

Promising Practices in Long Term Care: Can Work Organisation Treat Both Residents and Providers with Dignity and Respect?

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Abstract

Rather than expose and indict shortcomings of the existing system, the authors were recently involved in a study that sought to build a vision of what high quality residential care for the elderly could look like. Preliminary findings suggest that care is best fostered in contexts where care is understood as a relationship and where both residents and care workers are treated with dignity and respect. Drawing on qualitative case study data collected as part of a larger six countries (Canada, US, UK, Sweden, Germany and Norway), this article explores forms of work organisation that fostered respectful care relationships between staff and residents, and inspired quality care. The article also argues that the conditions of work are the conditions of care and suggests promising practices to support both.

Introduction

Resident-centred, client-centred, person-centred and patient-centred care are terms that are frequently used interchangeably in academic and clinical discourse (Brooker, 2004; Bauman et al. 2003; Starfield, 2011). Regardless of the term used, the notion that quality care should focus on the needs of the service recipient rather than the needs of the service is increasingly popular within long term residential care (LTC) for older people. However, there are two main problems with these approaches. One is that they are largely decontextualised and fail to recognise the residents' choices are highly restricted in the current context of: privatisation; constrained funding formulas that favour medically-linked care and limit the amount and kinds of social care that can be provided to residents; and highly managerialised work environments that reduce

and remove care providers' capacity to provide robust social care. The second problem overlaps with the first but pivots on the fact that a precondition for the enactment of resident-centred care are supportive conditions of work and work organisation for those providing the care.

Drawing on relevant literature and data collected as part of a larger, six country, qualitative study of promising practices in long-term residential care, this article explores these two overlapping problems and argues that the conditions of care are the conditions of work and vice-versa. Or in other words, care is a relationship that is fostered or stripped lean within the working conditions of those employed to provide care (Armstrong, 2015; Baines, 2016; Daly, 2015). These conditions are shaped at the level of policy by the regulatory regime, funding policies, privatisation and contracting-out policies. These conditions become workplace effects through the terms of employment, including wages, work assignments, supervision and supports to the care labour force. They impact on front-line of care in terms of pace and intensity of work, standardisation of care and repetition of technical rather than interactive tasks and the focus on medical care over social care. They are experienced by the residents in terms of: rushed and technical encounters with care providers; and few, if any, opportunities for interactive and dignity-enhancing social care.

Fortunately, more promising practices also exist. Some exist in jurisdictions with higher funding while others operate alongside stripped and leaned-out care and less for-profit ownerships or private sector managerial practices. Some managers and workers carve out spaces within these conditions, in opposition to neo-liberal constraints (Cunningham et al., 2013). These promising practices can create the conditions for actual resident-centred care. This article identifies eight practices that promote care as a relationship that happens within supportive conditions of work. The article then explores an example from our qualitative data and the promising practices underlying the practices. We conclude with a discussion of some of the factors sustaining promising practices in long term residential care which set the necessary conditions for a more robust realisation of resident-centred care.

Current Context of Long Term Residential Care: Conditions, Workplace Effects, Impacts and Experiences

Patient-centred and person-centred care is argued to be the dominant model of care in the UK and US and can be seen to promote models of care in which patients are viewed as partners in the process of their own medical care (Starfield, 2011). This model is limited in that it focuses almost exclusively on medical rather than social care and fails to recognise the larger contexts in which care is provided and received. Moreover, it tends to focus on micro interactions such as communication styles, informed choice and accumulation of knowledge on illness and disease (Cammer et al., 2014; Starfield, 2011) rather than recognising that all these interactions are shaped by policies such as funding and privatisation. Introducing a broader perspective that nevertheless limits its view to medical care, Bauman et al. (2003) argue that even the truncated form of patient-centred care noted above will not be effective without a fundamental reorganisation of the healthcare system and improved medical school training and curricula.

Moving away from patient-centred care, Epstein and Street (2011) observe that client-centred and person-centred care are “based on deep respect for patients as unique living beings, and the obligation to care for them on their own terms” (p. 100). However, these terms rarely mention, let alone engage meaningfully, with the larger social context of austerity policies, underfunding, rushed and overburdened care staff, or with models of management that focus on medical care, cost savings and efficiencies rather than on robust social care and supports. Indeed, though person-centred care was meant to incorporate the social and individual contexts of patients’ lives, Brooker (2004) asserts that “what lies behind the rhetoric in terms of practice may be questionable” (p. 215).

Similarly, rather than empowering people to live full social lives, resident-centred care generally operates at the nexus of rhetoric and of medical models aimed at reducing the costs of treating and managing the diseases and declining health of older people (Lilly, 2008). In large part this results from the ways that medical and social care generally operate as silos with little meaningful integration at the level of systems,

operating concepts or service delivery. It also results from the de-contextualisation of resident-centred care that fails to recognise the larger neoliberal context in which resident-centred long-term care occurs. By neoliberalism, we are referring to a system of governance and ideology that has been hegemonic world-wide since the early 1980s (Cahill, 2007). This socio-political-economic approach promotes the private market and for-profit methods as the source of all solutions and denigrates the provision of social programs, viewing care as a site of private profit making and personal responsibility (Braedley & Luxton, 2010; Harvey, 2007).

In terms of the larger social context, social science literature has drawn attention to pivotal changes in the welfare states in industrialised countries in the post-1980 era. These changes involved ongoing cuts to funding for social programs, contracting-out public services and a general shrinking of the public sector, increased privatisation of care services, including long term residential care. New Public Management (NPM), a governance model emphasising outcome measures and cost savings over process and inclusion (Armstrong, 2015, Cunningham et al., 2013;) became the hegemonic governance and management model associated with privatised care services, particularly those receiving government funding.

In many jurisdictions, for example in Ontario, Canada, the regulation of long term care exploded, in large part to address scandals located in for-profit, privatised care homes, and to prevent further violations of older people in care (Daly, 2015; Lloyd et al., 2014). Regulation in these jurisdictions is now so complex that it is difficult for care workers and LTC home operators to use their own discretion and autonomy to meet the needs of those in their care. It has also meant that because of economies of scale, larger institutions and chains are better able to meet the burden of contract compliance and reporting, while smaller operators are often driven out of the market (Harrington et al., 2015).

Other jurisdictions strongly resisted regulation, for example in the US where for-profit provision was already widespread as it was seen to infringe on the capacity to turn a healthy profit (Harrington et al., 2015).

Here, the struggle to regulate has been seen as an important way to safeguard vulnerable people.

As part of the changing neoliberal context, in the post-1980s era, NPM policies compelled changes within LTC organisations at the level of management and frontline care (Olsen, 2003; Peckham et al., 2014). These changes occurred because NPM operates as a method of governance-at-arm's-length from the government (aimed at accountability and risk management) as well as a way to determine levels of funding and whether to continue funding at all (Braedley & Luxton, 2010). At the level of management, huge volumes of documentation are required to provide governments with the data needed to meet these NPM goals (McDonald, 2006). Data are also required to comply with the government regulations discussed above. While some of this documentation has been loaded onto frontline care staff, much of it remains at the level of management (Cunningham et al., 2013). This seriously increased workload has necessitated the creation of new management-level positions to ensure that outcome measures and data are consistently submitted. The creation of these new management positions exerts pressure on tight budgets and compels belt-tightening in other areas of the organisation. At the level of managers and supervisors, workload has increased, meaning that less time is available for face-to-face interaction with those they supervisor and with residents (Cunningham et al., 2013; Daly et al. 2011). For example, most Registered Nurses provide supervision to lower designations of care workers and perform little, if any, hands on care as their time is preoccupied with providing the documentation required to maintain funding levels (Banerjee et al., 2012; Daly, 2015).

At the level of frontline care, NPM also generates far reaching changes. For example, though NPM claims to advance best practices, save on costs and promote quality care, in reality it standardises practice through the promotion of easy to script and quantify 'Best Practices' and reduces or removes difficult to quantify, open-ended, social care practices such as building and maintaining trust and care relationships. The standardisation of work makes it easier to increase pace and workload, leaving workers rushed and frustrated and residents underserved in key

areas of social wellbeing such as ongoing, dignity-enhancing interactions and relationships with care providers (Armstrong, 2015; Baines et al., 2015; Cunningham, 2008). Standardisation of work also makes it easier to replace higher paid and higher credentialed workers with lower paid and less credentialed workers (Cunningham et al., 2013). This lowering of wages for care workers provides a negative drag on wages for all those employed in LTC (Lilly, 2008).

As the figure below summarises the argument above (see Figure 1). The argument starts with a recognition that the conditions of work and care are shaped at the level of policy by the regulatory regime, funding policies, privatisation and contracting-out policies. These conditions become workplace effects through the terms of employment, including wages, work assignments, supervision and supports to the care labour force. They impact on the front-line of care in terms of pace and intensity of work, standardisation of care and repetition of technical rather than interactive tasks and the focus on medical care over social care. They are experienced by the residents in terms of: rushed and technical encounters with care providers; and fewer opportunities for interactive and dignity-enhancing social care.

Conditions of work and care	regulatory regime, funding policies, privatisation and contracting-out policies
Workplace effects	terms of employment, including wages, work assignments, supervision and supports to the care labour force
Impacts	pace and volume of work, standardisation of care, repetition of technical rather than interactive tasks and a focus on medical care over social care
Experienced by residents	rushed and technical encounters with care providers; and fewer

	opportunities for interactive and dignity-enhancing social care
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Figure 1. The conditions of work are the conditions of care

Methods

The data set is drawn from a larger set of international, qualitative case studies involving: interviews at all levels of the agency; participant observations; and a review of documents exploring promising practices in non-profit long term residential care in six countries in the global north, namely Canada, the US, the UK, Germany, Sweden and Norway. All the residential settings were medium sized (over 100 and under 200 employees) and all but four were located in large urban centres. All were non-profit and ethics approval was received for all studies.

In all the case studies, interviews were selected through criterion sampling (Glesne, 2015) involving a mix of management at all levels of the institution, clinical staff at all levels and support staff including dietary, laundry, cleaning and security guards. This generally resulted in around 40 interviews per case study. Interviews were in-depth, semi-structured, audio-recorded and transcribed verbatim. Research themes and questions posed within the interviews included: changes staff had experienced in the last few years; reasons for working and staying in the social services; changes they would like to see; advice they would give to others; and their experience of working in this environment.

Participant observations were naturalistic (Spradley, 2016) and involved a mixture of interaction and informal discussions with agency workers, service users and others present at the study site. Observations took place simultaneously on various units in pairs of two researchers in approximately six hour shifts from 7am until after midnight, over the course of five to seven days (saturation was generally reached by the end of day 5). Field notes were taken and transcribed; producing a large database.

Data analysis took place through team discussions during, as well as after, site visits and a constant comparison method until themes were identified and patterns discerned (Kirby et al., 2009). Part of this analysis

also included identifying promising practices. To be promising a practice has to meet the following principles:

- The practice treats both residents and providers with dignity and respect
- The practice understands care as a relationship

The next section discusses eight practices that seem to meet most or all of these complex principles.

Limitations of the study include that it covered only six, rich, industrialised countries. Some may see it as a limitation that the study was qualitative and therefore not aimed at generalisation. Consistent with qualitative methods, the goal was to discover rich insights, and findings that might be transferrable to an array of other contexts (Glesne 2015; Kirby et al. 2009).

Eight Practices that Promote Care as a Relationship

The eight practices discussed below meet the two principles outlined above namely that: the practice treats both residents and providers with dignity and respect; and understands care as a relationship. In short, these practices promote care as a relationship between residents and workers. The eight practices were drawn from the extensive database developed across the case studies described above. Data included interviews and participant observation data and a review of agency documents.

1. Adequate staff and an appropriate staff mix
2. A stable workforce
3. Time
4. Standards (principles), effectively enforced and funded
5. Appropriate training and education
6. Appropriate working conditions
7. An integrated system
8. Tolerating some risks

The eight practices are elaborated below as we observed them and had them described within the study sites. Though much more data exists to corroborate these promising practices, given the restrictions on space,

exemplar quotes, commentary and general observations are presented to provide a sense of the richness of the data.

1. Adequate staff and an appropriate staff mix

This practice, like others in this list, requires adequate funding to cover the costs of an adequate number of staff as well as a model of staffing in which there is a fluid mix of skills. In terms of adequate levels of staffing, in places like Sweden and Norway there was almost one staff member for each resident compared to one staff member for five residents in Canada (Bannerjee et al., 2012; Daly et al., 2010). Higher staff ratios meant that they had more time to build and sustain open-ended, ongoing caring relationships and interactions. It also meant that staff could identify unmet or under-met social and medical needs, and initiate new projects to meet them. Where we saw these higher staff ratios, the levels of resident violence and of drug use were significantly lower, providing just two indicators of how adequate staffing levels influence workers and residents.

Staff mix and task sharing was also important as institutions where staff shared tasks across job categories provided seamless and flexible care, rather than having residents have to wait until a particular category of worker was available to undertake a particular task. This, too, requires adequate staffing if it is not to result in overloaded workers.

Data from numerous international and national statistical bodies confirm that industrialised countries can afford adequate staffing; the decision not to spend on LTC reflects political will rather than inadequate national capacity (Baines 2016; Meagher and Szebehely 2013). Auspice also makes a difference as multiple studies have shown that staffing numbers are lower in corporate-owned residences than it is in not-for-profit or public ones (Daly 2015).

2. A stable workforce

Dignity-enhancing, open-ended care relationships develop best in situations with a consistent and permanent labour force. These kinds of practices are almost impossible to undertake in the context of a constantly changing group of staff. In the context of constrained funds and NPM, many organisations have tried to reduce staffing costs by

relying on agency staff, and/or on casual, temporary, on-call and other forms of part-time variable staff. Research showing that residents, especially those with dementia, experience improved overall well-being when staffing is stable and consistent (Brooker, 2004). The literature also confirms that high levels of stable and well supported staff result in lower rates of injuries due to resident violence (Bannerji et al., 2012; Daly et al., 2011). This improvement largely results from the fact that workers can form caring, ongoing relationships with residents and know what kinds of procedures, times of day or interactions may cause anxiety and trigger outbursts. Moreover, an adequate number of skilled and trained staff are available to take measures to avoid or buffer these triggers. This individualised and relationship-based knowledge and appropriate strategies can only emerge in contexts where staff work in consistent patterns and have sufficient time to get to know residents and build appropriate and respectful care plans.

Our data confirm that residents and families appreciate workers who have the opportunity to understand individual histories and work in ways that reflect individual priorities and needs (Baines and Daly, 2015). Similarly, workers reported that their work is more rewarding when they know the families as well as the residents, and can build care plans and care relationships together.

Our studies also show that the team work necessary to provide high quality and consistent support to residents is much easier when staff know each other and it is more difficult when they never know who will be at work for a given shift or the strengths and capacities of a constantly changing string of workers (Baines and Daly, 2015; Armstrong, 2015). In terms of promising practices, our data provided strong examples of the benefits of a stable workforce. In one example, management did not hire agency or casual staff and kept a list of part-time employees who were the first hired when full-time positions became available. This provided greater stability and higher quality care for the whole organisation.

3. Time

The heavy requirement for documentation by staff in some of our study jurisdictions (for example, Canada) meant that overall there was too little time for workers to care, to build open-ended relationships, to respond to needs and request, to have opened-ended talks with residents, families and volunteers, and to really get to know the people for whom they provided care. In many places in North America, we saw a great deal of time spent on completing documentation requirements rather than on direct care. In essence, our data shows more time spent on reporting what had been done rather than on doing it. For example, we witnessed workers sitting at meals not communicating with residents or helping them eat because they were required to fill out forms on how much each resident was drinking or eating. In Canada, in particular, some of paperwork compelled by the regulatory regime and NPM, could only be done by registered nurses. This division of duties reinforced occupational hierarchies and took nurses away from providing much needed direct care and support to residents and workers.

Though time overlaps with adequate and stable staffing, it is also an issue of how care is distributed within the time available and what tasks are understood as priorities. For example, in a Canadian LTC facility, a manager told us that completing the time-intensive documentation on residents was “the most important thing staff does on a shift”. She complained that “they let anything get in their way”. In contrast, the front-line staff reported that their most important work was “caring about the residents” and that documentation meant that they never had enough time.

Documentation requirements were more limited in Norway and Germany, where staff to resident ratios were considerably lower and priorities for how staff spent their time was focused on resident-engaged care. We saw care providers sitting and talking with residents throughout meal times and responding to individual needs as they arose on the units.

In another example, in North America, time that was not spent on documentation tended to focus on clinical interventions, symbolised by medical carts blocking hallways and large signs that said “do not talk to

the nurse distributing meds”. In contrast, in the facilities we studied in the UK and Sweden, medications were kept in individual rooms. Nursing stations were removed and replaced by lounges. Free meals encouraged workers to eat with residents without jeopardising their break times and providing more social connection between and among workers and residents.

Reflecting the emphasis on caring relationships and providing the time to sustain these, we observed care teams that included everyone from kitchen staff and receptionists to managers and nurse practitioners. For example, the RNs in the UK home helped with eating and interacted regularly with residents, rather than having their time preoccupied with documenting outcomes. In a promising example in Manitoba (Canada) we observed the receptionist visit each resident every day to deliver menus. She reported enjoying this work and was considered an important part of the care team. This flexibility reflected a focus on more social care and less on medical care. It provided more autonomy for workers on how they spent their time, while at the same time provided more time for care.

4. Standards (principles), effectively enforced and funded

There is a significant difference between standards, and standardisation and regulation.

Standards establish principles and provide the basis on which individual care providers can make decisions in an equitable and evidence-informed manner. Standards extend autonomy to those entrusted with meeting them and recognise that local differences may mean that standards are met in a variety of equally valid and effective ways. On the other hand, standardisation, which tends to underlay regulation, means one right way exists. This tends to ignore the individual needs of residents and removes autonomy and discretion from care providers. Our data show that in Canada, standardisation is widespread with detailed regulations and rules governing how many frontline workers provide care. This results in tightly scripted timelines, quantification and ordering of tasks. It removes autonomy from the frontline care worker

and provides little or no space for the individual needs and preferences of residents and families.

Our North American data show that residents, families and staff all complained about these regulations and rules. A widespread problem in LTC homes was that residents were required to eat meals within rigid and inflexible timeframes. For example, breakfast would be served at 8am, all residents had to be up and dressed before this and breakfast ended promptly by 9am. Many residents and their families reported that they would find it much more supportive if they could get up later, or more slowly and eat at their own pace rather than one imposed by the institution.

In contrast, in Germany, Sweden, and Norway, governing bodies establish principles to be followed in LTC and leave their specific interpretation up to those in LTC homes. Our data from these countries show examples of workers serving residents as much food as the resident wanted and as much as the worker understood as sufficient for that person. Our data also show workers getting people up for breakfast when the resident woke up and the worker judged the timing was appropriate rather than requiring all residents eat breakfast at the same time in order to meet the agenda of a private company or the regulations. Both these examples provide choice and autonomy for residents, while at the same time providing opportunities for the exercise of professional discretion and autonomy in the name of quality, personalised care for residents. These kinds of practices are possible in the context of principles but difficult or impossible to enact in the context of complex regulations negating individualised care and removing care worker discretion and autonomy.

5. Appropriate training and education

A well-trained and well-supported staff are seen as necessary prerequisites for quality care. Our data show that staff and families were very interested in ongoing training to meet new and existing needs within the resident population. In contexts such as in Canada and the US, funds for training were often scarce and workers were frustrated and demoralised by this. In particular, staff wanted training that would

support the development of care relationships. Where training was available, it frequently took the form of an online computer module. Courses were generally aimed at contract compliance such as teaching workplace health and safety regulations or wound care. Staff and families wanted training involving face-to-face interactions that extended their skills in building caring relationships and meeting the increasingly complex social and medical needs among the diverse resident population.

In a Canadian example, a staff hired to work in recreation found she was required to help residents eat, though she had no background or skills in this kind of work. Her training involved watching an online training video. She said all the video did was scare her about feeding people rather than provide the skills necessary to make eating not only an enjoyable social interaction but also a safe one.

In another Canadian example, the LTC home provided training that included staff members themselves experiencing what it feels like to be in a lift and to be bathed by others. A care worker we interviewed spoke about how exposed and insecure he felt when he was being bathed, even though they let him wear a bathing suit and behaved entirely professionally. He reported that the experience taught him to understand “what vulnerability feels like”, something he could not expect to learn from the online training videos that are too often used as a substitute for other forms of education.

In Norway, we observed workers teaching language skills to recently immigrated workers in order to help them understand local meanings. This training took place during paid work time for the trainers and the trainees. The staff told us that it was a process that promoted solidarity between recently hired and longer-term workers, built on workers’ communication skills and helped ensure smooth and clear communication with residents and families, which was a benefit to all.

6. Appropriate working conditions

A theme underlying our research project was the assumption that the conditions of work are the conditions of care and vice versa. Our data confirmed this assumption on many levels. This was substantiated in

residential facilities where better working conditions ensured a stable and positive workforce. It was also substantiated in various ways in cases where under-funding and NPM meant that conditions were poor and showed no signs that improvement, at least in the short term, was likely.

For example, in Canada, our data show that many workers found that their training was not useful if the conditions of work, such as pace and rigidity, did not allow them to use their personal and professional judgement. In addition, it was reported that training was not useful if rushed and highly scripted work processes meant that they did not have the time or resources to provide the care their training taught them was correct.

Working and practice conditions also had a more direct influence on the health of workers and residents. Our data show that the workers we interviewed in the US had no union protection, no paid sick leave, earned minimum wage (around \$7.25/hour) and had no pensions at their workplace. The result was workers told us they went to work sick because they desperately needed the wages. By going to work sick they often became sicker and too often shared their illness with the vulnerable residents. Low wages also meant that workers frequently worked multiple jobs to make ends meet and often worked seven days per week. They also continued working well past age 65, even though the work was physically and mentally demanding.

In the UK, our data confirms that some workers were on what is called zero hour's contracts, meaning they had no guarantee of minimum hours or indeed of any work at all. These contracts generate very high turnover and little continuity in care for residents. Workers in Sweden and Norway were much better paid in comparison, had more autonomy in decision-making, had pensions and sick leave and not surprisingly the LTC homes has a much more stable workforce. However, even in these countries, the research participants argued that there was significant room for improvement. During an interview, we asked a Human Resources manager in Norway what she would change if she were in charge. She said she would pay the women working in nursing homes the same wages as the men working in the oil rigs were paid. She argued

that care staff work “at least as hard, under conditions that are at least as bad.”

7. An integrated system

Our data showed that the LTC system was fragmented in some countries, not only across countries but also within countries. This was particularly the case in North America. In Canada, the fragmentation was promoted not only by the division of responsibility for health care among the federal, provincial, local governments and individuals but also by privatisation that promotes contracting out and corporate ownership.

For example, a housekeeper who had been a full-time employee at the LTC home where she worked and told us she had had lots of interaction with residents was seen as part of the larger care team. She reported that these interactions were rewarding for her and the residents. However, after housekeeping was contracted-out to a private company, she was required to focus exclusively on repetitive cleaning tasks throughout the home and told not to waste time talking with residents. This fragmented the care team of which she was once a member and reduced the quality of her work experience. It also cut residents off from an enthusiastic source of sociability. After a time, the private company providing the housekeeping lost the contract and the worker worried that she would either lose the job or be moved to a new facility, adding to her sense of dislocation and distance from any sense of being part of a care endeavour.

In the same LTC home, large signs informed residents and families not to talk to the sub-contracted dietary staff, who were employees of a large, international for-profit corporation and always pressured to work faster to get the job done with minimal staff. Conversations with residents and families were seen to distract them from their work and break the intensity of the pace at which they were required to work. This took dietary staff out of the realm of care, remaking them as automatons entirely separate from the life of the non-profit LTC home. It also remade meal times in an assembly-line way that detached care from meal

preparation and provision and prioritised the needs of the profit-driven company rather than the needs or interests of the residents.

In contrast, a Norwegian LTC home we studied was physically part of a larger complex housing a day care, an arts program, the town cinema, a climbing wall and a cafeteria. Residents and workers could visit all these places “with their indoor shoes” and those using these services could visit residents. It provided a seamless integration into the life of a community rather than fragmenting and segregating the care of older people from the larger social world. Workers in the LTC home moved back and forth between homecare and nursing home work, providing continuity for those needing care in the home and outside it as well providing a varied for workers and ensuring continuous care relationships.

8. Tolerating some risks

Our data show that it is important to take some risks in the provision of LTC rather than focusing solely on safety. The focus on safety over reasonable risks was apparent in our Canadian study sites. In one Canadian site, we observed those being admitted to the LTC home who had experienced falls in the past, were often put directly in wheelchairs to ensure they would not fall. As a result, they quickly ended up being unable to walk. A nurse told us this was regrettable but required because there were not enough staff to support residents walking and any falls meant penalties for the nursing home.

In Germany, in contrast, the first thing we observed was a resident with dementia competently cutting onions and getting advice on their preference from other residents. The staff reported that cutting onions was something the resident often did before she came to the home and doing this task normalised her life and gave her satisfaction. They weighed the risks of this task against the obvious benefits and decided to encourage her to undertake the tasks she loved rather than diminish her quality of life.

This contrasts with a Canadian site which does not provide soya sauce because the sodium in it is seen as a hazard. This rule operated in an LTC home where half the population was Asian and has been eating

soya for many, many years. Residents missed their soya sauce and those who could, got family members to sneak it in to them. However, family members told us that they had to be very, very careful or the soya sauce would be publically confiscated and they and their parent would be publically scolded (though the dietician told us that she quietly told family members they could sneak it in).

As Gwande (2014) argues, it is important to support joy in the context of residential care and this joy may come in the form of eating chocolate ice cream more than once a day. This joy can give pleasure to both workers and residents while its lack provides a reduced quality of life and seems to achieve questionable goals. As one of our research participants noted, “Avoiding all risk is not only impossible. It is boring.” This sentiment is embodied in the philosophy of a well-run and promising LTC home in Germany that asserted that it is important to add “more life in your years rather than just more years in your life.”

Example of Promising Practices: Staff Build a Program of Music in Everyday Life

The example discussed below is drawn from interview and participant observation data from a case study undertaken in a major city in Norway. The example is included to show how promising practices and many of the eight principles discussed above were at play in the everyday lives of those living and working in the organisations studied. The promising practices and principles in this example include:

- stable, permanent employment;
- good wages and working conditions contribute to staff morale and staff retention;
- high staff to resident ratio so staff results in staff having time to complete tasks and initiate new forms of care;
- the management team were responsive to and supportive of staff initiatives; management also were interested in new programming and encouraged staff to develop them and take risks; staff worked as a team and tried new things; the organisation provided possibilities for skill development (music in everyday life program);

- the organisation also provided resources for new programs and projects which resulted in the innovative project which quickly became a permanent program of music therapy and music in everyday life.

The chart below shows (see Chart 1), how much of a country's Gross Domestic Product is spent on long term care (live-in, residential care housing the elderly and some younger people with serious disabilities). Gross Domestic Product (GDP) looks only at public expenditures, meaning that out-of-pocket spending by citizens on services such as housing and care, not covered by the government, are not included. The chart shows that Norway spends a higher share of its GDP than any of the other countries we studied, except Sweden.

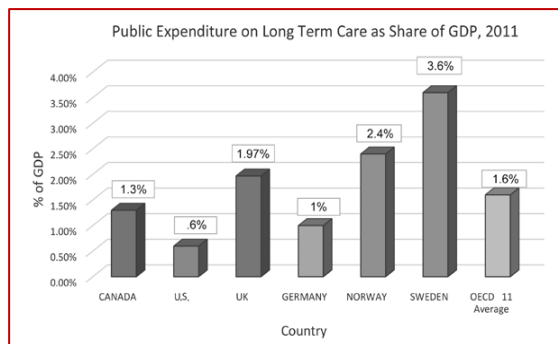


Chart 1. Long term Care: Public Expenditures (health and social components as share of GDP, 2013)

Source: OECD Health at a Glance 2013: OECD Indicators (Chapter: Long-term Care Expenditure); UK source: Long-term care: Need, use, and expenditure in the EU-27 (2012, European Commission).

Part of these monies are spent on ensuring that wages and working conditions for those employed in LTC in Norway are good enough so that staff turnover is very low. Staffing numbers are also higher than in most of the other countries we studied. Staff-to-resident ratios were 1:4 on the regular units; 1:3 on the dementia unit. This meant that care staff had the time to develop open-ended, ongoing care relationships with the residents and develop individualised and collective ways to improve their care and quality of life. This meant that staff had time to complete their regular duties and to identify areas where a new program or a new idea might improve care. Management placed a priority on face-to-face

social care, rather than completing extensive documentation which encouraged staff to use their autonomy and discretion in care tasks and identifying unmet needs or needs that could be met in better ways. Management and front-line supervisors also provided staff with the time to investigate these options for care, and sometimes to develop innovative, completely new programs.

For example, the nursing staff on the dementia unit, where the ratio was 1 staff for every 2 or 3 patients (depending on the overall severity of residents on the unit), noticed that residents responded positively to music. Music in the hallways and bedrooms seemed to calm and engage residents. It also was observed to energise residents when they seemed blue, uncommunicative or fatigued. It seemed to soothe residents when they were sad, agitated or withdrawn. Some of the staff had heard of music therapy programs in hospitals and the community and wondered if a music program could be helpful at the residence.

The RN on the dementia unit joined her staff in enthusiasm for this idea and applied for and received a small grant through the parent organisation that ran the residence. The grant's purpose was to investigate music's possible use in everyday life on the units. The RN provided leadership on the research work, with the support and interest of her staff.

Fortunately, a great deal of literature exists on the use of music and the team was able to assemble a cohesive argument and useful content. The staff reported that once they understood some of the theory and possible uses of music on the unit, they made specific goals for the music project. This included to: heighten the competence of staff and residents in uses of music in everyday life on the unit; to improve quality of life for residents; to make the unit safer for residents and workers; to reduce anti-psychotic and sleeping medicine; to strengthen attention span and the ability to listen among residents; to strengthen concentration; and so forth.

The team then developed two parts to the program: 1) the use of music in daily life (systematic and individual use of music and music therapy in everyday life provided by the nursing staff); and 2) formal music therapy

provided by a credentialed music therapist aimed at addressing specific challenges experienced by individual residents.

The music in everyday life program introduced music into everyday routines and special events on the unit. One aspect of this was the compilation of a list of each resident's favourite music. The list was put together by staff, family and the resident (wherever possible). The list was posted by each bedside along with taped or DVD recordings of the music. The staff members often sing bits or all of the songs, generally with the residents, during regular care routines and particularly at points in care routines where residents may become anxious, confused or sad.

The staff reported that most of them did not "sing" before this program, but due to their commitment to the program and the benefits it seemed to provide for residents, they overcame their reticence and learned to croon along with the tapes or sing along as best as they could. They reported that the immediate positive response from residents motivated them to keep trying and overcome personal embarrassment or lack of musical skills.

Well-loved songs were also sung with residents in informal interactions on the unit — in the hallway, in their rooms, in the bath if they were agitated and anywhere that a musical interaction might add comfort, fun or connection. Our data substantiates frequent exchanges between staff and residents involving short bits of singing a verse or two of a song. This was often accompanied by holding hands with residents and/or gentle dancing together in the hallways accompanied by bits of song. Other residents were often caught up in these exchanges and would pass a sociable few minutes in the company of other residents and staff, singing, swaying and dancing. The mood was consistently positive during these exchanges and the mood on the unit was calm.

In addition, much loved music was introduced to encourage exercise and movement during the week. Our data confirm that this appeared to be a rewarding form of socialisation and exercise for residents, visitors and staff. Our data also show that people who were rarely verbal seemed to love to dance to their favourite tunes and verbalise along to the music.

The LTC home also developed a choir as part of this music in everyday life program in which the majority of participants experienced dementia. This choir was led by a music therapist and provided a form of social care in that it was an opportunity to connect with other people and to share some pleasure collectively, even if the words to song were often not fully remembered.

The program met with such affirmation from residents, families and staff that it was quickly suggested that it move from a pilot to a permanent program. Evaluations that were undertaken to establish the positive outcomes of the program confirmed other, unexpected benefits for residents. For example, the use of medications for anxiety, depression and for sleep have dropped dramatically on the unit. In addition, quality of life measures have improved, violent incidents have decreased significantly and workers, residents and families report greater satisfaction from their work and their days. Following the establishment of music in everyday life as a permanent program, music therapists were hired to extend the program including one-on-one and group therapy for those who may benefit from formal sessions with a music therapist. Together, these programs extend and deepen the gains made through the staff-initiated, management supported, and resident-approved program for music in everyday life.

Conclusion

Neo-liberal governments are promoting market-based care while also calling for care focused on the care needs of the individual. The capacity to provide such care is undermined by the market-based strategies that are central to neo-liberalism. In this article, we argued that resident-centred and person-centred care are difficult if not impossible to realise currently within LTC because they are dogged by two main problems: 1) they are decontextualised and fail to recognise the highly constrained context in which residents' choices take place; and 2) the conditions of care are the conditions of work and vice-versa; they are inseparable. Some of the factors we analysed in the first part of this article, degrade the conditions of work and negatively impact on resident care. They include: privatisation and contracting-out; NPM; constrained funding formulas that favour medically-linked care and limit the amount and

kinds of social care that can be provided to residents; and highly managerialised work environments that reduce and remove care providers' capacity to provide robust social care. Only very strong managers with a great deal of autonomy can resist such pressures, and then only some of them (for further discussion see Aronson and Smith, 2010; Baines et al., 2014).

Drawing on our data and the literature, we argued further that care is a relationship that is fostered and robust within well resourced, non-standardised care institutions or stripped lean within privatised, highly regulated and scripted work organisation such as we found in residential homes where NPM practices dominated and lean funding resulted in inadequate resources, poor working conditions and unstable workforces.

Our argument drew on eight principles of promising practices in LTC developed from our data, and analysed an exemplar vignette from our data, that highlighted some of these promising practices in operation. The example underscored the argument that more resident-centred care can be realised in contexts where wages, working conditions and employment stability are high and training, supportive supervision and management support for staff initiatives are available and assured. On the flip-side, resident-centred care will not be realised in situations where: resources are lean and funding is undependable; staff are rushed and have little time to identify emerging and unmet needs or to envision new ways to meet them; there is no time to foster caring, dignity-enhancing relationships between care providers and care recipients; flexibility is not possible due to the tight scripting and standardisation of care aimed at lowering costs; and heavy requirements for documentation take care workers away from open-ended, resident-led interactions with residents and put them behind computer screens and files.

In sum, the eight principles discussed above highlight the need for adequate funding and for rules that set goalposts and guidelines but do not micromanage through standardisation and the removal of staff initiative and discretion. As noted earlier, the goal of resident-centred care is the centring of residents needs and changing the organisation to

meet the needs of residents, rather than changing residents to “fit” the organisation (Starfield 2011). However, this cannot occur without great difficulty within contexts framed by NPM, inadequate funding and the drive to save costs through privatisation. These overlapping forces harm social care with their mandates for profit making in the case of private care and cost-savings in the case of NPM. Indeed, organisations cannot hope to flexibly adapt to the needs of residents in the context of understaffing, heavy workloads and overwhelming demands for documentation.

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