." I was part of this team and was responsible for observing and writing field notes and conducting interviews with staff, family members, and residents. I was also involved in generating transition-specific interview questions (see Appendix A) that we provided to all team members to ask or use as a guide during the interviews. In return for my work on the team, I was given access to the project's data for analysis, which included all the interviews conducted by the team over the 1-week period at the site. All interviews conducted during that week were audiotaped, transcribed, and uploaded onto the research portal for access.

Recruitment Process

The research team's co-PIs visited the study site 2 weeks prior to the 1 week of on-site data collection. They held interviews with key stakeholders in the home (Nursing Director, Resident Director, and Director of Care). They also took the opportunity to hand out information about the study (using a flyer) and put up posters around the home to communicate the dates and purpose of the study and what participants could expect (observations, interviews, and a survey) if they took part in the study.

Members of the research team met each morning to discuss the logistics of organizing each person's role for the day (some were scheduled to observe on a certain floor while others were responsible for having participants complete a survey). It was also determined at the morning meeting if any interviews were scheduled and who would conduct them.

The first phase of the recruitment process was to identify appropriate key participants to interview. The term *appropriate* was understood by the research team to mean that each participant would be able to cognitively (absence of cognitive impairment) and verbally (English speaking) engage in an interview with team members. To determine whom to approach about a possible interview we first touched base with administration or front-line staff for suggestions of who might be available and appropriate to interview. The LTC staff were extremely knowledgeable about the residents in their care and able to provide information about whether or not a resident could be a possible study participant. To recruit staff or family member participants, a team member made initial contact and explained the study to them (some already knew about us and the reason we were in the home). They were then asked if they would like to take part in an interview. This person's contact information or time of next shift or visit to the home was then relayed to one of the PIs to make contact with the person.

The second phase of recruitment was to set up interviews with the identified participants. Given the importance of approaching individuals in a consistent and transparent way, those with the most research experience on the team (PIs, postdoctoral and PhD candidates) did the work of speaking to and setting up interviews with potential participants. A master list of all interviews booked and conducted in the home was kept by the PIs and updated as each new participant was added. Written consent was obtained before each interview. The informed consent process was approved by York University in conjunction with the research ethics protocol (York University Graduate Student Human Participants Research Protocol) (please see Appendix B).

Methodology

For my study, I chose a qualitative case study design with multiple sources of data to understand how various stakeholders (residents, staff, and families) experience and interpret transitions into and between LTCHs. In nursing research, using a case study approach takes into account that in order to understand a phenomenon of interest, one must first understand the social context in which it occurs (Yin, 2009). Case study designs are useful when the research is guided by a theoretical framework and when the aim of the research is to uncover structures or processes that contribute to inequity (Yin, 2009). Within a real-life context, case studies can provide a holistic view on a phenomenon of interest, offering insights into meanings about complex issues and structures (Yin, 2009).

Using a case study design within a FPE approach, I explored the interconnectedness and tensions between the political powers and economic controls that are inherent during transitioning into LTC. More importantly, situating this study design within my analytical perspective helped reveal how gender and gender relations are embedded within differing socioeconomic and political structures, processes, and discourses (Banerjee & Armstrong, 2015; Grigorovich, 2015).

I chose a case study using an inductive approach that is both descriptive and exploratory to convey the complex processes that occur during transitions, which are not easily separated from the social contexts within which they occur (Hentz, 2012). The study is exploratory in that the setting (a LTCH) and situation (transitions) in which the phenomena occurs have no clear, decisive, single set of expected outcomes and processes. There is very little current research on this topic, and I wanted to describe transitions and transitional experiences in the real-life context in which they occur (descriptive approach).

Case studies, when used, allow the researcher to explore structures, procedures, or organizations concerning simple or complex processes and relationships (Hentz, 2012). By constructing and deconstructing the phenomena of interest using triangulation (including a variety of stakeholders), theory is developed and themes identified. Using triangulation in this way, this study makes use of differing data sources within a given context, ensuring that the experience of transitioning is not viewed through only one lens but rather a variety of lenses (families, staff, and residents) (Patton, 1990). This was done in order that multiple facets of the phenomena and associated experiences would be revealed, explored, and understood.

An FPE approach provides the framework for this case study, to identify and highlight the aspects of transitional care that promote health care as a set of interrelated relationships rather than merely measurable tasks (Latchem & Kitzinger, 2015). The feminist lens is of particular relevance here in exploring how gender influences care planning in the LTC sector but also to expose power inequities in the care work of women (Armstrong et al., 2012). This type of critical lens provides the framework for how current transitional practices can be examined, with the assumption that the current conditions of work and care reflect broader historical, economic, political, sociocultural, and organizational structures (Choiniere et al., 2010).

One limitation of using a case study design is that the results are not necessarily generalizable to the entire population, but as Erickson argues, “the general lies in the particular” (as cited in Merriam & Tisdale, 2015, p. 255). Therefore, what we come to understand from a specific case study is often a catalyst for further research and theory development. One advantage of using a case study design is the close collaboration between researcher and participants, which fosters storytelling and sharing of experience (Baxter & Jack, 2008). This “coming together” creates an open space for researchers to better understand participants’ actions, thoughts, emotions, and feelings (Baxter & Jack, 2008).

Ethics Approval

Ethics approval was obtained through York University by the PIs on the larger *Transitions* project, for which I was an RA. In order to obtain ethics approval for my own research project and subsequent data collection, the PI on *Transitions* contacted the York University Office of Research Ethics via e-mail to determine whether separate ethics approval was required to allow me to take part in the semi-structured *Transitions* interviews, plus have access to other interviews being conducted by the research team that same week for my own study. As per the York Universities Research Ethics Research Coordinator, additional and separate ethics approval is not required "as long as the methodology remains the same for the research project"; no further ethics approval was needed (personal communication, 2015).

Site Selection

The site, hereafter referred to *Loftly*, an LTCH in an urban centre in Ontario, was selected by the PI as a pilot site for the larger province-wide study of *Transitions*. *Loftly* was chosen because it was not-for-profit LTCH, had a reputation for welcoming and serving a diverse population of older adults, and was in a large urban centre in Ontario. These aspects justify this particular site as the study setting because they relate to this study's perspectives and approach concerning the effects of neoliberal reforms on health care delivery and how these reforms influence the not-for-profit LTC sector.

Sample Selection

Maximum variation sampling or heterogeneous sampling was used as the purposive sampling technique to capture a wide range of perspectives (staff, families, and residents) relating to transitions (Patton, 1990, p. 172). This method of sampling provides an opportunity to gain insight from various individuals as they experience transitioning across different entry points into LTC. This strategy was used to identify common and central themes across the unit of study (case study) and within embedded units (transitional experiences). The unit of study is the urban LTCH and the embedded units are the experiences of staff, family, and residents dealing with transitions. A clear weakness of using a maximum variation sampling strategy is the heterogeneity among smaller sample sizes. This can be problematic as individual cases vary, making themes difficult to identify. Patton (1990) suggests that by applying the following logic this can be addressed and overcome: “Any common patterns that emerge from great variation are of particular interest and value in capturing the core experiences and central, shared aspects or impacts of a program” (Patton, 1990, p. 173).

For reasons of feasibility and in discussion with my thesis supervisor, I selected a small sample of the interviews at this one site. By using a variety of perspectives (staff, family members, and residents) to understand transitioning from every angle, the common themes identified are across individual behaviours, experiences, and situations.

Sample Size

In qualitative research, the sample size is not generally predetermined. Rather, the number of participants depends on how well the phenomenon of interest is addressed, and in what detail, in order to answer and address the study’s research questions (Mason, 2010). This is otherwise known as *saturation* (Mason, 2010). In purposeful sampling, the size of the sample is determined by informational considerations, in this case concerning the process of transitions from various stakeholders to obtain rich information. Those who could provide information on transitions were only those who had actually experienced a transition into or between LTCHs (as a resident, family member, or staff). A smaller sample size in this case (as compared to the much larger study *Transitions*) is helpful in illustrating and representing the unit of study (LTCH) within the social context of LTC and moving into an LTCH (Hentz, 2012). *Transitions* is set in the same setting as this study (LTC) and explores experiences from a much larger group of people within LTC, but participants are from the same three groups: staff, residents, and family members. Using this same context within my own study, I was able to illustrate how even a small sample size could represent the phenomenon of interest and unit of study if based in the same social context with participants who do the work of and experience transitioning. With the purpose of using several cases to investigate the phenomenon of interest, my sampling logic (Yin, 2009) led me to my sample size based on specific criteria. These criteria included a sample size that could maximize what we can learn about transitions by purposeful sampling of the "unique" experience of transitions among the participants (Yin, 2009).

A total of 31 interviews were conducted during the 1 week of on-site research. The participants who participated in interviews are shown in Table 1.

Table 1: List of Participants Interviewed for Transitions Study

Participants	**Total**
Registered nurse	1
Registered practical nurse	2
RAI-MDS coordinator	1
Personal support worker	6
Resident	3
Family member	5
Private caregiver	6
Behavioural support staff	1
Life enhancement specialist	1
Physiotherapist	1
Pharmacist	1
Dietary staff	2
Student	1
Total interviews	31

The rationale for which interviews I chose to include in the final sample was based on several factors. Interviewers were from several projects and not always the same people as discussed previously. In order to decide which interviews of the 31 to include in the sample, I listened to each one and read all 31 transcripts. I discovered that although each interviewer was given the transition questions to ask during the interview, not every person interviewed was asked about transitions. I surmised that interviews with staff were conducted on their breaks or during their shift, which meant that there may not have been enough time to ask the transition questions during the interview. Given the semi-structured interview format chosen for this study, the interview flow and content sometimes did not allow the researcher to "lead in" with the transition questions. Interviews in which this was the case were not included in the final sample.

The second factor in my rationale for deciding which interviews to include for data analysis was to choose all those interviews in which the process of transitioning and transitions into this one study site (and not experiences about another LTCH) was specifically addressed during the interview. I wanted to ensure that those interviews included were the ones in which the participant was able to speak about the experience of transitions. There were several interviews where a lead-in transition question was asked of the study participant but the person expressed having had no direct experience in the home with transitions. This was the case with the student and several of the dietary staff interviewed, and those interviews were not included in the final sample. By listening to all 31 interviews I was able to create inclusion and exclusion criteria based on the two rationales discussed above. The transitions that were captured from the 12 participants and explored during the semi-structured interviews were those from home to the study site and inter-institutional transitions (transition from another LTCH to the study site). Therefore, for feasibility and in discussion with my thesis supervisor, I chose to include the 12 interviews used in this study because the participant met the inclusion criteria (see below) and the rationale for choosing the interviews provided data for analysis and results. The final sample is shown in Table 2.

Table 2: Final Study Sample

Participant	**Sample Size**
Registered nurse	1
Registered practical Nurse	1
Personal support Worker	3
Resident	3
Family member	4
Total sample	12

Staff were involved with transitions in various ways during transitions at the study site. The nursing staff were in charge of the initial physical assessment of the resident, completing all admission paperwork and starting the new resident's care plan within the first 24 hours. This plan of care or care plan includes many documents not limited to medication administration records, Kardex (an electronic or paper document that briefly communicates important information about a resident such as physical abilities or allergies), physician order sheets, and demographic information. PSWs were responsible for getting the resident up for the first time (based on the care plan) and assisting in ADLs such as bathing, toileting, and assisting with eating, if needed. They were also often involved in orienting the new resident to the floor on an as-needed basis.

In general, to be included in the study, participants had to be able to understand important aspects and residents' experiences of transition processes such as assessments, admissions, or transfer processes. More specifically, in order for a resident or a family member to participate in the study they had to:

- Have been involved in a transition into the home

- Speak English

Residents needed to have no cognitive impairment (based on staff informing researchers of any diagnosed dementia, delirium, or Alzheimer's).

For staff to participate in the study they had to:

- Have worked at least 1 year within the facility
- Have experience with a new resident who had transitioned into *Loftly*

Exclusion criteria included the following:

- Residents who, due to cognitive impairment (evidenced by dementia, delirium, or Alzheimer's diagnosis as indicated by *Loftly* staff), were unable to consent to participate fully in the interviews
- Staff lacking any experience with transitions, or having experience with transitions but while working at another LTCH
- Staff who had been working at the study site for less than a year
- Family members who had experience with transitions but this experience did not include the move into the study site
- Interviews in which the transition questions were not asked

The team encountered challenges to conducting interviews at the study site due to time constraints and difficulty finding private areas to conduct the interviews. All staff were approached to be interviewed during their work day and they took time out of their day to be interviewed. The number of family members interviewed was dependent on how many visited their loved ones during the 1-week period that the research team was present. Participants in the study were not necessarily related. For example, family members interviewed were not always related to or involved in the transition of the residents who were interviewed.

Data Collection

Consent for participating in the study was discussed by the researchers with the participant at the beginning of each interview. The consent document explicitly stated that the participant had not been coerced in any way to take part in the interview and that they could opt out of the study at any time (see Appendix D). Data were stored on a secure data-sharing website that only research team members could access using individual user names and passwords. Data are being stored for 7 years.

The research questions were formulated through an initial review of the literature on transitions into and between LTCHs, health care reform in Canada, and relational care, previous research highlighting promising practices related to transitions and LTCH organizational structures. The preliminary research, as described above, along with the theoretical framework and study purpose were used to create the interview guides.

The interview guide was designed to begin with general questions about LTC and transitions as well as more specific questions about aspects of the transition process. There were also follow-up probing questions when required. Different interview questions were developed for staff, family, and residents based on their role and experience during transitions. Staff were asked about their general experience with transitions while working in the LTCH, followed by more specific probes based on their comments and involvement during their employment. Questions for families and residents were very specific and focused on the transition that brought them into the LTCH study site. (See Appendix A for sample interview guides.)

The data for this study were collected during a 1-week period in June 2015 (between Monday and Sunday) and included the following: interview data and preliminary research (literature review and interview question development). Semi-structured interviews were conducted during all three available shifts at the LTCH to capture more residents, staff, and family during a time that was most convenient for those being interviewed. The interview time was based on the availability of the participant and interviews were digitally recorded for accuracy and transcribed.

Data Analysis

As per ethics approval, permission was granted to access and utilize the interviews gathered by other researchers at the study site. To determine eligibility, I listened to each of the 31 interviews to be sure the participant met the criteria outlined earlier for inclusion in the sample. This was done because, given the dialogue during semi-structured interviews, at any time during the interview there could have been discussions about the participant's length of time at the facility, role in the facility, and experience (if any) with transitions. Once the 12 interviews were chosen on the basis of inclusion and exclusion criteria, each was printed and read twice (while listening to the recording of the interview) to confirm accuracy of the transcription.

Applying an inductive approach to conducting content analysis provided me with methods and theoretical underpinnings to investigate complex social structures embedded within the experience of transitioning into an LTCH (Munhall, 2012; Yin, 2009). I began content analysis with a Manifest approach whereby I first looked at what participants actually said—word for word (Bengtsson, 2016). This was to ensure that I stayed true to what was being said, to add to the trustworthiness of the study (Bengtsson, 2016). I made notes in the margin of the transcripts and began to point out sentences or groups of sentences that related to the research questions and the study's purpose. I re-read the transcripts repeatedly until no new sentences were identified as having to do with transitions. I began thematic analysis by gathering all sentences about the same topic or idea and putting them together onto one piece of paper or several papers. I colour-coded each page of raw data in order to colour-code the same sentences on each transcript. In this way, I was able to begin to identify themes and patterns as they related to transitions, defined as abstraction or aggregation in the literature (Graneheim & Lundman, 2004). I re-read the transcripts two times again at this point to ensure no new themes were found. Lastly, I began to interpret the themes to generate relationships, commonalties, and patterns as they relate to transitions.

As stated earlier, FPE informed my data analysis in considering how existing policies, structures, and organizational processes influence the process of transitioning into LTC as experienced by residents, staff, and families. The use of this lens guided me in looking for constraining and enabling factors identified across the sample and in considering contextual factors (e.g., conditions of work and care) and how these influenced participants' experiences of transitions.

My research followed several steps to ensure rigor based on Guba and Lincoln's (1994) work outlining the strategies for trustworthiness in qualitative research. This included considering transferability and confirmability while conducting my research and during the phases of data analysis (Morse, 2015).

Confirmability is the amount of neutrality or how much the results of the study are shaped by the participants' responses rather than the researcher's bias or personal beliefs (Guba & Lincoln, 1994). This type of trustworthiness in qualitative research can be strengthened in several ways. In this project a triangulation of sources was utilized in order to explore the phenomenon of interest from a variety of different points of view, from residents, families, and staff. This was done in order to explore the consistency of the responses but also to ensure that a description of the process and experiences of transitions was comprehensive and robust (Guba & Lincoln, 1994).

Transferability refers to the degree to which the research results can be applied to or generalized to other settings or contexts (Guba & Lincoln, 1994). In this case, by thoroughly describing the research context related to transitions and how neoliberal forces have shaped the delivery and funding of health care, in particular LTC, general themes about a specific event such as transitions could be identified. Transitioning into and between various health care settings is an event that takes place every day in health care. By exploring and analyzing the experiences of those doing the work of transitions, of those who are transitioning, and of those whose loved ones are transitioning (within LTC), it can be proposed that similar experiences are occurring during transitions into and between other health care settings.

Three strategies were identified and applied during the data analysis phase of the study to increase transparency of the data analysis process. First, relying on the theoretical propositions of the study by describing the phenomena of interest in detail (transitions), based on preliminary research, a thorough review of the literature guided research question development and informed the content of the interview guide. Guba and Lincoln (1994) would describe these steps as contributing to a "thick description" of transitions with the goal of describing the phenomenon in as much detail as possible so as to support transferring the study's results to other settings or people. Second, I developed thematic coding consistent with the research question using organized, planned, and consistent analysis techniques. This was achieved by keeping a paper audit trail on all raw data, through to generalizations and summaries, then categorizing themes across data sets while constantly referring to the research questions in order to link the research question with the results (Guba & Lincoln, 1994).

Lastly, using the above processes and strategies I was able to identify similarities and differences between the data sets (staff, family members, and residents) (Guba & Lincoln, 1994). When using a variety of sources, as in this study, any similarity or difference in the findings supports not only the credibility of the findings but also the confirmability of the results (Guba & Lincoln, 1994).

In summary, my study uses a qualitative case study design to explore and better understand how residents, staff, and families experience transitions and how this process meets both the personal needs of those moving into LTC and the professional needs of those working in LTC. An FPE approach is applied to critique how these transitions into and between LTCHs have been shaped by gendered and neoliberal forces, which have, over time, created tensions limiting relational care in long-term residential care planning and delivery. In the next chapter I present my findings and what the results suggest in terms of what could make transitions better and how neoliberal influences have impacted LTC structure and care delivery.

Chapter 5: Findings

In-depth analysis of the interviews was rich in representing staff, family, and residents' experiences related to transitioning into a LTCH. After reviewing and coding the interviews, four key themes were identified that illustrate what is occurring and what is being experienced by participants before, during, and after transitioning into LTC. Theme one "Going in blind—Participants' experience of the uncertain, unknown, and hidden." Theme two involves "Communication gaps—Experiences of discrepancies and miscommunication during the transition process". Theme three is called "Pushed and pulled—Transitions as hectic and rushed." And Theme four involves "Checklists, paperwork, and questionnaires—The logistics of transitioning". Participants' interviews not only illustrate the tensions, contradictions, and challenges inherent during transitions but, more importantly, identify promising practices that could make the process better.

Theme One: "Going in Blind"—Participants' Experience of the Uncertain, Unknown, and Hidden

Participants' narratives described an overwhelming sense of being uninformed before, during, and after transitions. This theme was represented in each group of participants' (staff, families, and residents) interviews in varying yet interconnected ways.

Staff described instances, with overwhelming consistency, when a new resident was set to move in that there is almost no information received about that resident in advance. One participant (RN) also noted that not having enough information about an incoming resident made it difficult to prepare staff, such as PSWs (who provide most of the direct hands-on care in LTCHs, such as ADLs). For these staff members, being able to meet the needs of a new resident and their families but also plan for the time required to provide care is dependent on how much information they are given about an incoming resident. What is clear is that the information shared with staff is primarily biomedically focused with an emphasis on ADLs and physical care. The RN, who had 4 years of experience at *Loftly*, expressed a commitment to providing the best care possible for new residents and their families but described feeling helpless, recalling one admission in particular when the family member broke down in tears during the admission paperwork process. The RN described understanding how difficult this transition must have been for the family member but also needing to “get the job done.” She stated:

> I would like it when, upon admission, I would have the chart right away. Because I could review [the] information that the CCAC has written down for that resident so that we could . . . I could prepare myself, I could prepare my PSW as well because they are in a way the first line when it comes to care.

The RN or RPN is often the first staff member that new residents and their families interact with when they arrive on move-in day. The RN who was interviewed took this responsibility to mean that with the right information about important aspects of care for a new resident, she could reassure staff, “I give them already a word of okay, this is what we’re going to be expecting. A new resident coming in, this is what is going to be the new resident that you’re going to be looking after”. When the nurse on move-in day is uninformed, there is a trickle-down effect to front-line workers who are then also working uninformed. This comment also suggests that the nurse wants to try and get the staff prepared for a new resident, but by not receiving the information in advance, this creates uncertainty.

PSW3, with 10 years’ experience at *Loftly*, responded with the following comment when asked about the first shift with a new resident and how that was experienced on a typical work day: “Oh, well, they will say, this person. . . . They would tell you, okay, this person, get them up. . . . But we have to read the Kardex basically. So as long as the person can get up, we get them up.” The Kardex is used in LTC as an on-line tool for staff and represents a quick “snapshot” of a resident’s current ambulation status, toileting routine, and dietary needs, etc. Staff can access this Kardex in the documentation system. This comment by PSW3 illustrates that very little information is available for staff to prepare themselves to care for a new resident and what is prioritized is the physical aspects of care.

PSWs reported that not knowing anything about a new resident and their family contributed to a work environment characterized by “trial and error” (PSW1) and “going in blind” (PSW3). These findings illustrate how being unprepared can lead to a lack of control over how staff members organize their work. The PSWs in this study are not being given the tools needed to work safely (patient information) but having to get the job done anyway. This was especially evident when a family member was not a reliable source of information or was unavailable to assist staff in getting to know the preferences, needs, and abilities of a new resident with cognitive impairment, as described by PSW1: “and you get some families that just are non-existent. So we have to figure that out by trial and error. And it’s hard with somebody whose faculties are completely gone. But believe it or not, we figure it out.” PSW3 explained that figuring it out meant having the time to get to know residents: “I think I need a good month or two. I want to feel that connection, yeah.” This statement implies that staff cannot get to know a new resident by simply reading a Kardex but rather that it takes time to get to know someone, to make that connection. This comment also suggests that it is in building and creating relationships that getting to know a new resident occurs. PSW3 also shared in the interview that what was most important for staff to know about a new resident was not their physical capabilities but, for example, “what time does she get up, does she like shower or bath, what clothes does she wear, is she an early morning, is she early breakfast.” This remark reflects that it is knowing the personal and unique aspects of a resident that is most important for staff when first caring for a new resident.

PSW3 described one particular resident who was new to the home, who would become aggressive and scream whenever the staff would try and shower her. Over time, the staff discovered that this resident had lived through the Holocaust and had been in a concentration camp. The word *shower* was a trigger for her, bringing back memories and emotions that affected how staff perceived her behaviour (as “refusing care” and “difficult”) but also how she was being responded to and cared for by staff. This experience illustrates that when staff are uninformed about a new resident’s past or preferences, caring for them and building relationships with them are challenging. It also shows the importance of having adequate staff, to have the time needed to get to know a new resident. The implications of PSW3’s story are that if challenging behaviours by a new resident are not acknowledged and understood, then resident labels such as “difficult” and “refusing care” limit opportunities for staff to get to know a new resident because of inaccurate assumptions. For staff to respond to and see past the behaviours of a new resident, they need extra time during the resident’s care in the early days and months of being in the home, to allow for two very important insights to be shared. First, staff would have the time to learn how a new resident likes things done (preferences such as what clothing they like to wear on a daily basis or how they take their medications) and also what works best with a resident who has dementia or Alzheimer’s (for example, telling a resident what they are going to do before doing it or allotting extra time during bathing or care activities in order to reduce sensory overload). Second, when there is more time for the new resident to become more familiar with staff, space is created for sharing more about themselves and how they want to be cared for and responded to.

PSWs spoke often about feeling unprepared to care for a new resident but also uninformed of who they are as individuals. This led to dialogue about the implications of this lack of insight. For example, staff described behaviours exhibited by some new residents for whom they were lacking information, and shared that the residents could be aggressive or refuse help in the beginning (RPN, PSW1, PSW2, PSW3). For PSWs trying to understand this behaviour it is very difficult initially to get a grasp of what is going on. Staff indicated that these behaviours improved once they got to know a new resident as they were better able to tailor their care and approach to new residents based on how well they knew them. Staff also suggested that the better they come to know a new resident as a person, including their lived experiences and preferences, the more successful the transition into LTC could be. PSW3 stated the following:

> I think they should let us know the history. Like the basic history. Like we need to learn from the resident. Because the residents come, and we need to know exactly what does your mom like for breakfast. . . . Those things help us.

Aggressive behaviour by a new resident, if not addressed, is labelled as “violent” and as refusing care. PSW3 reported, “but then at the same time, it (aggression) might not be a behaviour, it’s just that person don’t like this.” Staff want more time to get to know a new resident in order to create relationships that in turn facilitate individualized care and meeting the unique needs of each resident. The implications of a resident being labelled as “aggressive” could trigger a whole set of policies and potential actions related to staff safety or further labelling based on assumptions. Some of these implications could perhaps be prevented by getting to know a new resident when they first move into LTC.

This sentiment was echoed by others in the study, such as RPN1, who said, “We have a resident, it’s almost two months but still he is not cooperating for the care.” Similarly, in speaking about new residents, PSW2 commented that

> They’re mad. They’re upset. . . . So it leaves us now as PSWs to try and calm them down, if we could bring them into a different mood. Sometimes it works but sometimes it doesn’t. Some of them even lash out at us.

These comments shared during the interviews illustrate how some new residents display violence toward staff when moving into LTC, as well as the understanding among many staff members that residents are actually scared and in a panic about the unknown and things changing (PSW3, PSW2, RPN1).

These experiences reinforce the importance of relational care during transitions. Staff want to know unique and personal information about a new resident in order to know how to meet their needs. In prioritizing needs that are tied to quality of life, not just physical needs, staff members recognize the connection between successful transitions and relationships.

Resident participants spoke about their transitional experiences with feelings of confusion and a sense of fear about the unknown upon first moving in (RES1, RES2, RES3). A new resident is thrust into an LTC environment (sometimes within 1day) with people they don’t know and routines that are unfamiliar. Resident participants expressed not knowing the way things are run in the LTCH or the roles of staff members, which created even more anxiety (RES1, RES2, RES3). Residents expressed being unsure of what was going to happen to them once they moved into LTC and that they were not provided enough information to get oriented once they moved in. For example, RES1 indicated that “there is no orientation process that I . . . There’s nothing there. . . . And who do I speak to, to ask a question? . . . Very good point. It's very difficult to know who to ask here." Residents commented on not being told enough about their new home in terms of processes and routines and who staff are, their roles, and how to contact them, thus isolating residents in their new surroundings (RES1, RES2, RES3). RES3 shared two experiences that illustrate how important it is to know how things work in the home and how, when a resident does not know this, the person is often left to figure it out on their own:

> And you know, like moving somebody into a place with no plan to identify. . . . Like I have lost several pieces of clothing because I didn't know anything about the labelling of things. . . I've been in diapers for quite a . . . a couple of years now. And I was using pull-ups. And they don't use pull-ups here. And it took a while for me to figure out what was going on. Basically I had to learn how things work in a systematic way from the staff people.

These processes and routines that are new can be especially hard for residents with dementia, as their sense of disorientation is accentuated by cognitive impairment and memory loss. Even for those residents without cognitive impairment, LTC rules and regulations can be confounding. For example, RES3 shared during his interview that he had asked staff about having a lock put on his door for privacy. He stated:

> And people come in, like the laundry coming in. And there will probably be in the next few minutes somebody else coming in. And they just basically charge in. And many of the doors are open, left open all the time.

Even during the interview itself, twice staff knocked and came in the room to drop off laundry and other supplies. This illustrates the unpredictability experienced by residents when moving into LTC, as well as their lack of control over the schedule or who accesses them and their room throughout the day.

It was also suggested during our interviews that when residents with no cognitive impairment are placed in care areas with residents with dementia, loneliness and isolation are compounded. When asked, RES2 shared thoughts on what could be done to ease this transition: “I don’t know of any way they could do it differently, really. Just looking at the people and their behaviours, most of them have lost their marbles.” Dementia and Alzheimer’s behaviours can include wandering, yelling, screaming, aggression, or violence. When non-cognitively impaired residents transition into an LTCH and live on the same floor with residents who display these unpredictable behaviours, the new resident has fewer interactions with people they can converse with or get to know. Staff experience this first-hand when a new resident comes into the home who has no cognitive impairment and is living on a unit with other residents who suffer from dementia or Alzheimer’s. PSW1 reported:

> Because when you get the mixture of both, for the people with their faculties that come in here, that’s what I think depresses them the most. And that’s what’s difficult, is that they feel they no longer have any interaction. And I think if it was more fairly divided [referring to placing those residents with no cognitive impairment on one floor or unit together and those with cognitive impairment on another floor], I think the transition for them would be a lot easier.

Increasing numbers of persons entering LTC have some form of cognitive impairment. Residents without cognitive impairment who move into LTC are living alongside residents with varying degrees of dementia and Alzheimer’s. This means that those without impairment cannot always interact or socialize with those who live on the same unit, and opportunities for social interactions may be reduced as there are fewer people able to give advice, answer questions, or convey how the LTCH works.

Residents and families spoke about the challenges of not knowing important information when first transitioning into LTC. For example, they spoke about the identification badges staff wear and the inability to read them or staff not wearing them at all (RES3, FAM1). When a person first moves into LTC, knowing not only who works in the home but also those with whom you will be interacting during the admission and assessment process are vital pieces of information for families and residents. Transition is a time of heightened angst and stress even before the family and resident have the opportunity to get to know people or the facility. This sense of the “nameless” was a predominant theme throughout the admission process. Not being able to tell who it is you are speaking with on move-in day makes sharing relevant information with the correct staff a challenge. As RES3 stated, “There’s a flood of them (staff) . . . and they have things like that [referring to badges interviewers were wearing] but they’re flipped over and so you don’t see the name and so on.” Family members echoed this sentiment, as illustrated in the following comment by FAM1: “I cannot tell who is a volunteer and who isn’t. Or who is a student. . . . They don’t have a badge so I can’t tell.” RES1 described the situation of being unsure of the process for change or decision-making in a LTCH: “I have been in an administration position where I’m getting people to do things. It’s not all so easy here.” These remarks show that family members and new residents rely on knowing who people are and what they do in order to ease the transition into LTC.

Families narrated experiences of knowing very little in advance about the LTCH they moved their loved one into or what the actual transitional process would be like. They described the short turnaround time in finding out a bed was available and having to quickly move their loved one from home into LTC. This often involved not having time to tour the facility or having enough information from the home itself about the transition. FAM4 described the following experiences within the first few hours in *Loftly*: ". . . then again here, there's no real introduction or . . . I mean they walk you around. That's about it. Then you sign the forms and 'good luck'." Leaving their loved one in the care of unknown providers and in a place that is unfamiliar to them heightens the need for information so family members can help transition and prepare the new resident. FAM2 described the day they brought their loved one into LTC: "When we arrived it was like they weren't expecting him." Entrusting your loved one to a home is stressful, and if the transitional and admission processes are unclear or lacking, the process is made even more difficult. This also speaks to the need to have more time to spend with new families and residents to facilitate the moving-in process. Moving in requires that staff members allot time for the admission and assessment process but without extra staff or time to do so. This, in turn, as mentioned by FAM4, results in a rushed process where staff are quickly trying to fit in the paperwork on top of all of their other daily duties.

Families commented that even when tools were in place to communicate with family members, they were often not filled out or had incorrect and inaccurate information. For example, whiteboards are used as communication tools in LTCHs. They are often located in residents' rooms, the dining hall, or the nursing station, and they communicate information among staff, family members, and residents, such as the menu for the day and the names and roles of those on staff for each shift. FAM2 shared that "and even on the whiteboard . . . they are not keeping that up to date . . . who the nurse is for the morning, afternoon." When these communication tools are not updated every shift, families are unable to feel connected to the staff or their loved one because they do not know who is on shift or what activities are coming up. Families expressed wanting to know who is providing care for their loved one (and in what role) in order to support and maintain caring working relationships.

One resident identified several gaps in access to important information during transitions, such as information to help him to navigate through the LTC system, including which staff member(s) to contact for help and how to contact them. This reflects how new residents are literally “going in blind” when transitioning into and between LTCHs. Some new residents who regularly used the Internet tried to utilize the LTCHs website to find the proper contact person. For RES3 this meant, “how do I find the maintenance people and the nursing people and the authorities here, and so on?” New residents expressed the need to be informed, yet RES3 noted that an organizational chart for names and numbers was not provided and would have helped, sharing that “it should have been given to me when I arrived.” RES1 echoed this sentiment of wanting be as independent and engaged in the home as possible when first moving in: “And so as soon as I got in here, I set about finding out who pulls the strings.” Again, in order to be able to participate fully in the life of the new home and create relationships, information is essential. This suggest new residents want to know as much as they can about their new surroundings and need to be given accurate transition information prior to and during the move-in process.

Staff expressed that the lack of preparation of new residents and their families prior to moving into *Loftly* perpetuated the experience of “going in blind,” and they suggested how this could be prevented. The RN noted that the CCAC could do more to prepare the resident and the family for the move into LTC, “to prepare them of what to expect. And to give them some kind of background of what is a long-term care facility. Long-term care is not a one-to-one, you know, care.” PSW1 mentioned that if the new resident had used a homecare worker before moving in, then perhaps that same caregiver could continue with them in the home for a time, to ease the transition by having someone there with whom they had already established a relationship: “I think that would help the transition completely because, you know what, have homecare come with them for about a month until they’ve completely . . . and then you gradually switch over.” These comments indicate that it is the unknown during transitions that increases stress and anxiety. Staff members suggested that, with more preparation, more time, and a focus on relationships, these fears could be lessened. RES1 also expressed what would help new residents settle in and transition more successfully:

> There should be one person in this place but for your whole stay who is your buddy, your companion, your protector. Think of a name for it. Friend. The same person.

Theme Two: Communication Gaps—Experiences of Discrepancies and Miscommunication during the Transition Process

Families and residents spoke about the discrepancies between what they were told about the home and its activities prior to moving in and what the reality was once they arrived. This occurred in the context of families and residents receiving information about what the home offered in terms of supports and resources and what the process would be like on move-in day. Often this information conflicted with what families and residents experienced in terms of transitions. RES3 described this type of contradictory experience in the following comment:

> When I came, the arrival thing would be all of the people that I would be seeing. Not only this person but also seeing the nurses, the doctors, and so on. I would be given a whole run through of whatever. She [referring to the staff member who

> gave the resident and their family the initial tour of the LTCH] didn't turn up at all.

For this resident, when he toured *Loftly* with his family member and caregiver, the person doing the tour told them about all the people who would be present and involved on the day he moved into the home (RES3). What eventually happened was that only one person met them at the door and none of what was said actually occurred (RES3). RES1 describes a similar experience upon moving in: "I thought I'd get myself a little microwave, then I ordered it. It turned up down there. And they confiscated it." This quote reflects the lack of information residents are given about and the rules and processes in the home prior to moving in. This discrepancy illustrates that gaps in communication begin to occur even before the actual move-in day. Such discrepancies not only affect the transitional experience but lead to a missed opportunity to instil confidence and trust, impacting the new relationship between home and resident.

For persons with cognitive impairment, family members who have Power of Attorney (POA) are often the ones choosing the LTCH and making other decisions for a new resident. This means a family member is the main contact person for the LTCH. When family members are organizing, planning, and executing the move into LTC, they depend on communication from the staff to help make decisions and ease their loved one into the new environment. When there is a gap in this type of communication, family members can experience tensions or contradictions when the home they chose for their loved one cannot or does not have the services and support promised to meet the needs of the new resident. FAM3 illustrates this type of contradiction in the following comment:

> They [the LTCH] make promises that don't come about. It could even be in the beginning, they said, "Oh, we're going to have programs here." Yeah, yeah, yeah, it never happened. Stuff that's said that just doesn't happen, you know.

This family member identified that there was a gap between the type of care and activities the LTCH said they offered and the reality of what the home actually offered or was able to continue to offer. He reported that there were fewer activities in the home following changes in management and staff over the past two and a half years, noting, "we had a lot of change in activities. There's nothing after 6:30 now." This situation can create tensions between staff and families because what was expected and relied on for care is no longer happening. FAM1 also observed a decline in activities for the residents since moving her husband into the LTCH:

> Well, when we arrived . . . there were many, many activities. It was wonderful. And there were especially three people . . . four people, I knew very well. And there was a lot of activities. And also they arranged every month, they had a formal dinner downstairs. So that I would . . . or I could invite my son, the three of us, and have. . . . But they had a table that there was another patient and another person. And we would. . . . It was a lovely dinner with wine and a good dinner. But these people really . . . That was extra. They worked so hard, the staff, to prepare all that.

This quote from FAM1 illustrates how the activities and events available when she first moved her husband in (which were essential to his transition) helped them to maintain and create relationships in the home with staff, other residents, and their families. Unfortunately, these activities were not carried on in the home, as FAM1 describes, "and suddenly there were many changes [with management]" and "activity is at a lower level than it was when we arrived here."

These stories from FAM 1 and FAM3 show that the gap in communication between what the home offered for their loved ones and the long-term reality of upholding these activities is dependent on many factors that family and residents have no control over. For FAM1 and FAM3, the experience of this communication gap was seen in the number and types of activities in the home as well as the staff to support them. Activities and social programs in LTC provide the opportunity for new residents to meet others and for their families to interact with staff, focusing on the social aspects of care and relationships.

Staff members also shared experiences of encountering communication gaps or discrepancies, such as those between what family members say about their loved one's abilities and the resident's actual physical abilities and personal preferences. It can be extremely difficult for staff when inaccurate information about care is shared. Staff members argue that this discrepancy leads to difficulties in planning time for care. The nurse must assess the physical capabilities of each new resident and, in Ontario, provincial regulation states that an admission care plan must be completed within the first 24 hours upon admission and communicated to direct care staff within the same 24 hours after admission (*Long-Term Care Homes Act*, 2007). On the day of move-in, the nurse begins to gather information for the care plan from the resident or family (if the resident is unable to participate due to cognitive impairment). Initially, the information that is of utmost importance is how the resident ambulates, transfers, toilets, dresses, and eats, which must be communicated to the PSWs. When the resident is unable to provide answers to the assessment questions, it is what the family says about the resident's physical abilities that is communicated with staff. When these two aspects of care are incongruent (what the family says the new resident can do and what the person can actually do), frustrations and tensions arise. Families are not always aware of the level of care their loved one requires, as

PSW1 explains, “the family members will say unrealistic things, like ‘mom can shower herself.’ Meanwhile mom has had homecare for the last 10 years and hasn’t been showering herself.” This gap in communication and discrepancy in care needs places additional stress on the staff, residents, and families. Staff must also deal with family members’ lack of understanding in how the needs of their loved one have changed. This situation suggests that more time for staff and families to communicate clearly and accurately when a new resident moves in is critical to avoid miscommunication and tension.

Related stress arises for front-line care staff such as PSWs, the first people to care for the new resident, when they receive the report from the nurse about a resident’s physical abilities and these are grossly overestimated. Staff members then have the hard task of informing families of the actual abilities of their loved one, which can bring about more stress and confusion. Families also have a hard time when this gap in communication arises as they may sometimes blame the staff for not meeting the needs of their loved one or, worse, for the decline in physical abilities of their loved one after moving them into the LTCH. Residents can be caught in the middle between staff and family deciding how best to meet their needs while trying to express their own wants and preferences in the management of their care. For example, staff must contend with the tensions between family members’ preferences for their loved one and the wants of the new resident. When these two requests clash, staff are stuck in the middle trying to make each party happy while meeting the needs of both residents and families. PSW2 describes this discrepancy and its effect on residents’ behaviour:

> Some of the things make some of the residents get aggressive. Because we have them up in the wheelchair, the family members say, no, don’t put them back to bed. Leave them in the wheelchair. I don’t know why they don’t want. . . . And

> the resident wants to go to bed. They ask you to go to bed. But the family members say no, don't put them to bed. What can we do? . . . So you know, it's a challenging job between us and the residents.

The RPN interviewed also spoke about her interactions with family members: "especially some of the residents' family, they are so demanding, you know. So it puts us in stress." At times, the RPN said, families would give their loved one a medication that the doctor had not re-ordered in the LTCH; they could not understand why the doctor would take them off of it. This miscommunication puts residents at risk and undermines the staff's work. The RPN's example suggests the need for more communication between staff and families in order to conduct health teaching, field questions, and create working relationships. This also implies that more time devoted to communicating during transitions would be helpful in sharing information and align care planning.

One resident talked about his experience during the admission interview and how he was left out of the conversation. As told by RES3, on move-in day "she [nurse manager] talked business with my sister, assuming that my sister was in charge of me . . . . like that totally rolled me. I've been running my own life all of my life." This situation reflects a lost opportunity in that the resident was not allowed to express himself and communicate his own needs and preferences to staff; he was disregarded as the expert in his own life. RES1 expressed that the "challenge really is the loss of independence." When these types of gaps in communication occur, the resident loses autonomy and is not being respected as an individual in his or her own right.

When family members experience gaps in communication it can affect how they interact and connect with their loved one. FAM2 described staff not teaching them about their loved one's new mobility aid. This lack of communication made it more difficult for this person to continue being involved in their family member's care:

> Because I feel that as a family member, we're not helped in any way whatsoever on how to do things. For example, with the wheelchair, I go to the zoo and then I suddenly realize, boy, I need to know . . . I should have known this, I should wheel my husband backwards in certain areas. . . . I thought, wow, some people learn this I guess the hard way.

Prior to transitioning into LTC, many residents are cared for at home by a loved one, and these family members can find it difficult to give up this caregiver role completely. Therefore, being invited by staff to learn how to continue to be involved in that caring relationship in the LTCH was identified in this study as extremely important. As FAM2 explained, "with more useful advice and better communication with staff they could be 'look, this is what could be done to make him [husband] more comfortable.'. . . But you see there's no one to give any kind of advice." When communication gaps occur between staff and family, uncertainty develops, as family members are unsure of what to do and how to stay involved in their loved one's life, potentially leading to a decline in or loss of their relationship. Staff members feel pressure between what the resident wants and what the family says. Thus, for staff to engage in more dialogue and collaboration, not only is more time needed for interactions with family members, but an emphasis on the importance of these type of interactions could also be helpful.

One PSW (PSW3) spoke about not receiving information from other colleagues about a new resident, suggesting that this gap in communication had to do with a lack of time during morning rounds, time pressure for morning care, a reliance on casual staff, and the type of communication tools used. PSW3 described sometimes using the Kardex for information about a new resident (but that it is often not enough) but that it was during rounds when staff got the majority of information about a new resident. Morning (or afternoon/evening) rounds are two-fold. First, it is a verbal information-sharing huddle among the staff who are leaving and the staff who are just beginning their shifts to go over what occurred during the past 12 or 24 hours. Then, the new staff discuss the shift plan and any new resident information. PSW1 describes a typical set of instructions she receives in morning rounds from the RN:

> And they let us know of any changes, anything that may have happened in the night, who's had more behavioural issues than others, if there have been any say falls or near falls or anything like that. Anything that we should be looking for. If we need to get samples. You know, if there's anybody who's on outbreak or anything like that.

When all the personal details about residents are not provided, this gap in information sharing among staff makes caring for a new resident challenging. These types of communication gaps put pressure on staff to quickly figure out the specific needs and preferences of each new resident, given that there is no extra time or staff for doing that type of work. Staff comments, like those presented above, suggest that there are tensions between the resources (time and staff) required to gather that type of information and the proper communication channels (documentation) used to share it. For example, with more staff on each shift, there would be more time to learn about a new resident during morning rounds, as the day staff could take a little more time together to go through, in more detail, the care needs of a new resident based on the Kardex and other assessment tools. This extra staff could also result in the new resident being given more time for care, reducing work and time pressures for the staff.

Family member participants experienced gaps in communicating with staff about their loved one’s personal preferences, needs, wants, and lived experiences. This information was seen by families as important to share with staff in order for them to honour their loved one’s autonomy and uniqueness. Family members spoke about the challenges of communicating with staff that were new and unfamiliar and the time pressures on staff and PSWs in particular. FAM2 spoke about communication gaps and the challenge of meeting with multiple care team members and the struggles of working with unfamiliar staff:

> Okay, it [information] can go in the care plan. . . . You see, even though some things are in the care plan, like someone steps in here and has no idea what to do. And there have been so many different staff members. They just don’t know what to do.

When staffing changes occur or there is a reliance on part-time, casual, or agency staff, continuity of care can be interrupted for the resident. Family members may also express concern, as FAM3 describes: “So you start getting used to people, and it’s been constant shifting, constant change. So for my mother, it might not be a challenge but for me it is.” The variability of staff and the number of team members create challenges in communicating everything to all staff about each resident. Families have responded to this challenge by putting up signs in their loved one’s room with both personal information (preferences and likes) and physical ability instructions (weakness or injured area). These actions by family members speak to the number of unfamiliar staff in the home (who are inadequately informed about the particular needs of a new resident) and family trying to maintain continuity of care for their loved one in the only direct “at the bedside” way they know how (signage). In turn, the experience of part-time and casual LTCH staff who are unfamiliar with the unit they are working on and do not know as much about the residents (as full-time staff) is that work is much more difficult and hectic. PSW2 said, "I will do a night shift, 11 to 7, but only on this floor. I wouldn't do night shift on no other floor because I'm not familiar much with the people on the other floors." This comment implies that when staff are more familiar with the residents they care for they are more comfortable working with them because they know what to expect from them (PSW2). Residents also commented on casual staff and how staff not being familiar with the residents impacts care and work: RES2 stated, "And they get relief people from the agency. . . . They don't know their ass from their elbow." RES1 described a recent experience with an agency nurse on his own floor:

> Because what happens is they get these agency nurses to come to fill a hole . . . but of course to give you a typical example, two nights ago there was somebody out there, and of course I could see she was flapping around. . . . Technically we've got a nurse. But practically, no.

Many family members report coming into the home exhausted from providing care and/or express guilt from moving their loved one into a care home (FAM1, FAM3). Communicating with family is so important during this time, as moving their loved one into LTC can be a distressing time. Family concerns and support are often pushed aside during transitions, not because of a lack of caring by staff but because of time constraints. The discrepancy between communication with families and time required for this is illustrated in the following comment; the RN describes completing admissions at *Loftly* with family members and the missed opportunity to support those families emotionally: On the first day, the challenge with the family is they come in here exhausted already. . . . But those that come from home, they are exhausted with the transition." She then goes on:

> And emotionally they [family] are so worn down. . . . And then to come in here, there is guilt feelings. We could feel that at the same time. They would cry sometimes in the middle of the admission. And you're so busy already, you need to finish this. But then at the same time, you have to have an understanding for them that they . . . it is really very difficult for them.

The discrepancy between the type of care the RN wanted to provide and the care that she was able to provide while still completing her work is one of the tensions during transitions. The implications for staff when the type of care they want to provide is not supported with sufficient time and resources to do that work can lead to stress and a personal dilemma where the work they are performing does not align with their professional ethics. This suggests that more time needs to be allotted to spend with families on move-in day (with extra staff to cover the day-to-day running of the floor) in order to communicate with families and residents and have the time to provide relational support.

Theme Three: "Pushed and Pulled"—Transitioning as Hectic and Rushed

There are multiple staff members who assist with the transition process in LTC, and roles vary from facility to facility. In *Loftly*, the care structure (on one floor split into two units) is described by the RN:

> . . . the RN has to be on for 50 residents. And there is one RPN as a medication nurse and a treatment nurse. And there are three PSWs looking after 25 residents . . . and another on the west side, it's also three PSWs working.

Given this structure, during transitions the RN is responsible for the majority of the admission paperwork of the new resident (such as medication reconciliation, allergies, diet, age and health status, physical assessments, and vital signs). PSWs help in settling in the new resident (showing the person their room and instructing them in how to use the call bell) and reporting to the nurse on how well the new resident did in performing ADLs and transfers. PSWs and nurses work together to complete the assessment process within the first week of a new resident arriving.

In the study setting, the RN described the experience of admitting and assessing a new resident as working within a tight deadline, often on very short notice. When asked to describe an average turnaround time from when she finds out a new resident is coming and the actual day they arrive, the RN stated, “There were times like oh, okay, she’s coming in tomorrow, right away. Or even sometimes coming in—Oh, this afternoon [participant], there’s a new resident coming in. It’s like that.” This suggests very little warning is given to staff when a new admission is coming in, making it a challenge to prepare for it. If staff do not know when a new resident is coming, it is very difficult for transitions to be well planned in terms of staff and time. There are sometimes delays in getting all of the necessary documents from CCAC or the previous facility, which intensifies the busy-ness of the transition as staff are pushed to complete the admission even with missing documents. The RN indicated the implications of missing documents and the pressure to transition the new resident: “There are times like that [missing information]. There were times like that. So it’s very, very stressful for us when that happens.” Not having the necessary documents, but having to admit a new resident anyway, intensifies the need for staff to hurry and assess the new resident regardless of whether the correct paperwork is received. This suggests that a push for efficiency is occurring as staff must get the admission and assessment done regardless of having inadequate resources to do so. What was made clear by staff was that on admission day there was no change in the daily routines of the LTCH and no extra staff were provided; the process of transitioning a new resident occurred within a standard work day (RN).

One of the larger stressors reported by the RN during transitions was the Ministry regulations to initiate a nursing care plan within the first 24 hours after admission. Phrases such as "it's a lot to keep in mind" and "you're so busy already" were common in speaking about the admission day (RN). The RN illustrated this rushed and hectic process in the following statement:

> . . . the first day of admission is very challenging for me. Because on top of everything that you have to do, the admission, you really have to have . . . to give time for that because it's very crucial . . . for the resident, for the family at the same time.

To improve this transitional process, PSWs and nursing staff mentioned that if residents and their family members could come in before move-in day to complete all the necessary paperwork, it would not be such a stressful experience and there would be less work for the staff on move-in day. In addition, this implies that the time and staff required on move-in day needs to be increased in order to meet the needs of the residents and family while balancing workloads for staff.

Family member participants and one resident also spoke about the "one day" phenomenon during transitions. "One day" (24 hours) refers to the timeline the LHINs in Ontario have laid out in which a person waiting for LTC finds out about an available bed and then accepts it. This makes the practice of coming in to orient oneself before a move into LTC challenging. This was the case for FAM4's experience of transitioning into *Loftly*: "It was an emergency placement. . . . And so we had one day to decide whether to accept or not, and then one day to move. So it was quite rushed. . . . It was very hectic when I came in." Implications for staff concerning quick turnaround times for moving in a new resident include the increase in workload. Often no extra time is set aside to do the work of transitions, leaving staff to deal with the pressures of "getting the job done" at the expense of their own personal time or other LTCH residents' needs.

The current wait-list processes for LTC make it very difficult for family and residents to plan ahead or for staff to predict when a new resident will arrive. FAM3 spoke about the "pull" to get organized and ready to move their loved one in: "Okay, my sister and I arrived the day before just to see what room she was going to have, and this and that." RES3 had a similar story about transition and described the pre-move timeline as "Count them—5 days to collapse my place. . . . And to turn that around suddenly. And I had to be here and stay overnight to be able to define myself as a resident." These stories illustrate the very short notice that families and residents have when deciding to choose a LTCH, making an already stressful move even more hectic. It also suggests that more notice, and thus more time, would address the hectic and stressful process of transitioning.

Families described move-in day as a very hectic push by staff to hurry up and complete the move and admission and to settle their loved one in as fast as possible. FAM2 spoke about moving her husband into *Loftly*:

> Students I guess came to get my husband [out of bed]. They didn't know how to operate the sling or anything. So everything was delayed. Then it was a big rush to get him into the dining room for breakfast. . . . Everyone seemed to be working in a panic mode. So it was like, I need to sign this, sign that . . . . So everything

> was rushed . . . I think I was probably at the workstation there, signing this and that. So that could have gone a little smoother.

Similarly, FAM3 had a simple but telling description of the transitional experience: “It was a whirlwind.” This sense of feeling rushed was also mentioned by RES3, who stated, “This facility gave me 20 minutes of a questionnaire that I got questioned from the nurse . . . and that was it.” It is incidences like these that illustrate the busy-ness of transitions and that there is not enough time allotted to new residents on move-in day.

Staff shared stories of how transitioning into LTC can be traumatic, upsetting, and emotional for many new residents and their families. They also shared that these emotions can range from depression, sadness, and guilt to anger and frustration. The RN interviewed spoke about the push of families’ expectations and the pull of the reality of care happening in LTC:

> Because it is, as I said, one PSW has about eight to nine patients to look after. And if both are needing help and you cannot leave the other person in the toilet themselves, and how are you going to be able to? So there is a waiting period. And most of the time, the family is like, “Nobody is there for my family.”

RES2 shared her experience of how LTC can be hectic and rushed, especially during the peak hours of the shift:

> Well, it depends on the time of day. There are sort of rush hours here. It’s like trying to get everybody up for breakfast all at the same time. And that takes quite a lot of time. Because you can’t give everybody half an hour in the morning. If they need it, they maybe take a quarter of an hour. But how many people can you get up between 7:00 and 8:00 if you give everybody a quarter of an hour? In that

> case, it doesn’t work. There’s 25 people to a slice. . . . So we’d normally have about three PSWs . . . so it is rushed then.

This push and pull is evident in transitions, when staff do not have the time to carry out the services they would like to provide. The RPN interviewed echoed similar experiences with families and residents when they arrive and within the first few days. The RPN said, “You know, the long-term care, it’s a strange place for them . . . they need time to adapt to the situation.” Thus, trying to settle the new resident in quickly in order to have the home feel more familiar is what staff would like, but given that there is not enough time or resources to do that, residents can sometimes display negative behaviours or are uncooperative (RPN). The pressure that staff experience to meet new resident and family expectations for care only intensifies during transitions as staff have an increased workload with no extra time to do it.

PSWs experience first-hand new residents’ reactions toward the transitional process into LTC. Staff members report that new residents react to transitioning in varying ways and display behaviours in reaction to the process. PSW1 described this as “lots and lots of depression. They feel abandoned. You can see it, they feel abandoned.” And the following comment by PSW2 illustrates her experience with resident difficulty in transitioning: “There’s a reason why they brought you guys here so we could take care of you. But some of them don’t accept it.” These comments illustrate a response by residents to a fundamental shift in the process of transitioning older adults into LTC. The behaviours experienced by staff and displayed by new residents pushed into LTC speak to the level of support required when transitioning. This implies that allotting more time to spend with new residents in transitional activities may help to address and identify the above behaviours described by staff.

Staff members share that transitioning is a major disruption, with some new residents literally “pushed” into LTC. Hence staff feel a pull to ease the process and settle a new resident into the home quickly. Not only does supporting a new resident’s move into the home ease their anxiety and fear, but staff workload intensifies further when a new resident continues to display behaviours after moving in that challenge staff to complete their daily care tasks.

Families also report being pushed and pulled during transition, as illustrated in a simple vignette told by FAM2:

> . . . because you have to make out the sheet about the clothing, I had everything laid out on the bed but suddenly now they needed to put [husband] on the bed. So now I collect all the stuff and get it all messed up again [laughs]. And then I tried this again. And there was some interference. No, maybe the person here needed to meet with me. So then of course I leave everything again. Like it was, you know, mess everything up again [laughs].

This suggests that the process of transitioning is full of moments when the family is pulled to get their loved one moved in as soon as possible in order to get them settled, but that they are often pushed out of the transition because the process is so hurried. Given that residents and their families want more information and direction during the move-in process, more time with staff is needed in order to collaborate and work together.

Theme Four: “Checklists, Paperwork, and Questionnaires”—The Logistics of Transitioning

The type of information gathered by the RN on move-in day was described as a series of checklists, assessments, and documentation to facilitate both Ministry and LTCH guidelines.

Front-line staff (nursing and PSW staff) identified similar tools, such as checklists, for gathering information from residents and/or their families during the initial transition into the facility. Much of this information was clinically based, such as medications, ADLs, diagnoses, and allergies. For example, the RN stated the following:

> Because by the time upon admission, you have to start. . . . You have 24 hours deadline for nursing care plan. So you have to start this right away, the nursing care plan on that 24-hour period. Otherwise that is late already. . . . They want it like at least the ADLs—eating, dressing, transferring. Those are mobility, those are needed right away.

She continued:

> You also communicate with the PSW. Okay, the clothing, it has to be labelled. Does the family want having laundry here or not? Those kinds of things. So you have to confirm that all the information is correct. You have to have a background history of falls, pain, behaviour concerns, and incontinence. So the overall care. Even is he being seen by the specialist? . . . Within that 1week period, you have to get the doctor to assess the patient. . . . And then you have to do a referral to the occupational therapist, referral to the RD [registered dietician]. You have to do head-to-toe assessment. And if they have open wounds or anything like that.

This exhaustive list and mandatory paperwork plus assessments are on top of an already busy day for staff. When care is organized in this way, there is very little freedom for residents to talk about themselves and to share their histories and what they like. For staff, this implies that there is no opportunity for them to ask questions that they believe are necessary in order to help care for a new resident, such as personal preferences and histories. As more personal details about a new resident, and the time to learn about these details, are overlooked during transitions, staff members are less and less able to gather the information they believe is necessary to provide quality care.

Staff experience the admission and assessment period in various ways as they have quite different responsibilities. PSWs are primarily responsible for assessing the new residents' capabilities in ADLs, and communicate them to the nursing staff. Part of this is determining if these capabilities are congruent with what the family or resident stated on the admission. PSW1 describes this process as follows: "We do an assessment when they come in, and we do a Kardex and everything like that, and our nurses do it. So at least I have something." PSW1 went on to say:

> So when new residents come in, we do like a new admission as well. Like we let them [RNs] know, okay, this is what tasks they could complete when getting ready for bed. We do like a checklist, too. They can comb their hair, they can get dressed, they can brush their teeth, and they can wash their face. They know that their pants go on.

PSW1's description of the early days with a new resident includes "the first night shift, the staff will say, 'Okay, you know what, they're good-assist times one to the bathroom.' But, you know, you've got to watch because they'll get out of bed." The PSWs document what type of support the resident requires during care so that nursing staff can make decisions about further assessments and make changes to the care plan. The RN's responsibility is then to "review as well what the PSW is coding [documenting], if it really coincides with what is going on with the patient" (RN). This process suggests that front-line staff need to go beyond the checklists and physical assessments and gather information that is more personal about a new resident in order to get to know them as individuals and then be able to share that information with other staff in a consistent way. The implications for staff are first, using an assessment tool that also focuses on the non-physical aspects of care, and second, having extra staff on shift so more time can be spent talking to new residents.

For nursing staff, their role is to gather information to begin to fill out the necessary paperwork, consisting of checklists and tick-sheets. The RN role at *Loftly* was to assess the new resident

> and fill out every single form—the resident's name, the resident's date of birth, allergies, what kind of diet is he having, how many person assist does he need, is he ambulatory, is he in a wheelchair, is he in a walker, and those kinds of things that you have to keep in mind. So those are the things. (RN)

Then the RN determines the new resident's ADL abilities (relying on input from PSWs and other staff as well as the resident and/or family discussions). These are then documented and conveyed to the various staff members. It is the PSWs who perform these ADLs with residents, starting day one, and report back to the nurse how well the resident is performing these activities and what other information may be helpful, such as whether the resident requires the assistance of one or two persons when transferring from bed to chair, etc.

As illustrated by the comments above, many checklists and tick-sheets are used during transitions to gather the more measurable aspects of care (toileting, feeding, transferring). In contrast, PSWs, families, and residents identified that these tools do not gather all of the important personal details to facilitate the care of and relationships with new residents.

According to staff members, the information they must collect is often not what is needed in order to maintain quality of life for each resident. Instead, staff argued that successful transitions rely on the gathering of personal history, preferences, and other resident background information. This is because providing information that describes an individual creates a space for relational care while setting up care work that is based on the unique needs of individuals rather than the more measurable aspects of care (i.e., physical tasks). PSW3 notes that the information that is gathered upon transitioning is not always what is wanted: “Sometimes you’ll get the person’s Kardex that they don’t like fish, they like pork, or they don’t’ like pork, they like fish. But we need more of the details, yeah.” Again, being able to get to know the resident was identified as key to providing quality care.

Family members discussed the information that was gathered about their loved ones, noting the priority given to clinical data and the more measurable physical capabilities and needs. For example, FAM2 described what their admission interview was like, recalling questions focused on medications and past medical history but not about their loved ones’ preferences or wants:

> But at least the medication was correct. So that was good. . . .Okay, I guess it was more about what he did. . . . You know, had he had a tetanus shot, had he had . . . That sort of thing. . . . But I would think there would have been some questions, you know, about his interests.

When the admission interview and paperwork do not capture the sharing of personal information about a new resident, an opportunity is missed to begin building care that is relational. In other words, creating relationships with residents is rooted in taking time to understand their needs and interests. When the focus of transitions is primarily about physical aspects of care, creating relationships between staff and resident is challenging. Not knowing a new resident's personal needs and preferences, which staff and families identify as important to know, makes it challenging to begin the process of creating care relationships between staff and new residents.

FAM1 spoke about the importance of communicating to the staff who their loved one is as a person and how this should be communicated starting day one in order to establish relationships with staff:

> If it's possible for the family to have a little session with the staff [about] what is the wrong thing or what do they like? That would help a lot. I think that is what I underlined [referring to the research handout provided to participants explaining the study]. It's very stressful. To make it easier, it's important for the caregivers to find out more . . . the likes and dislikes of that person, or their problems or something.

When speaking specifically about the first few days after moving in and what it would mean to residents and staff to be able to spend more time together in order to get to know a new person, FAM1 identified the following:

> Maybe one caregiver first to be more familiar with that person so that it makes it easier at the beginning. I think that, I would say, is important. Because if you have eight on the floor. . . . So I think it's important at the beginning to assign one to find out a little bit more of that person.

This implies that new resident information, which families prioritize, is not those items being captured on checklists and medication lists; rather, it is in the individual resident details where relationships are made. This speaks to the importance of continuity of staff in LTC. To get to know someone one must consistently spend time together in order to get to know one another. This is better facilitated with the same staff on the same unit each shift.

Residents also commented on the type of information gathered during the admission interview while transitioning into LTRC. RES3 described the admission process as a set of yes and no questions focusing on the more clinical aspects of their care. RES3 also pointed out that there was no time allotted for an open question-and-answer discussion, where so much more information could be shared and gathered in dialogue. As RES 3 recounted:

> She ran me through a set of things—are you allergic to this or that? . . . And there was no pragmatic things. . . . And there was no open-ending thing. . . . There was no openness of. . . In other words, she had her set questions that she had to ask, her clinical things. But there was no open forum.

This implies that the tools to gather information and the structure of transitions are not meeting the needs of residents nor creating an open space to share and discuss those needs. This finding suggests that residents would like an opportunity to share with staff who they are as individuals and be given the time to do so during the admission process. RES2 commented on the amount of paperwork as well, saying, “The girls have too much paperwork to do. . . . Instead of doing all this paperwork, they should be doing practical hands-on stuff.”

In other examples, a family member and a resident spoke about how they experienced the initial admission and assessment process when moving into *Loftly*. They described this process as highly structured, impersonal, and hurried. FAM2 talked specifically about the care plan meeting, which generally happens within the first few weeks in the LTCH. It is a collaborative meeting with various team members (nursing, physician, dietary, physiotherapy, occupational therapy, life enrichment specialists) to discuss the goals and care of each new resident and how the LTCH can support this care. This family member's comments reflect the regulation in LTC: During the meeting she noticed that everyone was on their computers filling in all the necessary forms (to satisfy Ministry guidelines). She described her experience as follows:

> But I found with the care meeting itself, well, with the doctor, I had written down exactly his medication and everything, and he just rattled that off so fast. But at least I could check this off, check that off, have some questions. But you know, he did that very quickly. Very quickly. And then he's on his computer the whole time. And with the others that were in there, they were probably filling in for like the manager or whoever. And it was more "I am so and so." I don't know if it was like a help me do something different for your husband. You know, about his meal planning or that sort of thing. . . . And so it's like they've done their part, and the care meeting is completed. (FAM2)

This demonstrates the priority placed on recording certain information rather than a focus on actual care information that would contribute to the act of caring. FAM2's experience also shows that family members' contributions are not valued the overall care planning of a new resident, thus opportunities to invite family as care partners are missed. What is also relevant about this meeting is the use of the computer, which created not only a physical barrier to connecting with the family member (eyes down and typing) but also highlights the prioritizing of the "gathering" and "documentation" of Ministry-mandated data.

Residents also spoke about the logistics of transitioning and what was being missed, such as making connections starting day one. RES3 stated, "And there was nothing like I'm a new client . . . just plunk, here you are. . . . And there was no documentation or orientation at all." This remark indicates that the work of transitions is focused on the tasks of moving a new resident in instead of on the personal aspects of transitioning to foster relationships. When residents are not given the opportunity to share about themselves, it implies they are not the expert in their own lives; when moving into LTC, quality-of-life indicators (e.g., spending time with others) no longer matter as much as having physical needs met.

The four themes presented in this section capture the expressed experiences of staff, residents, and family members regarding transitioning into LTC. All participants described time and communication as being central to the experience of moving in, and that what is needed is more of both. For example, more time is needed in the LTC home for a thorough transition (take a tour, explain/learn details of the home or get to know one another), ensuring that the needs of new residents, family, and staff are asked about and then addressed. Participants identify communication as central to improving transitions into LTC through storytelling, meeting new people, and getting to know staff. Both communication and adequate time are dependent on having enough staff (and institutional support) to do the work of transitions. Despite the challenges and pressures when moving someone new into LTC, the findings suggest that staff members are striving to meet the needs of residents by committing to the care of each resident and family member while acknowledging the importance of care as a relationship.

Chapter 6: Discussion

This study highlights the experiences of new residents, family members, and staff as they transition, experience their loved ones' transitioning, and do the work of transitioning, respectively, into an LTCH. The four themes identified in my findings have led me to the following conclusions:

- More continuity in the processes and support are needed before, during, and after transitioning into LTC.
- More time (and thus staff) needs to be spent on the process of transitioning.
- Relational care needs to be valued more in the context of LTC.

Here I will discuss how my critical perspective has encouraged me to explore how relational care (creating relationships) is valued during transitions by residents, families, and staff and how all three groups experience challenges in providing and receiving that care. I will address how those who do the work of transitioning and those experiencing transitions deal with contradictions between what they suggest would make the process better and what's currently happening and how this relates to neoliberal and gendered forces.

My findings add to the knowledge of transitions and support the evidence on the ways gendered forces and neoliberal reform have impacted care and care work in LTC. These reforms have changed how LTCHs are funded and structured and directly affect those who do the work of and experience transitions. Increased government oversight, through standardization and an emphasis on measuring and counting, makes LTC one of the most regulated sectors in health care. These reform directions influence what care is prioritized and how that care is organized while contributing to the commodification and marketization of care.

To maximize efficiencies and optimize cost savings, LTC has turned toward increased management and control of care work such as those things that are most easily measured and counted (clinical or biomedical-based indicators). This focus has gendered implications as well, because those things that are not so easily counted (such as the relational aspects of care or engagement between staff and residents and families) are seen as less important in terms of who provides them (the majority of whom are women) and how they are funded. This intersection between gendered and market forces comes together to devalue the relational aspects of care (Armstrong et al., 2001, p. 125).

The Need for More Continuity during Transitions

Implications for Staff

Staff identified in this study that they are not given enough information about a new resident during two very important times of the transition: first, prior to a new resident moving in, and second, when going in to care for a new resident. What was made clear in my literature review is that staff must complete various Ministry assessments and tools within a set amount of time. What has also been highlighted is the fact that these tools focus more on certain aspects of care over others. The checklists and tick-sheets staff use to gather information from new residents and their families prioritize biomedical factors, medications, and ADLs and limit the sharing of the more relational aspects of care that staff deem just as important (if not more so) in order to react to and engage with new residents. Working in this way forces staff to “go in blind” and work using a “trial and error” approach. More importantly, it reflects the push for efficiencies in LTC and how staff are not provided with the right information to meet the needs of new residents and their family members.

An emphasis mostly on ADLs and continence during transitions means nurse and PSW work is organized more by the time it takes to perform physical tasks with a new resident. While this is important, it places less emphasis on the time it also takes to create relationships with new residents while engaging in care tasks together. By having time to focus on the relations of care, the physical indictors become moments of opportunities. For example, getting to know how someone is in the morning can give staff a better sense about what a resident is more likely to eat and when, improving that person's nutrition level or decreasing their anxiety.

The results of my findings reflect the ways in which government strives for accountability in LTC: what is counted is what is measured. The issue with this approach is that it fundamentally undermines the relational aspects of care that are just as important in terms of quality of life, autonomy, and choice for residents, their family members, and staff. If the government does not address different ways of defining accountability, then LTCHs will continue to be challenged to respond to the increasing acuity of its residents. Instead, government could address accountability in LTC in terms of continuity of care, which has been shown to increase care quality and satisfaction for both HCPs and residents (CFNU, 2015). Continuity of care can be understood in terms of a more stable workforce in LTC (such as more permanent full-time positions) that is able to engage in relationships with each other as well as residents and family members more often.

Providing care that is relational (psychosocial, emotional) makes other types of interactions and care between provider and resident or family better. Neoliberalism and gendered forces have influenced the LTC system whereby it has become one over the other, physical or relational. Adams and Nelson (2009) found that nurses noted restructuring left them with little time in personal contact with residents. The findings from this study go further to suggest that it is this restructuring that is eroding continuity during transitions, as staff are unable to meet the needs of the residents and family members and struggle to keep the transition resident centred. In response to these trends in LTC, research by Toles et al. (2012) indicates that "up-staffing" during transitions (meaning having more staff available on move-in day) could improve transitions by allowing more time to focus on the goals and preferences of families and new residents. The findings from my study add to the evidence stressing that improved continuity during transitions, which includes more clear and accurate information sharing, time to share more personal things about oneself, and a more consistent orientation and pre-move education, would allow for engagement of staff, families, and residents to create a space for relationships.

Standardization is both gendered and reflective of market-based forces (a push to mandate which type of care is prioritized) in that it is a way of controlling the work that is done (documented) and devaluing the care that is otherwise not documented (for example, one cannot document in RAI-MDS the time spent with a resident to help them choose what they want to wear for the day). This neoliberal push is reflected in LTC as efficiencies in terms of staffing and spending. This can be seen in the proportion of for-profit homes in Ontario (the highest in Canada) and to not-for-profit homes, which have had to apply neoliberal activities in order to stay in business (Daly, 2015). Consequently, standardization is part of how cost-saving strategies and efficiencies are realized. Implications of these strategies for staff include working with less-than-ideal staffing ratios or HCPs doing unpaid work, such as missing lunch breaks or staying late after a shift to "get the job done" (Adams & Nelson, 2009). This is evident in my transitions study's findings that on move-in day no changes to work assignments are made and no time is allotted throughout the shift to actually transition a new resident and their family to the home.

Strategies such as these limit the continuity of information sharing among staff, family members, and resident.

The standardized tools staff must complete throughout a given shift also reflect a gendered assumption toward care. Care that is assumed to be inherently female in characteristic, such as emotional care but also care that is supportive and non-curative (as is the case in LTC performed by a mostly female workforce), is undervalued in LTC as well as in other health care sectors and tends to be viewed at a lower status when compared to the more biomedical and acute areas of care work (Adams & Nelson, 2009). This undervaluing is rooted in social and economic forces, including gender differences influenced by the more dominant paternalistic medical model. Due to a lack of recognition of the importance of skilled care work, insufficient attention is given to the importance of transitions. When this happens, the care work provided by RNs, RPNs and PSWs (the majority of whom are women) intensifies as these front-line care workers try to respond to the various and unique mind–body needs of new residents (such as providing a good orientation, introducing oneself) but are not given any time to do so in their already busy day.

For staff, relational care means that the care they are able to provide is attuned to the individual needs of each resident or family member, making the difficult and challenging parts of working in LTC (behavioural issues of new residents due to cognitive impairment or a response to lack of control over the situation) easier to deal with. A study conducted by Rockwell (2012) discussed how LTC care planning is currently dominated by institutional and organizational practices, which challenge the accountability and use of person-centred care to support the socioemotional well-being of residents. This qualitative transitions study adds to this research by identifying that similar, structural obstacles and challenges are occurring during transitions. The findings suggest that given the hectic and stressful process of moving into LTC, more accountability and consistency are essential to prepare for the new resident and plan for the transition on move-in day. Findings from my study also suggest that when staff do not receive accurate and current information about a new resident, starting from the initial admission to within the first few days, providing care is more challenging because of their unfamiliarity with the new resident. Those who do the work of transitions want to know as much as they can about a new resident before move-in day in order to prepare and plan for the increase in workload and intensity of work during this busy time. When care planning occurs under the overarching notion of cost savings, there is no priority placed on the relational aspects of care (such as staff spending enough time with a new resident) but instead on the biomedical aspects of care. The findings suggest that when staff know a resident better and are more familiar with the person, they are better able to predict and respond to new resident behaviours and, in doing so, provide him or her with optimal care and meaningful support.

Research conducted in the area of social work, by Koenig et al. (2014), focused on the tensions between family and older adults surrounding the decision to move into assisted living. They describe the transition as a process taking place over several months and not a one-time event. This qualitative transitions study adds to the research base by including staff perspectives and focusing on the fact that it is “getting to know one another” and building relationships that are important aspects of the ongoing transitional process (a month or longer). My study goes further to note that it is over these first few months when new residents may express feelings of anxiety or fear as aggressive behaviours, while their reluctance and behaviours decline once they become more familiar with staff. This is especially true when a new resident suffers from dementia or Alzheimer’s and is thrust into a new environment, exacerbating confusion. It is this concept of getting to know the “all” of someone (rooted in holism) that encompasses relational care. It shows that the more staff and residents come to know one another and develop a mind–body–spirit knowledge, “caring for” moves to “caring with.” For example, staff described not being able to respond adequately to family members’ questions and inquiries because staff had to complete the admission paperwork as quickly as possible in order to move on with their day. Staff also spoke about the need to quickly “settle” someone in and assess the physical capabilities of a new resident before the next shift change in order to provide information to the in-coming staff. Previous research in the area of transitions has focused on mid-range theories and transition models to improve transitions and maintain continuity (Davies, 2005; Davies & Nolan, 2004; McNamara, 2011). This qualitative transition research adds to this body of work by focusing on the constraints of institutional policies, which challenge the ability of transitions to be more relational. Staff report feeling pressured between wanting to provide care that is resident- and family-focused, while working within a system that optimizes resource utilization and cost savings. When this occurs, staff care work is intensified as they must do the work of transitions while also caring for, and documenting the care on, many other residents.

When care work is organized with a focus on monitoring and managing a transition instead of on supporting structures that can better respond to the unpredictability and chaos of moving a new resident into LTC, staff will continue to experience work intensification and workload increases (Banerjee & Armstrong, 2015). The findings from my transitions study support the findings from Banerjee and Armstrong (2015): Staff describe transitioning residents and family members who are visibly struggling emotionally with the process but are directed instead (to ensure compliance with ministry standards and guidelines) to get the tasks of transitioning complete.

Implications for Residents and Family Members

In Ontario, the turnaround time to move into an LTCH bed can be very short, as little as 1 to 3 days' notice of a bed becoming available. Even when a move into LTC is planned in advance by family or a resident, move-in day has been reported as stressful and hectic (Melrose, 2004). Current transition research focuses on the quantifiable and measurable aspects of a transition to determine the success of that transition (Caruso et al., 2014; Gruneir et al., 2012; Herndon at al., 2013; Swann, 2006). These include, for example, the use and completeness of standardized tools such as communication sheets, medication administration records, and prevention of adverse events such as falls. In contrast to these measures, my qualitative transitions research illustrates that while residents and families understand the importance of the questionnaires and paperwork, they place a higher priority on the sharing of stories and histories with staff—one's lived experience.

In my study, residents and family members identified gaps in communication, such as discrepancies and miscommunication, which undermine the ideals of relational care. Davies (2005) has recommended strategies for family to help support their loved one as they move into LTC, such as attending social events, being involved with staff, and being introduced to other residents. The results of my study show that family members are limited in being able to be involved in the care of their loved one, have difficulties communicating in a consistent way with the different staff in the home, and identify discrepancies between what the home said it offered (in the way of care and activities) and the reality once their loved one arrived.

Residents experienced this same type of discrepancy in communication as a missed opportunity during the admission process; they reported being ignored or talked around, having little opportunity for open discussion with staff to express themselves or communicate personal wants and needs. This result is congruent with research by Rockwell (2012), who highlighted that the reality of resident-centred care is often challenged in LTC when care planning and decision-making are organized by policies from outside the home itself. There is no time for continuity of care with family members or new residents as the "job" of transitioning occurs within the constraints of government oversight and standardization. Regulatory standards have implications for new residents and family members in that when staff experience increased work intensification during transitions, it is reflected in the experiences of those moving into LTC.

The way in which information is collected when a new resident moves in is an example of recent standardization and oversight within the LTC sector. This standardization was introduced as a move to ensure quality, but it does not capture what is most important to family members and residents during transitions. Research on transitions has focused primarily on the use of and effectiveness of assessment tools, supporting that they improve transitions and continuity (Caruso et al., 2014; Gruneir et al., 2012; Herndon et al., 2013; Swann, 2006). The findings from this study focusing on one facility highlight the fact that these tools are not gathering all of the information that is deemed most important to residents, such as personal information and preferences or likes and dislikes. Interestingly, government funding for LTCHs only reinforce the emphasis placed on the more measurable aspects of care, as these are funded most heavily. Research conducted in the study facility suggests that LTCHs are not encouraged to include more of the personal and psychosocial information during the transitional admission and assessment process because it is not directly tied to funding. The resident participants in this study reported that getting to know one another was one of the most important aspects of transitioning into LTC, which supports relationship-centred care as a tool to not only improve transitions but also address the disparity between residents' needs and the push for efficiency.

Storytelling and narrative documentation as part of data collection have been recommended as effective ways to capture information (that may otherwise be missed using more standardized documentation tools) during assessments of older adults, as well as to develop strategies for care in the LTC setting (Finn, 2015; Smith & Kreklewetz, 2012).

Continuity of sharing information before, during, and after moving into LTC was of particular importance in my study, as participants reported communication discrepancies across all aspects of transitioning. The study by Boockvar and Burack (2007) looked at whether managerial-level relationships between sending and receiving facilities improved the transfer process. The findings showed that when the receiving LTCH offered specialized geriatric care and the sending hospital had unique characteristics (for example, delivery system design or inter-organizational affiliations), there was an improved transfer process (Boockvar & Burack, 2007). The results from my study address the shortcoming in the research by highlighting the need to create transitional relationships among the LTCH front-line staff, community caregivers, families, and residents to facilitate continuity of care. Continuity of care for residents requires communication across multiple care agencies. *Continuity* in this area refers to, for example, staff being able to get information from a homecare provider about the new resident or having the homecare provider help ease the transition into the LTCH by continuing to provide care for a short period of time after the resident has moved in. Unfortunately, funding this type of ongoing transitional caregiver support is the responsibility of the resident or family.

The lack of continuity in the communication of information during transitions must be explored while keeping in mind broader institutional and organization processes within which this discontinuity is occurring. Current care structures place very little emphasis on the time and resources needed to create meaningful relationships among staff, families, and residents and instead promote efficiencies wherever possible (Greenwood et al., 2001). These efficiencies can be thought of during transitions as systemic, structural, and economic in nature. In my study, the efficiencies families described speak to an emphasis on certain types of information over others (past medical history and medications over getting to know one another), admission paperwork (while families are standing in halls at times not being able to fully answer questions) and settling in (no introductions or meet-and-greet). During the admission and assessment process resident and family participants identify that the majority of the paperwork to fill out was tick-sheets and yes-and-no type questions. Few open-ended questions or time for discussion was included in the time that staff member(s) and the new resident or family spent together. These findings support research by Banerjee and Armstrong (2015), which looked at the tensions LTC regulations impose on care in terms of documentation and paperwork. They highlight in their study that standardized documents (such as those described above) fail to address the relational aspects of care (Banerjee & Armstrong, 2015). My study's findings illustrate how these efficiencies are experienced by residents and family during the admission process (a time fraught with stress and disorganization) and suggest that during transitions continuity can improve if more inclusive transition activities are used (Heliker & Scholler-Jaquish, 2006).

Residents spoke about how they were not invited to share openly or to ask questions to acclimate themselves to the new home. Residents noted that even after the "transition" itself was complete they were still unsure about whom to contact for assistance, about the LTCH's schedule, or about smaller details such as the on-site laundry process. Residents expressed the importance of being oriented to their surroundings and finding out about the home's routines and various staff roles. Murphy et al. (2013) explored the experiences of older adults relocating from one long-term setting to another and found that, prior to a move, residents want information (knowledge of the new facility, preparation for moving) and continuity (knowing your nurse, family relationships, and relationships with other residents) (Murphy et al., 2013). My study findings add to this research with examples of what can occur when new residents and families are not informed or oriented properly: One resident had the microwave he purchased confiscated because of a rule he was not aware of; another noted that it was easier to just “wait and see” how things worked in the home instead of ask for help. Continuity through communication and orientation was well identified in this transitional study as being important to prioritize.

More Time (and Thus Staff) Needed for a Successful Transition

Implications for Staff

The second key finding in this study is the need for more time during transitions. The findings from this study show that those who do the work of transitions report the work is rushed and hectic. This study highlights that staff particularly struggle during transitions, as their care work intensifies when they must help a resident move in and must complete all transitional paperwork and assessments on top of their regular work day with no extra supports or resources. This finding is consistent with research by Choiniere (2011), who explored care work in LTC and found that front-line staff and their working conditions are being restructured in a way that leads to intensification of workload and ultimately to burnout. My findings suggest that the paperwork, process, and work of transitions are creating tensions between the relational care people need and the reality of what must get done.

The results of my qualitative transitions study sheds light on the need for more staff in LTC while highlighting the pressure staff experience to get the job done as fast as possible. My findings also suggest that staff acknowledge that what they are doing in terms of care and time spent on transitions is not enough. When a new resident is set to move in, staffing levels remain the same and no extra time is allotted for the assessment and admission of a new resident, which, as this study suggests, places staff in an ethical dilemma. They feel pressure to complete the transition but also want to respond to residents and family members in a way that aligns with "doing the right thing."

My findings suggest that by not having enough staff on move-in day it affects the experience of transitioning in a way that staff, residents, and family members find challenging. Staffing in LTC has not responded to the closures of hospital beds in Ontario or the increased acuity and complexity of residents moving into LTC. I propose that government institute a minimum staffing standard in LTC that reflects accurate workload levels for staff. The CFNU has made a similar recommendation, because without this type of standard, staff experience the burden of extra care reflected in more overtime, injury, burnout, and illness (CFNU, 2015). Having enough staff is important for quality of life and safety in LTC, as many residents are made vulnerable by illness or impairment.

Nurses must complete the admission on top of their regular workload and report that the push for efficiency during transitions limits their ability for relational care. The lack of time and resources given to transitions in LTC only reinforce neoliberal and gender forces, which do not provide any opportunity for "being with" a new resident and their family. What is given priority during transitions is information that can be quickly gathered and streamlined (medications, current diagnosis). Hence, time spent with new residents and their families is limited to only as much time as it takes to complete the forms and paperwork, which this study suggests is not enough. Based on my study findings, standardization requires that staff get individuals to meals by a certain time to ensure vulnerable residents are getting the care they need, but it does not reflect what different individuals want, and it places more stress on staff to get people up and washed and into the dining area by a certain time.

Some of the information gathered upon admission is necessary and helpful. Safely transferring a new resident and attending to their physical needs are imperative. This study demonstrates there are critical issues beyond these basic aspects of care. Staff identified that having a personal understanding of each resident’s lived experience would make the transition process better. Front-line staff expressed that connecting with a new resident as quickly as possible helps facilitate acceptance of the care they are providing. Current literature suggests that approaching transitions using relational care as a guide allows staff and families the opportunity to engage in new patterns of interactions and behaviours (Eika et al., 2014). My findings also show that staff and residents want to work closely together during the first few days of moving to make the process less stressful. This transitions study also adds to the research, showing that when residents display behaviours such as refusing care or exhibiting aggression, it is often because they are in an unfamiliar place and are scared and anxious. Familiarity of people, surroundings, and routines can help facilitate the settling-in process, as expressed by the participants in this study.

Staff shared that the more they come to know someone, the easier it is to care for them and respond to their individual needs, especially for those residents with cognitive impairment who display behaviours staff would regard as “refusing care.” For these residents, it is imperative that more time for care is planned to give staff the time to figure out how best to work with such residents. Research by Adams and Nelson (2009) supports these findings; they made the observation that nursing staff are better able to calm a resident with dementia when the staff member has spent adequate time with the resident prior to the incident. Residents also expressed that although having their physical needs met in LTC was essential to their reason for transitioning into the home, the need to spend time and engage with others was essential for their quality of life. My study highlights that residents are keenly aware of and acknowledge the heavy workload of staff caring for some residents (and the added documentation), and often identify that more staff would provide more time to be spent with each resident.

Staff often reported working within a tension between being able to provide the care they know a resident or family member needs but not being able to do this because of the work that must be completed. Structuring care and workload in the LTC sector in a way that allows staff to work to their full scope of practice, skills, and training could better allow staff to engage in relational care with not only new residents but with family members as well.

Residents, staff, and family members all proposed that in order to improve the move-in process, but also assist new residents in building relationships with others, assigning the same staff member to a resident would be beneficial in facilitating the transitional process. The pre-move-in process was also discussed by staff, who recommended that families and residents be briefed in a very specific way regarding the type of care being offered by the home; the processes that are in place for toileting, feeding, and laundry; and filling out paperwork in advance. Staff recommend that to better manage expectations about the type of care that will be provided in an LTCH, preparing family members and new residents for what to expect before moving in would be helpful.

Implications for Residents and Family Members

There is abundant evidence that when families move their loved one into LTC, they experience a range of emotions, from guilt to relief (Davies, 2005; Davies & Nolan, 2004; Reuss et al., 2005). Few studies include the experience of transitioning from the perspective of the resident and how the focus on efficiency and prioritization of certain types of care impacts the transitional experience. The findings from my study extend the current body of transitions research by capturing the voices of the residents and exploring how they experience transitions and what could make it better.

This qualitative transitions research especially highlights the lack of knowledge and the uncertainties occurring before, during, and after transitioning into LTC. Residents identified that they had no knowledge of the staff and were not told who the staff were, what the schedule or process of the LTCH was, and whom to contact, and how, if they had a question. There is very little research in the area of resident and family orientation activities when moving into LTC. In my study, residents and families described being unsure of what to expect on move-in day but also not having any time during the admission process to ask questions. Residents experienced confusion and stress when they were not told key aspects that relate to their care, such as the toileting routine and rules of the home. Family members in this study also described moments when they were unsure about who someone (staff) was or being able to anticipate the next steps in the transition. For example, identity badges are frequently flipped over so they cannot be read, staff communication boards may have yesterday’s staff names and date, or only after moving in does one find out that the home does not provide pull-up incontinent products.

Findings from this qualitative transitions study add to the transitions research by highlighting the lack of time staff invest in the process of moving a new resident into an LTCH and identifying how, by prioritizing certain aspects of care over others, staff, residents, and family members miss an opportunity to use the transitional experience as the beginning of a working and caring relationship. For example, a resident is spoken over and not directly addressed, staff rush through the paperwork because of how much there is to fill out, and staff sit behind a computer to fill out more forms. These experiences by residents and family members illustrate the effect of cost-saving strategies in LTC that pull nurses into prioritizing duties other than emotional and social care (Choiniere, 2011). More time is needed for activities that residents identify as being integral to their quality of life, such as being welcomed; getting to know the physical environment, routines, and staff members; and having time to share histories and other relevant stories.

The Need to Value Relational Care

Implications for Staff

The third key finding in this study is the need to value relational care during transitions. As previously discussed, current transitional activities in LTC tend to be task-focused and take into account the more biomedical aspects of a new resident (Glenny & Stolee, 2009). The findings from my study are consistent with the research presented by Glenny and Stolee (2009) in that staff described tick-sheets to fill out and medication lists to obtain while asking about past hospitalizations and disease. While my study supports the importance of gathering information such as level of assistance needed for eating or bathing as important transition issues, staff, residents, and family comments all suggest that other care is also needed for a successful transition into LTCHs. Furthermore, research on staff experiences during transitions is lacking, which makes this study's exploration of front-line staff (RNs, RPNs, and PSWs) very timely. Although all three groups are responsible for different aspects of care and tasks during transitions, the findings suggest that each group experiences similar time pressures and work intensification. For example, PSWs were told to "get them up" on the first day, with very little understanding of what they are walking into; the RN stressed that if she could have the paperwork the day before a resident moved in, to fill out as much as possible in advance and thus help on move-in day, she could get it all done on top of her regular duties; and the RPN described some residents' family as so demanding that it, in the RPN's words, "put us in stress." These shared experiences reflect current care structures in LTC that de-emphasize relationships, undervalue emotional labour, and prioritize efficiencies.

Staff described tensions when family members wanted something different from what the resident wanted or when the resident's actual abilities (for example, walking and transferring) conflicted with what the family reported. When this happens, caring for a new resident is even more difficult and time-consuming; connecting or building relationships grows with repeated interactions over time to gain an understanding about each new resident and their actual abilities. Until this "getting-to-know" happens, care work can be challenging and difficult, especially when staff are relying on resident information given by family members. This work intensification also reflects broader health care marketization whereby financial incentives lead to strategies (lowered staffing levels) to maximize cost savings, limiting the opportunities to build collaborative relationships (Berta et al., 2014). This qualitative transitions study illustrates that staff workload is improved when family members are part of the care team and work collaboratively with staff while sharing information back and forth. Interestingly, my study also found that when there is casual staff in the home, relationships suffer, as family and residents reported concerns with casual workers being unfamiliar with the home's residents, processes, and people, supporting the finding that it is in relationships that trust and familiarity grow.

In this qualitative transitions study, staff reported an ethical obligation to try and meet the needs of new residents and their family (for example, consoling a family member crying during the admission interview or when a new resident refuses care), even in the face of intense workload pressures and time constraints. This type of work encompasses the relational care staff engage in outside of their formal job requirements. What the findings from my study highlight is that the time-consuming and taxing work of responding and listening to the emotional needs of new residents and family members is made easier if staff know more personal things about the resident (Syed et al., 2016). Staff experiences also imply a gendered assumption toward care, where labour that is not seen as contributing to the economic market is undervalued (Syed et al., 2016). My study identifies that emotional labour or empathy work, which is done primarily by women, is discounted as “real” work and not formally included in the scheduling of one’s work day (time is scheduled for meals, wound care, and medication administration). For example, PSWs care for around eight residents per shift, while a nurse may be giving meds for up to 40 residents (Daly, 2015). My study results show that staff are working with limited resources (staff and time), resulting in a trade-off between working in a way one deems professionally ethical and meeting a certain level of care.

Implications for Residents and Family Members

There is very little research about residents’ experiences during transitions; therefore, this study specifically included residents in the sample to explore how they experience transitions during the act of moving into an LTCH. Sullivan and Williams (2017) performed a meta-synthesis to explore qualitative research that included the perspective of the resident during transitions into LTC in Canada and the US. The articles used in the sample described the experiences after a new resident had already moved in. Two articles describe how resident–staff connections were viewed as positive and meaningful experiences, based on actions by staff, but failed to address how this translates into resident transition-related experiences (Sullivan & Williams, 2017). My study goes further, adding that not only do residents value being given the opportunity and space to create and build relationships when first meeting LTC staff but also have valuable insights into how, during transitions, this is not happening. Residents suggested that to improve transitioning, more and consistent staff are needed each shift, a real tour should be given of the home, and the processes and routine of the home should be made clear starting day one—in others words, “introduce somebody to this new environment” (RES3).

Residents in this study described having no orientation to the LTCH on move-in day, making it very difficult to know whom to talk to or whom to go to for help. They also described being unsure of the home’s processes or rules, leading to a trial-and-error approach requiring residents themselves to become an advocate for their own needs and support. For example, residents spoke of having to find the maintenance person to get something fixed, losing key pieces of laundry before knowing the labelling process, and not being introduced to other staff or residents on the floor. The implication of these experiences is not only a lack of coordination during transitions but also a missed opportunity to “do with” residents instead of “do for.” This is an important distinction and one that is entrenched in the ideals of relational care: In order to “do with” one must be able to gain a fuller understanding of a new resident. The findings from this study suggest that this “coming to know someone” can only happen if relationship-building is acknowledged and planned for during transitions. This qualitative transitions study adds to current research by acknowledging the empowering impact that relational care can have for residents both with and without cognitive impairment, as the risk of being “silenced” during transitions is high. In my study, a staff member spoke about a new resident who screamed and became quite agitated anytime staff tried to shower her. This went on for some time until it was discovered that this resident had survived the Holocaust and being sent to a concentration camp. After this knowledge was shared among staff, the word *shower* was no longer used with this resident and the act of showering was not as emotionally upsetting for the resident. When pieces of information such as this are missed, the result is less than ideal care for residents. If governments funded care that went beyond the clinical to more relationship-centred care, culture, stories, and historical data could be shared and communicated among family and staff and then appropriate plans made to support the needs of each resident.

In this study, family members experienced multiple transitions with their loved ones and held varying caregiver roles throughout the years (direct caregiver, spouse, or son/daughter) prior to them moving into *Loftly*. On move-in day, family members identified a rushed process, where filling in paperwork and signing forms was prioritized. This transitional process was described as "panic-driven" work with constant shuffling of papers with no opportunity to sit down and engage in open discussion. When family members are undervalued as care partners during transitions, it reflects a devaluing of the importance in creating working and sharing relationships with family in favour of efficiencies. My study adds to the research confirming the importance that family members place on informing staff about their loved one (e.g., through signs or memory boxes) and how they want to be involved in the care of their loved one (e.g., knowing how to use the wheelchair or bed controls).

Another challenge that family members identified upon moving their loved one into *Loftly* was the lack of available staff, staff having multiple job responsibilities while on shift, and constantly changing or new staff. These situations made it very difficult for family members to share or receive information from staff about their loved one. Even with various strategies in place for the purpose of communication and consistency of care among staff (such as white boards, signs, care plans, Kardex), this study highlights that these measures did not necessarily lead to better communication between staff and family members. It could be argued that these signs and white boards lead to further alienation of family and isolation for residents. In my view, this is because when staff see signs (that family have made) in the resident rooms about what to do or not do with a resident or signs with more personal information (such as what they like or don't like), staff are less likely to engage with family members for answers, as the assumption is "it is on the sign." Residents may not be consulted or asked questions from staff about preferences for their care because "it is on the sign." This highlights the contradictions within a system that has turned to more regulation in order to ensure quality, but is unable to translate this into transitional experiences due to competing priorities.

The lack of time, resources, and staff allotted to the process of transitioning can be attributed to the idea of "care as profit" and the push for cost-saving strategies. LTCHs operate using a business model whereby they are given a set amount of money per resident and then must construct a system whereby the most efficient practices are realized to cut costs in order to maximize profit. This is realized through the notion that LTCHs can increase efficiencies and maximize cost savings in two distinct ways: first, by standardizing the care tasks of residents, and second, by reducing the number of staff to perform them (Choiniere, 2011). This in turn leads to time constraints, as staff must care for a maximum number of residents. The resulting intensification of work means even those staff members who want to spend more time with residents (sitting and talking with a resident or taking one's time for care of a resident with dementia) are pressured to spend their time on other things such as bathing and feeding (Choiniere, 2011).

Chapter 7: Conclusion

Personal stories and life histories (not to be mistaken with health histories gathered by LTC staff upon a resident's transitioning, which focus on past illness, disease, and surgeries) are important in the context of getting to know someone. The findings from this study highlight the need for more staff and time to be spent on transitions. It also identifies that there needs to be more importance placed on relationships in LTC and during transitions. This means that more resources are needed when transitions to a LTCH occur (time to tour the home, conduct introductions, answer questions, and be together during the transition). Beyond these results, I have identified conditions of care and work that limit experiencing transitions as relational: an overemphasis on reporting, measuring, and counting, plus discontinuity and miscommunication. Since the early 2000s there has been a call to reform LTC in Ontario (Daly, 2015). In response, the government has turned toward an increase in regulation and oversight for the LTC sector.

My study supports other research in finding that care priorities in LTC are influenced by neoliberal (or market-based) forces. When they intersect with gendered forces, the result is a standardized, medicalized approach to care. An FPE approach reveal that it is the more dominant cure-oriented, biomedical factors that are most quantifiable in health care and thus can be managed and monitored. This can be thought of in terms of government-mandated care plans (Resident Assessment Protocols) that are specific to clinical risks such as decubitus ulcers (also known as bed sores or pressure ulcers) or falls. This care plan is generated using the RAI-MDS to create a standardized plan for care but is also tied to compensation. Mood state and psychological well-being care plans are also generated within the RAI-MDS. What is being highlighted here is that despite the psychological and emotional aspects of "mood" and "well-being," the tools used to assess and guide care are still predominantly focused on counting and measuring.

The standardization described above (tools to report and plan care) reflects a neoliberal push for efficiency. What my study findings add is that some *standards* in care are important It is important to know, for instance, how a new resident ambulates or if they have any allergies. Standards of care are different than standardization and are an important factor when promoting care in LTC that goes beyond the clinical, toward the more relational. Standards do not have to mean a "generic or identical care approach" for all; standards of care guide practice to ensure that the right assessment, right intervention, and support are applied in both clinical and non-clinical situations by the most appropriate provider. One recommendation stemming from this study is that government policy acknowledge the unique and specific contributions that an appropriate staff mix can provide in LTC. HCPs working at their full scope of practice in LTC can promote individualized care, taking into account the cultural and personal aspects of each resident.

The effects of neoliberal restructuring include maximizing cost-saving strategies in LTC processes through more numerical-based indicators (Choiniere, 2011). The processes introduced to make transitioning into LTC more streamlined and efficient have come into conflict with the fact that transitioning is a process, unfolding over time, and needs to be rooted in relationships in order to meet the work and care needs of staff, family, and residents. This is reflected in my study when residents and family describe the paperwork and admission upon moving in, but there is no orientation or support before or after that, and when residents and family member use words such as "hectic" and "rushed" to describe the transition experience. My findings add to transitions research by Davies and Nolan (2004), who stress the importance of staff engaging with family in work partnerships to ease the transitions of their loved one. These partnerships are ongoing and reciprocal, and they benefit the resident as information about the person is shared more quickly (Davies & Nolan, 2004).

Currently, the way government has assured care quality in LTC for the public is via increased standardization, such as documentation and public reporting of results. Regulation includes what type of care is documented (observed) and thus measured. What can be measured is prioritized (toileting, eating, ambulation) as most important in terms of workload and funding. This leaves the less measurable aspects of care undervalued (which coincides with the limited amount of social and emotional documentation) as quantified or measured by staff using the RAI-MDS. This focus on the measurable places such things as building relationships, spending time together, and emotional support (which is a large part of the work performed by LTC staff) outside the realm of formal work requirements but well within professional practice requirements that regulated HCPs are held to. The implications of this finding is that responding to the emotional, social, and psychological needs of new residents is happening perhaps at the expense of HCP breaks or time off, leading to intensification of work and staff burnout (Syed et al., 2016).

It is important to note that neoliberal forces are evident in both for-profit and not-for-profit LTCHs, since both types of homes are dependent on the same financial compensation to provide care for residents. For-profit homes stress efficiencies in order to maximize profits, while not-for-profit homes turn to cost-savings strategies. Both must plan for the care of its residents using funding envelopes based on physical aspects of care. For example, LTCHs are mandated to track incontinence and fluid intake, but it is how these data are captured (regulatory oversight and standardization) that leads to the push for efficiency in how the homes are staffed and structured. In my study, staff experienced tension when wanting to provide care that responds to resident and family needs during transitions, recognizing how difficult and stressful this process is, but not being able to take or find the time to do this. This is an example of relational care clashing with the cost efficiencies inherent in the current LTC environment.

The tensions discussed above emerge in LTC where regulatory oversight and personhood come together. Staff in this study experience this tension in ways that limit the scope of their practice and intensify workload. This finding is of particular importance when thinking about the conditions of work as the conditions of care. It is very difficult to provide quality care when the work environment is itself challenging. For example, in LTCHs, violence and abuse toward staff are documented in the literature, and HCPs experience these tensions every day (Banerjee et al., 2009; CFNU, 2015). Policymakers must reflect on the working conditions in LTC and then address the institutional and structural policies that create the conditions of working in LTC. Policies and structures such as having adequate staffing ratios or an appropriate staff mix to respond to the sometimes unique and unpredictable behaviours of older adults living in LTC need to be broadly implemented within the LTC environment. My study findings support the argument that LTCHs are critical transitional points where neoliberal forces intersect with gender to influence care quality and care work. My findings also reflect that the conditions of work are less than ideal for staff. Government policy needs to address how working conditions in LTC create care conditions that are precarious for staff and unsafe for residents.

This qualitative transitions study identifies that relational care is not only about creating relationships but that the care happening in LTC can be more relationship focused (and less about measuring the care of residents). For example, residents should be allowed to make decisions about what they have in their rooms (in this study a microwave was not allowed due to safety concerns), or a new resident and their loved one(s) should be able to guide the move-in process in a way that meets their individual and unique transitional needs. What is most important to note here is that HCPs develop relationships during the everyday tasks they engage in with residents but what is being highlighted is that the care HCPs engage in could be more relational (Alzheimer Society Canada, 2018; RNAO, 2005, 2008). This relationship-focused work then becomes the unseen (unpaid) labour that LTC staff try to perform on top of what they already do—for example, assisting with feeding a resident at their own pace or allowing a resident to wake up in the morning when the person chooses.

My findings are also a reflection of the impact of federal funding cuts over time (CFNU, 2015). Without a national strategy to lead a culture change in LTC toward a more relationship-centred approach to care, those who transition into LTC (HCPs, residents, and family) will continue to experience variation in services. To address this discontinuity of care, LTC policy requires a fundamental shift toward understanding care as a relationship and the impact continuity of care has on the conditions of work and quality of care.

In summary, the findings from this study suggest that increased continuity (in terms of staffing and communication), time spent together (for example, more time to fill out paperwork and ask questions) and more staff (to help with providing a thorough orientation) would help to improve transitions into LTC. Under neoliberalism, care is defined in terms of market, best organized using business approaches to care. This in turn has implications for those who do the work of, and experience transitions into, LTC. What my study highlights is that the policies regulating LTC and the care provided have actually led to a devaluing of certain types of care (such as spending time together or getting to know one another), which can limit staff, residents, and family members' experience of transitions as relational.

Implications for Nursing Practice and Research

Study participants identified promising practices that could make the process of transitioning even better. An initial recommendation included being able to tour the home, prior to moving in, more than once and/or having a trial period (termed *respite care*) whereby the new resident stays for increasingly more time before a permanent move-in date is set. This recommendation speaks to the need for more continuity during transitions by providing opportunities to become familiar with the home and interact with those who work there. This recommendation also allows family members (if geographically close) to ease into the transition of their loved one if the resident is coming from home. This promising practice is supported by the findings from this study and one conducted in Norway which found that relationships are highly valued by those in transition and continuity is achieved not with more forms and tick-sheets but in "being with" others (Eika et al., 2014).

Another recommendation is the inclusion of the homecare agency caregiver (if present) in the care of the resident at the LTCH for an extended period of time after the resident has moved in. Staff identified that their relationship with new residents would be better facilitated (and decrease residents' refusal of care) if the homecare agency caregiver also participated in the care of the new resident at the LTCH for a period of time after they had moved in. These homecare agency caregivers have an intimate knowledge of and a deeply connected relationship with the residents they have provided cared for, and staff could use them as a resource in getting to know a new resident more quickly. Lastly, staff and residents would like what is communicated to be those things that are most personal, such as a resident's personal history and lived experiences. In my study, documenting this on the Kardex or making memory boxes outside the residents’ rooms and bringing in familiar objects from home were all ways family members, staff, and residents felt they could facilitate new transitional relationships.

The results of this study have multiple implications for nursing practice and research. Currently, much of the role of the RN in LTC is focused on management-like duties such as filling out paperwork and completing weekly and monthly audits—in essence reporting and recording. Although much of this work is mandated by government, this study has highlighted whether the role of the RN in LTC could be better utilized. In an environment that research shows is understaffed and overworked, nurses should be doing more than just reporting (McGilton et al., 2012). My study supports the argument that nurses need to be doing more than just organizing the “logistics” of care and instead actively participating in creating collaborative relationships with front-line staff while bridging relationships between management, family members, and the health care team. In facilitating such relationships the RN can lead staff and teams to create environments that are relationship-centred by focusing more on the aspects of nursing practice that empower, educate, and transform. The RNAO invites LTCHs to become LTC-Best Practice Spotlight Organizations (LTC-BPSOs) to work in collaboration with the RNAO in implementing and evaluating clinical Best Practice Guidelines (BPG) (RNAO, 2018b). These LTC-BPSOs engage nursing, senior leadership, and clinical staff in the goal of disseminating knowledge from experiences and outcomes to inform guidelines. In a BPSO, the RN takes on the role of liaison to support guideline implementation, evaluation, and sustainability (RNAO, 2018b).

This qualitative transitions study also highlights the strict divisions of labour inherent at the study site (not all LTC settings may be organized in this way) and how this leads to fragmentation of services and a lack of continuity during transitions. How are we better able to act as a team in the LTC sector? Applying a team-based relational approach to transitions would certainly shift the current approach to care and challenge neoliberal ideals, which have led to the marketization of health care delivery. The RNAO (2005, 2008; 2017, 2018b) also recognizes the need for LTC to adapt and change in order to meet the needs of each resident with dignity and respect. The RNAO advocates for the transformation of LTC to keep residents healthy and safe, through such initiatives as the LTC Best Practices Program (RNAO, 2005, 2008) and an LTC Toolkit (RNAO, 2017), while also taking their message to Queen's Park, challenging government to increase staffing and maintain an effective mix of staff based on resident needs (NPs, RNs, RPNs, and PSWs) (RNAO, 2018a). The findings from my study and discussion suggest that individual staff and groups of staff in LTC have specialized and personal knowledge that contributes to the care of residents. Conveying this knowing, the unique parts of each resident, among nurses and PSWs is central to building relationships with the most vulnerable residents in LTC.

Policy Implications

The research conducted for this study and the data analyzed have policy implications. In Ontario there is no minimum staffing ratio required in LTC. Recommendations based on my study include creating policy for a minimum staffing ratio in LTC to ensure there is enough staff to adequately care for each resident. To accomplish this, the funding model for LTCHs would have to change to include funding for care that leads to positive health outcomes for residents (such as funding the increased time it takes to toilet a resident more often to address incontinence) and supports the relational care that staff, residents, and family members take part in.

Maintaining a minimum hours per day per resident would also increase the time each resident could spend with staff. It would also give HCPs the time they need to engage in care that is experienced as more relational (giving residents choice of how and when their care happens or taking the time to allow residents to take part in their care as much as possible to maintain and foster independence), taking the focus away from efficiency of care. This would lead to less staff burnout and lower turnover rates and thus less reliance on part-time, casual, and agency staff.

When more permanent full-time staff are working in LTC, there is increased continuity for family and residents as relationships can develop and grow during daily interactions. This can also facilitate the sharing of information among the team as the focus is less on “figuring things out” and “getting to know someone as quickly as possible” and more on collaborating and communication. If LTCHs can increase the number of permanent staff positions, work–life benefits for HCPs, such as paid sick-time, health care benefits, and vacation, will ensue. This study posits that when the conditions of work improve, the conditions of care improve. Therefore, looking critically at not just health and quality-of-life outcomes for residents but those of care workers is also important (Kelly & Bourgeault, 2015; RNAO, 2018a).

Improving relational care in LTC means that policies must be in place that require staff training and education about the concept of relational care, its benefits, and what this means in terms of current practice. My study shows that staff are already engaging in relational care with residents, but policies need to be in place that support the intentional reorganizing of the current conditions of work in LTC (workload, staffing, and staffing mix) to create more opportunities (and support) for relationship-centred care.

When policies outside of LTC influence the work that occurs in LTC, what is possible in terms of relational care becomes a challenge. An FPE critique of the RAI-MDS tool itself and other similar assessment and data-gathering tools in LTC highlights that the current focus is too much on what can be measured and less on care as a relationship: working together with a resident without the constraints of time or funding. Getting to know one another is what staff, residents, and family members consider most important when first moving into LTC, yet it is not being addressed in the policies that regulate transitions.

From a broader political viewpoint, the commodification of health care and marketization of services must be challenged in order to address the shortcomings currently happening in the LTC setting. When homes are granted funding based on the acuity levels of its residents (those with the highest needs receive the most funding) two things happen. LTCHs have no incentive to support residents in becoming more independent or maintaining their level of activity once moved into the home. Second, homes are more likely to “game” the system to maximize funding (Bevan & Hood, 2006). Both of these scenarios impact care and quality. Combine these strategies with less than ideal staffing levels and scarcity of resources and what ensues is a system that is financially reliable on the documentation, measuring, and reporting while being pulled further from any opportunity for relational care (Bevan & Hood, 2006; RNAO, 2018a).

The mix of staffing in LTC is important to note here, but also what each member of the health care team contributes to the care of each resident. PSWs spend the most amount of time with residents. This is because of the physical care PSWs are trained to provide (bathing, toileting, transferring, and feeding). Policy needs to recognize the specialized knowledge that PSWs gain through repeated interactions with residents and the valuable contribution this understanding can have on LTC care work and quality (Kelly & Bourgeault, 2015). Nurses are also vital members of the care team and need to be positioned within LTCHs to push through care improvements, playing a key role in relational care while identifying shortcomings in care.

Using a team-based relational approach to care in LTC would require policy and funding changes to address the systemic tensions concerning workload intensification in LTC and safety.

Limitations

This study is limited to one LTCH in an urban location in Ontario. The findings are not completely transferable to other LTC practice settings, for two reasons. First, there is a lack of similar transitions research to compare to and, more importantly, a lack of research that uses the perspective of multiple groups of participants (staff, family, and residents). Second, it is unclear if the research facility and the participants reflect all of the perspectives of those doing the work of or experiencing LTC transitions. Because each LTCH works as its own separate entity, staff roles and responsibilities at *Loftly* during transitions may not reflect what happens at other homes. Other limitations to the study include the small sample size, limiting the transfer of results to other similar care settings, and recruiting participants by speaking to staff first, which may inserts bias into the chosen sample. The exclusion criteria may have excluded participants who could inform the research question in a comprehensive and viable way. Using a case study design with only one unit of study (the study site) limits the scope and validity of the results.

Further research in this area could look at the educational needs of those beginning the process of transitioning into LTC (from home) and how they can be better supported during the pre-move-in process. Future research should also look at the experience of those transitioning from LTC to hospital and back to LTC in order capture how these transitions are happening to and from an acute care facility compared to coming from home. Lastly, future research could look at what might improve relational care in terms of education and training for staff to approach care using a relationship-centred approach, and the importance of creating reciprocal working relationships with other staff and family members.

The time to critically appraise and challenge care quality and work conditions in LTC is now. As an RN and nurse researcher myself it is both an ethical and professional responsibility to question and explore how care quality, staffing and workload in LTC have developed over time as well as propose what policy-makers and government must do to shift the LTC landscape.

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Appendix A

Key Informant Interview Guide: Examining Promising Practices for Older Adults Transitioning into and between Long-Term Care Facilities in Ontario

Introduction:

Research suggests that the transitions experienced by older adults into long-term residential care and between long-term residences and other sectors have a significant impact on the health and well-being of the older adult, are a time of great stress for families, and have critical system and provider/worker implications. Yet there is a paucity of systematic attention paid to identifying and implementing the promising practices for this transition. Our pilot study seeks to begin gathering the experiences and perspectives of resident representatives, their families, and providers about the promising transition processes they have encountered.

The questions asked within this interview are open-ended to allow for a full range of responses. The interview will be guided by eight broad questions, many with follow-up questions or prompts to encourage participants to consider all aspects of the issue. Your responses will be confidential. Neither your name, nor the name of your agency, will be used in any write-up or presentation of the results.

1. Please briefly describe your experience/history with long-term residential care.
    a. Probe—how long has the family member been a resident/ how long they have been part of resident's council/ how long have they worked in this/another long-term care setting?
2. What are your experiences with transitions into long-term residential care/ between different long-term residences/ between long-term care and other sectors?
    a. Probe the type of experiences—how many transitions witnessed, what type of transitions, etc.
3. What promising practices have you observed or do you know of that improve residents' experiences of care transitions into and between long-term care in Ontario?
    a. Probe: assessments, transfers, and admission processes
4. What factors contribute to a high-quality transition experience, including:
    a) assessments (e.g., tools, efficacy, staff training, family involvement, ownership status, etc.)?
    b) *transfer* experiences (e.g., options available, family involvement, communication, etc.)?
    c) *admission* experiences (e.g., familiarizing resident to location, consistent provider, information availability, etc.)?
5. Are there any challenges that you faced during transitions?
6. What could be changed to improve the experience?

7. Is the transition experience different on the basis of gender, racialization/ethnicity?
    a. Probe specific examples/experiences.

8. Do you have any additional comments or recommendations regarding transitions practices?

Appendix B

OFFICE OF RESEARCH ETHICS (ORE)

Memo

To: Jacqueline Choiniere & Tamara Daly, School of Nursing/School of Health Policy & Management

From: Alison M. Collins-Mrakas, Sr. Manager and Policy Advisor, Research Ethics

Issue Date: Fri Sep 13 2013

Expiry Date: Sat Sep 13 2014

RE: **Examining promising practices for older adults transitioning into and between long-term care facilities in Ontario [Ethics Protocol #575]**
Certificate #: e2013-254

I am writing to inform you that the Human Participants Review Sub-Committee has reviewed and approved the above project.

Yours sincerely,

Sr. Manager and Policy Advisor,
Office of Research Ethics

Appendix C

Key Words for Transitions Research

nurse-to-nurse communications

transitional care

coordination of professionals

active engagement in care

promotion of patients and families

evidence-based planning and monitoring

comprehensive assessments

identify, anticipate, help alleviate barriers

patient navigators

system navigators

effective transitions across health care settings

“common thread”

family and informal caregivers

fragmentation and incomplete transfer of information between HCP

continuum of care

care plans and treatment goals

standardize transitions and promising practices

system navigation with “navigator”

fragmented care

transition planning

challenges, opportunities, and benefits with health care transitions

transitions in care

quality improvement, LTC transitions, and aged

transfer, discharge; strategies

person-centeredness

advanced discharge planning

staff member interactions with families

time-limited services or transitional care outreach services

interactions that foster learning, communication, self-efficacy, etc.

optimize delivery of transitional care

Appendix D

Consent Form

Informed Consent Form: Key Informant Interviews

Study Name: ***Examining promising practices for older adults transitioning into and between long-term care facilities in Ontario***

Date:

Researchers:

1. Jacqueline Choiniere, RN, PhD, School of Nursing, **Co-Principal Investigator**
2. Tamara Daly, PhD, School of Health Policy & Management, **Co-Principal Investigator**

Purpose of the Research: This pilot project seeks to identify the factors that facilitate high quality transition practices (including assessments, transfers and admissions processes) when older adults are admitted into long-term care facilities and/or transition among LTC homes and between long-term care and other sectors. Our study will seek to identify promising practices for residents, families and workers/providers.

Criteria for Inclusion in the Study: We are seeking those who work in long-term care homes, including nurses, personal support workers, Directors of Care, and CCAC representatives, as well as individuals from the family and resident councils and family members of residents in each of the three homes selected.

What You Will Be Asked to Do in the Research: We are interested in your experiences with, and understandings of, what constitutes high quality transitions of older adults into, among and between long-term care residences. We are interested in these high quality, or promising practices from resident, family member and worker/provider points of view. You will be invited to participate in either a face-to-face or a telephone interview, lasting between 60 and 90 minutes. You will have the opportunity to ask any questions or seek clarification of any aspect of the study and can decline answering any of the questions. After signing the informed consent form, you will be asked a series of open-ended questions focusing on your experiences with and perspectives about transitions (including transfer, assessments and admission processes). The interview will be audiotaped and transcribed.

Risks and Discomforts: We do not foresee any risks or discomfort from your participation in the research. If, during the interview, there are sensitive topics raised related to your experiences, you can opt out of answering any of the questions without negative consequences.

Benefits of the Research and Benefits to You: Participants may benefit indirectly by contributing to our knowledge base about promising transition practices into long-term residential care and between this and other sectors, for older adults. Each participant will also receive a modest honorarium for participating in the interview.

Voluntary Participation: Your participation in the study is completely voluntary and you may choose to stop participating at any time. Your decision not to volunteer will not influence the nature of the ongoing relationship you may have with the researchers, study staff or York University either now, or in the future.

Withdrawal from the Study: You can stop participating in the study at any time, for any reason, if you so decide. If you decide to stop participating, you will still be eligible to receive the honorarium. Your decision to stop participating, or to refuse to answer particular questions, will not affect your relationship with the researchers, York University, or any other group associated with this project. In the event you withdraw from the study, all associated data collected will be immediately destroyed wherever possible.

Confidentiality: The researchers will place a priority on maintaining the confidentiality of all information you supply during the research. Your name will not appear in any report or publication of the research. Pseudonyms will be used and information that could identify individuals or organizations will be protected if quotations from participants are used in reports or publications. Sound files will be deleted after transcription has been completed and checked for accuracy. Upon completion of the data analysis, transcripts will be archived for a minimum of 7 years in password protected computers and a locked cabinet in Dr. Choiniere's office and only research staff will have access to this information. The data will be destroyed after the retention period.

Questions About the Research? If you have questions about the research in general or about your role in the study, please feel free to contact either Dr. Jacqueline Choiniere or Dr. Tamara Daly. This research has been reviewed and approved by the Human Participants Review Sub-Committee, York University's Ethics Review Board and conforms to the standards of the Canadian Tri-Council Research Ethics guidelines. If you have any questions about this process, or about your rights as a participant in the study, please contact the Advisor for the Office of Research Ethics, 5th Floor, York Research Tower, York University.

Legal Rights and Signatures:

I *(________________________), [print your name here]* consent to participate in *Providers' Assessments of Interprofessional Care (IPC) models/approaches to ease the current Alternative Level of Care (ALC) pressures within the Central LHIN study*. I have understood the nature of this project and wish to participate. I am not waiving any of my legal rights by signing this form. My signature below indicates my consent.

Signature____________________ **Date**__________________

Participant

Signature_______________________ **Date____________________**

Principal Investigator