Mount Saint Vincent University

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Relationships matter: What we know about meaningful relationships in long-term care

facilities

by

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Abstract

Meaningful relationships in long-term care (LTC) are considered to be an important part of the LTC experience. Utilizing a person-centred care (PCC) framework, this research explores meaningful relationships among three dyads in LTC: residents and residents, residents and staff members, and staff members and family members, including analysis of those residents with dementia.

To gain insight into the contributors and barriers to developing meaningful relationships, I conducted a secondary data analysis of resident interviews, as well as staff and family focus group data from the Care and Construction study using a grounded theory approach. The 2012 Care and Construction project examined the impact of different models of care on resident quality of life (QOL) in nursing homes (Nova Scotia Centre on Aging, 2015a). Three themes – communication, staffing and activities emerged from the analysis. Opportunities for consistent communication between residents, staff, and family that provide a mutual feeling of "family" was revealed as a contributor to the development of meaningful relationships. Staffing within the LTC facility was identified as a barrier, such that being short-staffed and staff rotation, prohibits the ability to spend quality time together and opportunities to become "friends", rather than remain in a patient /caretaker relationship. Opportunities to participate in activities that encourage socialization was evident as contributing to meaningful relationships among and between residents, staff, and family.

Learnings from the findings produced implications for policy, practice, and education to improve the QOL of LTC residents. The LTC sector would benefit from a more comprehensive understanding of the way positive relationships improve QOL for

residents. Educational workshops that encourage positive communication through the guidance of policies will be beneficial. In addition, having sufficient staffing ratio is critical, therefore a staffing ratio policy is fundamental to make change. Similarly, education on the importance of PCC may increase opportunities for broader understanding and enable positive ways forward. It is crucial that individuals understand the positive benefits to PCC. Finally, building designs that include common spaces for communication and activities to take place, as well as adequate options for activities would strengthen the opportunities to develop relationships in LTC, which is important for relationship development.

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Chapter 1: Introduction

Providing the growing population of older adults with quality long-term care (LTC) is becoming a challenge, as Canadians are facing an increasing need for LTC (Canadian Life and Health Insurance Association Inc., 2012). As of July 2015, Statistics Canada reported that there were more persons aged 65 years and older, than children under the age of 15. This number is expected to increase, accounting for 20.1 percent of the population in 2024 (Statistics Canada, 2015a). Approximately one in four Canadians will be 65 years or older by 2030 (Statistics Canada, 2014). In 2011, there were 5 million older adults 65 and over, and 7.9% living in nursing homes or senior residences (Statistics Canada, 2012). In 2012, the estimated prevalence of dementia in Canada was 500,000 with 45% of those aged 45 and older living in LTC (Wong, S.L, Gilmour, H., & Ramage-Morin, P.L, 2016). Given the number of older adults with dementia in LTC, it is significant include the perspective of dementia in this research to understand how these older adults can develop relationships and if those factors differ.

There is a growing demand for LTC in Canada that is partially informed by population aging, as well as other demographic changes (Curry, 2015). However, the availability to meet the demand of LTC is not the only issue worth discussing. The literature suggests that meaningful relationships are real and crucial within a LTC setting; especially with respect to quality of life (QOL) which is viewed as a construct in this research (Degenholtz, Resnick, Bulger, & Chia, 2014). There has been substantial effort made in identifying the general characteristics of QOL for older adults (Schenk, Meyer, Behr, Kuhlmey, & Holzhausen, 2013). Since QOL in older adults is commonly perceived as a multidimensional construct, a distinction between "objective" and "subjective"

aspects has been made. Objective QOL captures the quality of conditions, including nutrition, objective functioning, and housing. Subjective QOL captures the quality of experience, which include satisfaction with conditions and well-being. "Objective living conditions", such as room environment, temperature, and noise are the focus of many nursing home quality assessment instruments (Schenk et al., 2013). It is crucial that we explore the more intimate and subjective QOL; the aspect of personal relationships.

The Nova Scotia Centre on Aging, located at Mount Saint Vincent University, took part in a study titled "*Care and Construction: Assessing Differences in Nursing Home Models of Care on Resident Quality of Life*", funded by The Canadian Institutes of Health Research in partnership with the Nova Scotia Health Research Foundation in 2012. The basis of the project was to examine how changes in physical design and staffing approaches impact nursing home resident QOL (Nova Scotia Centre on Aging, 2015c). Information was gathered through interviews, surveys, focus groups, and case studies that further involved interviews, participant observation, and activity monitoring. It was found, from the resident, family, and staff perspectives, that positive relationships between residents, family, and staff, as well as more home-likeness within the nursing home, were related to higher resident QOL (Nova Scotia Centre on Aging, 2015c).

This study utilized focus group secondary data produced from the Care and Construction project, to further explore meaningful relationships between residents, residents and staff members, and residents and family members in LTC. The data reflected the perspectives of the family and staff, as well as the residents, to discover the factors that contribute to enabling and disabling the formation of these meaningful relationships. Research suggests the value in relationships between residents, staff

members, and family members, such that they are part of a care team. For residents, especially those living with dementia, the relationship between staff and family may contribute to positive and supportive relationships through the knowledge they both contribute regarding resident care. Older adults with dementia face several difficulties due to cognitive deterioration. With that being said, positive relationships may matter more for someone with dementia because they keep the individual active, and their families are able to contribute to their care. Relationships between staff and family can also positively influence their care, by having everyone work together and contribute their knowledge to meet the individual needs of the resident. Due to the resident involvement, it was important to consider the incidence of dementia that is prevalent in LTC when discussing these relationships. Current estimates reveal that 44.4 million older adults have some type of dementia, a number that is expected to increase to 135.5 million by 2050 (Mark, 2016). These relationships appear to be important for the overall experience of LTC for residents, staff members, and family members. Meaningful relationships can be defined through commonalities, interests, and connections between individuals (Nova Scotia Centre on Aging, 2015a). If the residents, family, and staff have meaningful relationships and interactions with one another, then it is likely that the experience of everyone involved will be a positive one.

I chose this topic of study because I felt a positive connection to relationships within LTC. I was interested in the results of the Care and Construction project, particularly the information that the researchers discovered on relationships. Relationships are an aspect of human behaviour, which is what I identify with best due to my psychology background. I was interested in understanding what helps to create a

positive meaningful relationship, using PCC as a guide; for example, paying attention to the needs of others when getting to know them. Understanding and respect will help to reciprocate a mutual connection. Further, I sought to understand how relationships between staff and family can help with resident care through working as a team to meet the needs of the resident. I was eager to put the focus group data to good use and explore it for my own personal and academic growth, given that it was my first-time diving into such in-depth analysis. I have exercised these topics in other ways. I have been involved in research at the Centre on Aging that looked at home care, which is another area of continuing care. I have also completed several proposals and papers that involved LTC and person-centred care (PCC). As well, I have experienced a close family member living in LTC. The decision to include the dementia piece was an easy one, as I had watched this family member live with the disease.

Having an undergraduate degree in psychology has provided me with an interest in and adequate knowledge on human behaviour and the wellbeing of others, especially those as they age through the life course. I believe that my academic and personal experiences have helped shape the current research study. Both areas have provided me with sufficient knowledge and passion that will assist with the process. I want to understand how to better enable positive relationships in LTC between residents, residents and staff, and staff and family that will further have the potential to contribute to better quality care and PCC for residents. The aim of the research is it do just that; to find out what factors act as contributors and barriers to the development of meaningful relationships.

I hope to use this research to inform education and practice, if nothing else. Ideally, informing policy is an end goal, but I understand that education and awareness is the first step, perhaps through sharing knowledge with LTC facilities. While I have no set decisions on my professional future, this research will help greatly with knowing how to answer an important question – in this case contributors and barriers - and how to package it is in a way that is useful to others. I hope to one day be in a position where I can utilize and translate information in a way that will create programs or policies that can be implemented in LTC settings.

My interest, knowledge, and curiosity in the topic contributed to my interpretation and analysis of the findings. While this is a grounded theory study, the previous knowledge that I have on the topic of relationships in LTC was helpful when doing my analysis because I had a base coming in. The idea that grounded theory researchers need to start their analysis with a 'blank slate' and no knowledge of previous literature, is considered a misconception. In order to discover a good grounded theory, one must understand the role of the literature (Urquhart & Fernández, 2013).

Rationale

It has been suggested that relationships between residents, staff, and family make a significant contribution to the QOL of residents in LTC (Kane, 2001). However, there has been a lack of understanding of these relationships, particularly what a meaningful relationship involves, adequate staff to address the increasing complexity of residents, and workload or availability to communicate and establish a connection with residents and their families (McCormack, Roberts, Meyer, Morgan, & Boscart, 2012). A deeper understanding of these relationships, as well as common themes and factors, assisted with

learning their meaning and their impact. Residents, families, and staff have commented on the value of positive relationships with one another, as well as the importance of communication and collaboration that focuses on the resident's wellbeing (Bauer & Nay, 2011; Wilson & Davies, 2009). Having positive relationships means that the residents, staff members, and family members can get along, communicate, and work together in caring for the resident. By doing so, they are essentially in a position to enhance the overall experience of the resident.

Understanding what enables and disables meaningful relationships has become clearer as a result of this research study. However, the field will also benefit from further research on relationships within the LTC setting, focusing deeply on each perspectives experiences with relationships, both positively and negatively. This will help generate an understanding of the potential meaning of relationships for residents, staff members, and family members. This knowledge may create the potential to offer information that can assist with guiding policy, practice, theory, and education in LTC. Having knowledge of this information could ultimately allow for an increased awareness and the implementation of training initiatives that teach the importance of taking the time to develop meaningful relationships. Knowing the factors that contribute to this development can also be taught to staff members and family members, so that they were in a better position to develop relationships with residents, but also with each other.

Chapter 2: Framework

Person-Centred Care

Residents in LTC facilities can face challenges with continuity of self (Pirhonen & Pietilä, 2015). The change in lifestyle that comes from leaving their home,

neighbourhood, and social surroundings can produce the fear of losing one's self. As well, traditional care facilities may represent institutions that challenge one's self with their patient-like role expectations (Pirhonen & Pietilä, 2015). For this research, PCC is being used as a theory to explore what it means to have meaningful relationships and what contributes to their development. It also has a unique connection to philosophy, policy, and practice through its presence in models of care. Each of these areas will be explored in this section.

PCC as a theory represents a holistic model that underlines the perspectives and the experiences of the person (Pirhonen & Pietilä, 2015). It is a term that was initially developed by Kitwood through his work on dementia care; an area that has gone through a revolutionary change to its standards in recent decades (Kitwood, 1997, p. 86). It is guided by the assumption that each person has their own unique and personal history that makes them, and their needs, different (Kitwood, 1997, p. 15). There has been a philosophical debate around what it means to be a person. Carl Rogers and Kitwood have had the most influence on the development of PCC of older adults and the "person" (McCormack et al., 2012). Actualizing tendency, a term coined by Rogers (1990), is what he understood to be the innate drive that humans have towards growth and fulfillment. He claimed that this emerges through positive relationships that embody the conditions of self-worth, these being congruence or genuineness with a person, unconditional positive regard, and empathy (McCormack et al., 2012). Kitwood looked to Rogers' humanistic ideas for his work on dementia care and his development of personhood. He defined personhood as "the standing or status that is bestowed upon one human being, by others, in the context of relationship and social being" (Kitwood, 1997, p. 8).

PCC is characterized by a shift in philosophy that aims to recognize the place of older adults in the community, by keeping them involved in the decisions regarding their care delivery (Pirhonen & Pietilä, 2015). PCC in policy and practice is important when developing positive meaningful relationships in LTC, such that each person's needs are considered. In recognition of the depersonalizing effects of LTC, significant changes are being implemented within the LTC setting, internationally, through the use of PCC (McCormack et al., 2012). In policy, PCC is being applied to include more efficient assessment methods, positive care planning, adequate activities, and a focus on individual needs as appose to institutional (Kitwood, 1997, p.86). Institutional norms, routines, and rituals are encouraged to be replaced by services that meet the needs of older adults, emphasizing the criticality of "the person" (McCormack et al., 2012). As a result, the use of PCC in policy development for older adult services is becoming the new focus when applying care to older adults in LTC (McGilton et al., 2012).

Relationships have been promoted as an instrument for providing PCC to older adults (Roberts & Bowers, 2015). In LTC practice, a PCC approach would involve individuals feeling appreciated, the option for involvement in interesting activities throughout the day, experiences that matter, the honouring of daily choices and preferences of residents, and developing and sustaining relationships (McGilton et al., 2012). It is established by creating and nurturing relationships among all care providers, older adults, and family, and is most concerned with the involvement of residents and family in decision-making. To achieve this, staff need to be familiar with residents and work together with others if they are going to be effective in supporting the QOL of older adults and providing the appropriate care to do so. This dynamic of working together to

achieve PCC will be difficult to implement without relationships among residents, staff

members, and family members (McGilton et al., 2012).

In the last 60 years, there has been an international shift in the approaches to care

for older adults, shaped by health care policies for older adults, international care

perspectives, and changing ideologies around nursing care (Murphy, 2007). Previous

research has proposed that older adult care should be person-centred. However, Murphy

(2007) discovered that that is not always the case in practice. Respondents revealed a

discrepancy between how they felt care should look like, and the actual care that was

given based on the extent to which they were able to deliver quality care (Murphy, 2007).

PCC is highlighted as crucial to the experience of residents both with and without

dementia living in LTC (Winzelberg et al., 2005). Engaging in PCC will ultimately help

create and sustain meaningful relationships with everyone involved in a care relationship,

and specifically family and staff.

Kitwood has strongly influenced contemporary dementia care, and has set the

groundwork for others (Brooker, Dewing, Innes, Nolan). He has advocated for the same

care of persons for those with and without dementia, since services for people with

dementia have traditionally shown the loss of their personhood. However, the personhood

philosophy has generated several concerns. Kitwood presented the person as an embodied

subject, but this idea is undeveloped (Dewing, 2008). Interdependence and negotiated

choice in relationships with others is ultimately the emphasis of PCC (McCormack et al.,

2012). Others have critiqued and further developed his work as a framework used to

support PCC (McCormack et al., 2012). Several additional critiques, to name a few,

concern problems with rigour, application into practice, and personhood philosophy

(Dewing, 2008). Regarding rigour, critics state that Kitwood's work is unfinished and not refined. As well, he failed to leave a clear and explicit audit trail of sources that influenced his work. Therefore, it is felt that there is limited data available to be examined (Dewing, 2008). Applying his work in practice has generated several critiques. It is suggested that he overlooks family and friends when discussing his ideas on PCC, and focuses solely on the person, particularly the person with dementia (Dewing, 2008). Nonetheless, "others" are referenced in Kitwood's seminal work, 'Moral Concern for Others'. The problem may actually be failure to broadly develop this theme so that it can be transferred into practice (Dewing, 2008).

While referencing Tom Kitwood is critical, given his contribution to PCC, it is also appropriate to include those researchers who have learned from his work. Many researchers in the field of PCC reference Kitwood in their research. Some agree with his ideas, while others have critiqued the significance of his ideas. It is crucial to recognize that those researchers who have come after Kitwood have their own distinct ideas, or ideas which have a basis in his work, but have enhanced it. For example, Nolan developed four important and helpful dimensions of PCC:

1. *Being in relation: a person exists in relationships with others*

2. *Being in a social world: persons are social beings with biographies and life plans*

3. *Being in place: context is essential to the way that personhood is understood*

4. *Being with self: to feel recognized, respected and trusted are essential to a person's view of self* (Nolan et al., 2006, p. 128).

PCC has moved beyond Kitwood's initial thinking and developed into a more conceptual, multidimensional construct. A PCC approach focuses on personhood as a

status that is given by others, recognizing the importance of a person's individual needs. I

utilize it in the analysis to understand what residents need in order to develop

relationships with other residents and staff members. The theory is also useful for

understanding what staff require to develop relationships with residents, as well as what

staff and family need in order to develop relationships with each other. Having these

relationships and understanding the needs of others is essentially an aspect of PCC and

allows for the continued application of it, which is why it is the best framework for this

research study. It is the best fit due to its unique characteristic as a connection for theory,

policy, and practice. In order to have personhood, as well as QOL, it is essential that we

have meaningful relationships that consist of feeling close, being recognized,

acknowledged, and valued, and feeling a sense of belonging in relationships with others.

Chapter 3: Literature Review

This review of the literature will cover the relationships between residents, staff

members, and family members in a long-term care facility. Discussion will include the

exploration of these relationships, including a conversation on residents with dementia,

and the barriers that can assist in preventing the formation of these relationships. The

review is organized to connect the literature to the PCC theory and framework.

Relationships and Person-Centred Care

Older adults, staff members, and family members have commented on the

significance of interpersonal relationships and have even considered them as essential to

PCC. Wilson and Davies (2009) draw upon the perspectives of residents, staff, and

families, to define the staff's contribution to the development of relationships. They

found that the approach to care that staff used was crucial to the type of relationships that

developed. Staff that took the time to learn about the resident during their care routines were better able to deliver PCC, which has resulted in the development of positive relationships with the residents and their families. The development of these relationships has been appreciated by residents, staff, and families (Wilson & Davies, 2009).

In another study, survey findings from the Care and Construction project report that positive relationships between residents, staff members, and family members within the nursing home were associated with higher resident QOL (Keefe et al., 2015). Survey findings suggested, from the family perspective, that lower resident cognitive function was associated with lower family perceptions of resident QOL, as well as open, respectful, and supportive relationships between family and staff (Keefe et al., 2015).

Literature suggests a shift towards employing PCC when caring for older adults, as well as older adults with dementia (Shenk, 2012). Shenk (2012) highlights the literature on staff and family relationships in assisted living, as well as the importance of relationships between residents and staff. They state that in order for staff to provide quality care, relationships are crucial; particularly between staff and residents, and staff and family. Previous research shows that caregivers find meaning in their work through the relationships that they develop with those they care for, and because of that, they feel they are able to be successful in their job (Shenk, 2012). The importance of relationships and interactions among multiple parties has been suggested to represents a positive caregiving experience. It is important that all perspectives are considered when aiming to provide good quality care and a positive experience. Each party has their own unique and valuable input to contribute in order to achieve these goals. By concentrating on the importance of these relationships, as well as communication and interaction, the

caregiving and care receiving experience can become collective rather than institutional (Shenk, 2012). With that being said, these relationships are important, as they can help with creating PCC and a good quality experience for the residents, staff members, and family members in LTC. If staff members and family members can learn from one another and work together to meet the needs of the resident, they are in a better position to use PCC approaches when caring for a resident.

Staff-Family Relationships

There are many positive effects flowing from the development of relationships between staff and family members that are collaborative, one of which is PCC. To support collaboration, open and flexible communication processes are critical (Bauer & Nay, 2011). Families who describe feeling comfortable with the care environment report having open communication and a collaborative relationship with the staff that focuses on the wellbeing of the resident (Bauer & Nay, 2011). This communication with staff and family is seen as essential to help the resident and the family understand issues of care delivery and changing care needs, and furthermore provide family with the opportunity to share their knowledge of the resident and their unique past experiences of care. This can also produce trust between staff and families, as well as working together to understand and negotiate roles (Wilson, Davies, & Nolan, 2009).

The importance of relationships also arose from the in-depth case studies in the 2012 Care and Construction study. Case study findings suggested that families recognized relationships with staff as allowing them to be included as part of the care team and contribute to resident QOL, through support in monitoring resident medical and personal care needs. They also suggested that relationships between family and staff can

produce an understanding of resident needs (Keefe et al., 2015). Family members considered good quality relationships with staff to involve the ability to feel comfortable voicing concerns to staff and friendly conversation when given the opportunity (Nova Scotia Centre on Aging, 2015b). Family members commented on the staff's willingness to explain issues of care in ways they could understand. Both staff members and family members also commented on the importance of respect. Family members felt that it was important that staff members respected them. Staff believed in the importance of respectful relationships with residents (Nova Scotia Centre on Aging, 2015b).

Positive relationships between family and staff are beneficial to care quality and PCC because residents are given more attention, staff feel satisfied with their work, and families feel a sense of involvement in caring for their relative (Austin et al., 2009). In addition, the care environment, both physical and social, can support or detract from relationships between staff and family. The literature suggests that there are cases where both staff and family share the common goal of meeting the residents' needs. However, unless staff recognize and address the needs of the family and utilize their knowledge and skills to the benefit of the resident, it will be difficult to nurture a collaborative family-staff relationship (Bauer & Nay, 2011).

It has been reported that family caregivers hold themselves responsible for placing their relative with dementia in a nursing home and experience feelings of guilt (Johansson, Ruzin, Graneheim, & Lindgren, 2014). They still want to, and remain, involved in care decision making (Graneheim, Johansson, & Lindgren, 2013). Previous research suggests that if the staff learn biographical knowledge of the individual, better quality care can be achieved, particularly PCC. This is information that can be provided

by the residents (Johansson et al., 2014). However, when residents are not feeling up to having a conversation, or are not cognitively inclined to do so, family members are useful for sharing these life stories with the staff, allowing the staff to appreciate what matters to the residents (Wilson et al., 2009). Haesler, Bauer, & Nay (2007) also add that these relationships help bring to light the resident's uniqueness. Despite staff's views of relatives as being demanding, they have been called upon for resources that will enhance the resident's well-being (Graneheim et al., 2013), and are recognized for the contributions they make (Johansson et al., 2014). It appears that the knowledge family caregivers' have on their relatives' life story can be beneficial for planning and implementing care (Graneheim et al., 2013). It is important to mention that while the family can be helpful in relaying this information to the staff, there is always the possibility of inaccurate representation.

Smebye and Kirkevold (2013), too, recognize the importance of sharing life-stories with staff in an effort to personalize care to the resident and use/provide PCC. They also offer the idea that relationships in dementia care tend to go unnoticed. Smebye and Kirkevold (2013) explored how relationships between staff, family, and resident influenced personhood in people with dementia, as well as a unique context for caring. They state that family carers and professional caregivers provide different information and knowledge. Professional caregivers have general knowledge of dementia, such as the impact and the appropriate interventions. Family carers have detailed knowledge of the person with dementia based on a lifetime of shared experiences (Smebye & Kirkevold, 2013).

Research suggests that challenges arise when there is an inconsistency between the structure of the organization, such as the roles and tasks that families are able to contribute (Kellett et al., 2010). Kellett and colleagues (2010) explored the implementation of a participatory approach to dementia care through a Family Biography Workshop. The goal was to create a role for family caregivers of residents with dementia to help staff with personalized care. The workshop facilitated the engagement of staff, family members, and friends, allowing them to co-construct biographies of the lives of the person with dementia (Kellett et al., 2010). Other purposes of the workshop were to make sure that family and residents were heard and to understand the resident and their life history. The use of the life story and family biographical approaches was found to be an effective tool to empower staff to engage in flexible care practices as a result of relationships with family and residents. In turn, family caregivers have identified feelings of empowerment from contributing family knowledge that was valued by staff (Kellett et al., 2010).

It is possible that the quality of care for residents can be enhanced by positive relationships between staff and family. Positive relationships have the potential to enhance care through personalized and PCC delivery. This personalized care can be developed through and by trust, communication, joint-involvement, empowerment, cooperation, and shared knowledge of the resident and past experiences of care. Meaningful relationships can also be supported and achieved through and by PCC. The framework captures the significance and importance of the factors mentioned above that can be employed and enhanced by positive relationships among everyone involved, including care approaches, shared knowledge, and joint-involvement. As well, it

recognizes the importance of these meaningful relationships for all residents, including those with dementia. Meaningful relationships are vital if PCC is going to be used properly.

Barriers to Staff-Family Relationships

Research suggests a lack of support for staff members and family members to develop relationships with each other. As well, the relationships between paid staff and unpaid family caregivers is understudied. Wilson et al. (2009) state common challenges suggested in the relationships between care-home staff and family carers from studies in the United States, Australia, Sweden, and the United Kingdom. Utley-Smith et al. (2009) and Graneheim et al. (2013) provide an understanding of negative family-staff encounters, where staff consider demanding families to be difficult and time consuming. This can create an ineffective feedback loop. Unresolved family-staff conflicts can lead to staff keeping their distance, which would in turn cause family members to mistrust staff. When family members are avoided or ignored, they may become more demanding, increasing their requests for information and attention (Utley-Smith et al., 2009). Attention to this area is critical, because families continue to stay involved when their relative moves to a nursing home, providing care and support. However, there is research to suggest that families feel guilt, burden, and an obligation to oversee care, creating tension between families and staff (Zimmerman et al., 2013).

Bauer et al. (2009) identified barriers and recommendations to constructive family-staff relationships in residential care using literature on relationships between staff members and family members. They identified barriers to implementing participatory family care that included resistance to change on behalf of the staff, the lack of

encouragement of family involvement, failure to acknowledge and address the needs of

the family, and ineffective communication between families and staff. They recommend

the need for increased education for both families and staff on developing relationships

and handling workloads and staffing issues; improved communication skills and

negotiation techniques for both staff and families; strong support from administration and

management; as well as the development of care models that focus on collaboration with

families (Bauer et al., 2009). Bauer and Nay (2011) also suggest that the ability of the

family to stay involved with the resident after they are admitted often depends on the

attitudes and level of cooperation of the care staff (Bauer & Nay, 2011). While care staff

have stated that they consider interacting with family as part of their work, they do not

always treat it as a priority (Johansson et al., 2014).

Holmgren, Emami, Eriksson, and Eriksson (2013) discovered through fieldwork

that some care staff used the word 'expert' when referring to their roles, which

illuminates the existence of a divide between the relative and staff. They further

considered family as informal caregivers, playing a restrictive role. This was observed

from the way that the staff made the relatives wait in public areas while they performed

their daily care activities (Holmgren et al., 2013).

Despite their willingness to comment on viewing relatives as an important

resource for both the residents and themselves, and even communicating this in the core

value statement for the nursing homes, there have been some discrepancies. Staff stress

good relationships with the family members, and their willingness to maintain them,

however they have been observed as judgmental towards the relatives, frequently

stereotyping them based on areas such as ethnic origin, family relations, conduct, and

social status (Holmgren et al., 2013). Smebye and Kirkevold (2013) highlight that although staff emphasize the importance of biographical and life-history information, it is not always registered systematically. In several examples, relatives have been instructed to fill out information sheets, whereas interviews by staff would encourage relationships, interconnectedness, and partnerships (Smebye & Kirkevold, 2013).

Quality of Life and Person-Centred Care

QOL is one significant aspect and a suggested outcome of meaningful relationships, particularly as they relate to the LTC setting. A current social priority involves improving nursing home quality. For residents, practitioners, and policy makers, QOL for nursing home residents is important (Shippee, Henning-Smith, Kane, & Lewis, 2015b). Knowledge on QOL can contribute to evidence-based feedback that can help improve care (Shippee, Hong, Henning-Smith, & Kane, 2015a). QOL has had different definitions, as it is a broad construct. Assessments of QOL can focus on specific diseases such as Alzheimer's disease, as well as health and functional status, and a broader range of QOL domains (Godin, Keefe, Kelloway, & Hirdes, 2015). The perspective of the residents on their QOL has been argued to be the only appropriate assessment. However, family and staff can be decision makers for residents, acting to ensure the resident's QOL (Godin et al., 2015). Residents in a nursing home can be experiencing cognitive impairment and poor health, elements that prove difficult to change. Therefore, to improve resident QOL, focusing on other aspects is crucial (Godin et al., 2015).

A factor analysis of data from the three perspectives, resident, family, and staff, revealed that four factors contribute to resident QOL. These include care and support, autonomy, food, and activities (Keefe, Kelloway, McInnis, Earl, Stadnyk, & Rak, 2015).

QOL of nursing home residents also include several other elements such as safety, resident satisfaction, and perceptions of quality of care (Keefe et al., 2015). The Care and Construction project team defined resident QOL as the incorporation of meaningful relationships, resident autonomy, meaningful activities, resident affect, and home-likeness. (Keefe et al., 2015). Engaging in these relationships is suggested to have the potential to contribute to the overall QOL of residents, family, and staff. A significant part of QOL is feeling connected to others in a positive and meaningful relationship, where PCC is present.

Quality of Life with Dementia

Assessing QOL makes assumptions to suggest that individuals have the intellectual ability to make judgments about their lives. Therefore, QOL can be difficult to assess, as it depends greatly on an individual's sense of well-being. With individuals with dementia, assessment can be affected by their cognitive impairment and their capacity to understand and communicate their feelings (Crespo et al., 2011). Nonetheless, understanding the QOL of residents with dementia is significant given the increase in residents with dementia in a nursing home, and is helpful for arranging for appropriate interventions or programs (Crespo et al., 2011). PCC is an appropriate care approach for the QOL of residents with dementia.

Several factors have been suggested as influential to dementia QOL, however the level of influence depends on if the information is relayed from the individual with dementia or their proxies. Nonetheless, the literature supports that family members play a significant role in helping an individual with dementia live a worthy life (Moyle et al., 2013). Also, family members have perceived care staff to make significant contributions

to how a resident with dementia was valued (Moyle et al., 2013). These findings on family and staff perspectives are important, as they can help in creating opportunities for family and staff cooperation, allowing integration of family in the LTC community and care decisions (Moyle et al., 2013). There is also the possibility of impacting the QOL of residents with dementia, or their experience in their home.

Communication and Person-Centred Care

Providing good quality care involves good communication and interaction between residents, caregivers and residents, and family and staff (Shenk, 2012). However, communication can be challenging for people with dementia and their caregivers (Saunders, de Medeiros, Doyle, & Mosby, 2012). This challenge is also one of the earliest symptoms of the disease (Stanyon, Griffiths, Thomas, & Gordon, 2016). It has even been suggested to contribute to stress, mortality, and the decrease in QOL for both parties. The negativity that can arise from these issues with communication could be reduced by understanding how people with dementia create and maintain relationships in LTC and the processes of communication they use. In the early stages of dementia, there is often immense silence in conversations. This may stem from difficulty with keeping up with the pace and understanding content. Those participating in the conversation can slow down their speech, repeat or rephrase, and ensure that the individual is following along (Saunders et al., 2012).

Kitwood's PCC approach stresses the importance of communication between healthcare workers, those they care for, and their families. The act of communication can be complex with people with dementia, and therefore requires considerable and specialized resources. Research on communication and speech characteristics has

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suggested that 'elderspeak' or a vocal tone that appears controlling, can interfere with the

smooth flow of care activities (Stanyon et al., 2016). This is just one aspect of Kitwood's

notion of malignant social psychology; a term that represents a caring environment that is

damaging to personhood and undermines the physical well-being of a person (Kitwood,

1997, p. 46). These acts are often not intentional, suggesting that education and training

may be appropriate for caregivers and staff. According to Kitwood, sensitizing staff to

the idea of malignant social psychology is a simple task that can be achieved through

short training sessions (Kitwood, 1997, p. 49). Teaching communication techniques to

workers in the health care field can increase communication behaviour. One example of

these techniques includes using short sentences (Stanyon et al., 2016). Others include

direct eye contact with the resident, clear and simple sentences with a welcoming tone,

and positive nonverbal cues (Eggenberger, Heimer & Bennett, 2013).

Stanyon and colleagues (2016) investigated how healthcare workers

communicate, involving participants who felt that their communication styles were

effective. Everyone involved believed that it was crucial to have a complete

understanding of dementia. For example, participants expressed the need for realizing

what an interaction will look like, what a person with dementia can understand, and

therefore adapting the conversation accordingly and accepting the need for repetition of

instructions or frequent answers to questions (Stanyon et al., 2016). For participants who

spent short periods of time with people with dementia, they expressed that issues with

communication arose due to an insufficient amount of knowledge regarding individual

preferences, and recommended improvements for training (Stanyon et al., 2016). Good

communication can contribute to the development of relationships in LTC. Relationships

are an important aspect and a contributing factor in creating a positive experience for the residents.

Current knowledge suggests the significance of relationships from the perspective of residents, family, and staff. Relationships between family and staff are helpful when working together to provide PCC to the resident and have been associated with higher resident QOL. With dementia, these relationships can instill personhood and help provide PCC. This personalized care can be developed through and by trust, communication, joint-involvement, empowerment, cooperation, and shared knowledge of the resident and past experiences of care. However, there can be challenges to employing these relationships including lack of support to develop relationships, as well as conflicting emotions and tension among family and staff.

Chapter 4: Methodology

Research Questions

This research explored meaningful relationships between family members and care staff in LTC facilities, from the perspective of the resident, family, and staff. The intent was to discover the factors that contribute to enabling meaningful relationships, and/or the barriers to the evolution of these relationships. As we know, meaningful relationships among residents, family, and staff have been suggested to influence the QOL of residents. However, greater specificity is needed to understand how these meaningful relationships come about. In particular, it is crucial to understand what contributes to the development of these relationships, as well as the barriers, from all perspectives. Literature has suggested the importance of relationships between residents, family members, and care staff. For residents, especially for residents with dementia, it

may be the relationship between staff and family that best enables positive and supportive relationships to occur positively.

The research questions were: What are contributors and barriers to meaningful relationships among residents, family, and staff in LTC facilities? In what ways are these influencers similar or different when understanding meaningful relationships with residents with dementia? This question on dementia became more of a perspective rather than a question, due to the insufficient data and factors found to answer it. Given that dementia was not an initial focus of the overall study, it was not referenced adequately in the transcripts. However, it is important to include dementia in discussion on long-term care given the reality of its presence in many nursing homes and its limited, but present, emergence in the transcripts.

Care and Construction

A content analysis utilizing secondary data from the NSCA *Care & Construction: Assessing Differences in Nursing Home Models of Care on Resident Quality of Life* study was conducted. The data analyzed was comprised of the family and staff focus groups, as well as the resident in-depth interviews. The original study was funded by the Canadian Institutes for Health Research (FRN#114120) in partnership with the Nova Scotia Health Research Foundation (Matching-2011-7173) in 2011. I analyzed the follow-up focus group data from the family members and staff, as well as the resident in-depth interview data on meaningful relationships. This data allowed for an exploration of what we know about these relationships from the staff, family, and resident perspectives.

Nova Scotia's continuing care sector underwent significant changes, as part of the Continuing Care Strategy (Keefe et al., 2015). These changes were implemented as a

result of a strong desire to assist Nova Scotians in achieving maximum health and independence, through government programs and services (Department of Health and Wellness, 2008). As a result, Nova Scotia opened a number of new and replacement residential LTC facilities which involved shifts in staff scope of practice and innovative physical designs, such as small, self-contained households replacing hospital-like wards. As well, nursing homes were implementing philosophies that underlined resident-centered care (Keefe et al., 2015). Impelled by these changes, a diverse team of researchers, administrators, and sector representatives examined the impact of different models of care on resident QOL in nursing homes. The main research question the Care and Construction team/project examined was, *to what extent and in what ways do differences in the nursing home model of care impact resident quality of life?* (Keefe et al., 2015). Nursing homes involved in the project represented three models of care from across Nova Scotia, with model of care referring to differences in physical design and staffing approaches. The facilities were categorized as New-Full scope, New-Augmented, and Traditional (Nova Scotia Centre on Aging, 2015c). Twenty-three nursing homes in Nova Scotia were involved; 11 New-Full scope; 5 New-Augmented; and 7 Traditional (See Table 1.). The key dependent variable, resident QOL, included elements such as quality of care, degree of resident autonomy, and level of involvement in activities. Multiple methods were used in the research design, involving more than 1,600 participants. The research design consisted of surveys, interviews, focus groups, and case studies including interview, participant observation, and activity monitoring (Keefe et al., 2015).

	Physical Design	Staff Approach
New-Full-scope	Small, self-contained households	CCAs responsible for all tasks, including dietary and housekeeping
New-Augmented	Small, self-contained households	CCAs provide care needs and limited dietary and housekeeping
Traditional	floors/units	CCAs provide only care needs, other staff provide dietary and housekeeping services

Table 1. Overview of the project's models of care by physical design and staff approach (Nova Scotia Centre on Aging, 2015)

Resident Perspective

Following the initial survey, residents were asked if they would be interested in a follow-up interview. The purpose was to obtain richer qualitative data regarding the questions on QOL, homelikeness, relationships etc. within each of the three categories of facilities. A list of residents who stated that they would be interested in participating in follow up research on the survey was sent to the homes for review. This was to confirm that the participants were still living at the home and had no issues with health or cognitive function that would interfere with their participation in the in-depth interviews (Nova Scotia Centre on Aging, 2015c). At the New-Full-scope and New-Augmented homes, there were only 9-10 residents who stated their interest in participating, so all of them were sent recruitment letters. The recruitment letters provided information on the times that the interviews would be taking place at the homes, and that they may be approached for an interview (Nova Scotia Centre on Aging, 2015c). In the Traditional home, 36 residents were interested in participating. The chair of the resident working

group determined 17 residents that would receive a recruitment letter (Nova Scotia

Centre on Aging, 2015c). The interviewers met the residents at their homes and asked if

they were still willing to participate in an interview. Upon completion of the five

interviews in each facility type, those residents not interviewed but who received letters

were given a thank-you card for their interest (Nova Scotia Centre on Aging, 2015c).

Family Perspective

Qualitative follow up data was collected in the form of focus groups with family

members to provide more in-depth responses about their experiences as family within

LTC. Family member for the focus groups were recruited from the 384 family members

who participated in the survey. One or more nursing homes from each of the models

were chosen, in an effort to gather follow up data from each. Twelve family members of

residents in each of the three homes who provided contact information for participation

were contacted via mail. One to two weeks after the letters were sent out, follow up

phone calls were made regarding interest and availability for participation. Information

regarding time selection was communicated via telephone or email to the family

members (Nova Scotia Centre on Aging, 2015c). In total, there was 21 family members

who participated in the three focus groups: five participants in the New–Full-scope

homes focus group; seven in the New–Augmented home focus group, and nine

participants in the Traditional home focus group. (Nova Scotia Centre on Aging, 2015c).

These focus groups occurred in October and November of 2012 and were transcribed by

staff of the Care and Construction project.

Staff Perspective

Staff members were recruited via staff meetings, bulletin board notices, and face-to-face conversations. There were 38 staff members from four different homes involved in the six staff focus groups. These focus groups were held prior to the staff survey in order to test what key concepts should be operationalized in the survey. At least one focus group of staff members occurred in each category of facility. Open-ended questions were examined for insights into the enhancers and barriers to relationship between staff, family and residents (Nova Scotia Centre on Aging, 2015c). Data was summarized into themes and will be incorporated into the findings as such.

Instruments

There were two data collection instruments used in the family focus groups. These were the participant profile and the focus group guide. The participant profile consisted of demographic questions from the survey. These questions involved information about the family member and the person living in the nursing home (See Appendix A) (Nova Scotia Centre on Aging 2015a). The focus group guide consisted of open-ended questions on the experience of the family member (see Appendix A) (Nova Scotia Centre on Aging, 2015c).

Some of the questions used for the resident interviews were taken from the survey, and consisted of demographics (i.e., age and marital status), time in the nursing home, health questions, and the overall QOL (See Appendix C). The working group also created supplementary questions to investigate different parts of nursing home life and the impact on QOL (Nova Scotia Centre on Aging, 2015c).

Types of questions that were analyzed from the family focus group can be found in Appendix A. Types of questions that were analyzed from the staff focus groups can be found in Appendix B. Types of questions that were analyzed from the resident in-depth interviews can be found in Appendix C.

Ethics

The protocol for the participant follow up was submitted to four research ethic review boards (Mount Saint Vincent University, Saint Mary's University, University of Prince Edward Island, and Capital District Health Authority) for ethics approval and to two nursing home providers Northwood (2 study sites) and Shannex (15 study sites) for formal review (Nova Scotia Centre on Aging, 2015c). There were a number of modifications to the protocol throughout the data collection, and these changes were re-submitted for approval. Drafts of the family focus group guide were submitted in Fall 2011. In August 2012, the respective data collection instruments were revised based on the survey results (Nova Scotia Centre on Aging 2015c).

Participants were provided with two copies of the consent form, prior to the beginning of data collection. Participants and the researcher reviewed the consent form together, and participants were given the opportunity to ask any questions. Both the participant and researcher signed two copies of the consent form, leaving one copy with the participant and the other with the project office for storage (Nova Scotia Centre on Aging, 2015c).

For this secondary data analysis, any identifiable information in the focus groups and interview transcriptions were removed. The transcripts were stored on my password

protected laptop and flash drive. The research was approved in October 2016 by the
University Research Ethics Board at Mount Saint Vincent University (#2016-075).

Demographics

Several exemplar quotes from the analyzed interviews and focus groups were
included in the findings. Below is information on those individuals who were included
and contributed quality quotes to the themes and subthemes that emerged from the
analysis.

Table 2: An overview of the demographic information of the resident interview
participants.

Name	Age	Gender	Relationship Status	Perceived health status (100=best)	Duration in the Home (Years)	Type of Home
NR1	60		Single	80/100 Physical; 30/100 Mental	5	Traditional
NR3	73	Female	Widowed	65/100	3	Traditional
NR4	79	Female	Divorced	75/100	2	Traditional
NR5	88	Male	Widowed	75/100	3	Traditional
NR6	78	Female	Divorced	40/100	2	Traditional
TR1	57	Female	Divorced	N/A	3 and a half	New-Augmented
TR2	75	Female	Widowed	80/100	8	New-Augmented
TR3	94	Female	Widowed	100/100	Does not remember	New-Augmented
TR4	52	Female	Common-law	N/A	2 years	New-Augmented
TR5	85	Male	Married	90/100	1 month and a half	New-Augmented
SR1	78	Female	Widowed	50/100	2	New-Full-Scope
SR2	85	Female	Widowed	70/100	2	New-Full-Scope
SR3	48	Female	Divorced	50/100	2	New-Full-Scope

| SR4 | 78 | Female | Widowed | N/A | N/A | New-Full-Scope |
| SR5 | N/A | N/A | Widowed | 90/100 | 2 | New-Full-Scope |

While the residents interviewed did not have dementia, there was some discussion around other residents that they observe with cognitive decline. This is helpful for addressing how the contributors and barriers to meaningful relationships are different for residents with dementia. In the traditional focus group, there were 3 individuals discussing a relative with dementia; in the new-augmented focus group there were 5 family members discussing their residents who all have Alzheimer's; and in the new-full-scope focus group there was 1 participant speaking of their relative with Alzheimer's and 2 with dementia. Their conversations surrounding resident care are reflected above and there were instances where specific reference was made to dementia and Alzheimer's, however the appropriate information was not found for the second research question on dementia. While the question cannot be answered in the same way in terms of factors, it is important to be aware of the realities and inclusion of dementia in long-term care. Often in the literature dementia is excluded and viewed in a negative light. The World Health Organization reports that there is a prevalent stigma against older adults with dementia (Milne, 2010).

Table 3: An overview of the demographic information of the family focus group participants and residents (F = family and friends).

	Model of Home	Participants Relationship to Resident	Age of Resident	Duration in the Home (Years)	Health Status of Resident
F1	Traditional	Child (Resident is their mother)	92	2	Had a mild stroke

F2	Traditional	Friend	75	4	Has MS; Completely disabled
F3	Traditional	Cousin	63	3	Has severe Cerebral Palsy; Non-verbal
F4	Traditional	Child (Resident is their mother)	92	6	Dementia
F5	Traditional	Child (Resident is their mother)	96	3	Mild Dementia; in a wheelchair.
F6	Traditional	Child-In-Law (Married to P5)	96	3	Mild Dementia, she's in a wheelchair.
F7	Traditional	Sister	83	1	Alzheimer's
F8	Traditional	Child (Resident is their mother)	96	3	Very alert, well able to take care of herself.
F9	Traditional	Grandmother (Daughter of P8)	96	3	Very alert, well able to take care of herself.
F10	New-Augmented	Child (Resident is their mother)	94	2	N/A
F11	New-Augmented	Child (Resident is their father)	N/A	N/A	Alzheimer's
F12	New-Augmented	Spouse (Residents wife)	N/A	4	Alzheimer's
F13	New-Augmented	Spouse (Residents wife)	N/A	2	Alzheimer's
F14	New-Augmented	Spouse (Residents wife)	N/A	8 months	Alzheimer's
F15	New-Augmented	Spouse (Residents husband)	N/A	N/A	Alzheimer's
F16	New-Full-Scope	Second cousin	75	Less than a year	Dementia
F17	New-Full-Scope	Child (Resident is their mother)	87	3	Alzheimer's

F18	New-Full-Scope	Child (Resident is their mother)	96	2 and a half	No use of her right arm; affected speech and balance
F19	New-Full-Scope	Resident is their aunt	90	2 years 8 months	Alzheimer's
F20	New-Full-Scope	Child (Resident is their mother)	93	2	She's had broken hips, "this that and the other thing".

Analysis

Analysis of the contributors and barriers to meaningful relationships in LTC was guided by a grounded theory approach.

Grounded Theory. Grounded theory proposes that researchers can construct theory that is grounded in data through detailed exploration and theoretical sensitivity. Researchers internationally have used this method to conduct qualitative research in varied disciplines (Charmaz, 2014). This method is suitable for researchers who seek to understand processes or situations (Richards & Morse, 2013). In the case of this research, it was the goal to understand relationships between family and staff in LTC facilities from the perspectives of the family, staff, and residents. In particular, what we know about these relationships, and what contributes to them. Developed by both Glaser and Strauss, Glaser contributed the idea of theoretical sensitivity and Strauss, the method of creating theory from data (Richards & Morse, 2013). Theoretical sensitivity refers to the seeking of theory and continuously working with records of data to discover the concepts that may contribute to theoretical insight. Glaser and Strauss' collaboration led to the idea that one must engage in continuous interaction between data collection and analysis until a theory is created that fits the data; a theory grounded in the data. The goal of grounded

theory, therefore, is discovering theoretical concepts in the data (Richards & Morse, 2013).

Originally, criteria set by the methodological frame of quantitative research could not be fulfilled by qualitative research, as it could not meet reliability, validity, or objectivity standards in the mid-century (Charmaz, 2014). Glaser and Strauss (1965, 1968) challenged these developments through the integration of research and theory. They disproved the assumption that theorizing was for theorists who did not conduct empirical research, but instead contemplated the structure of society. With that, Glaser and Strauss integrated theorizing and everyday empirical problems, and argued that qualitative research has different standards than quantitative inquiry, and therefore cannot be judged by the criteria for quantitative research.

In the early 1990s, there appeared to be a division between Glaser and Strauss, resulting in two types of grounded theory; Glaserian grounded theory and Straussian grounded theory (Richards & Morse, 2013). Glaserian grounded theory forms an objectivist perspective, allowing the data to tell its story, expose concepts and categories, and ultimately form a theory. Straussian grounded theory considers all possibilities that could connect to the data, and focuses on developing more abstract concepts, essentially going above and beyond the data at hand (Richards & Morse, 2013). Both Glaser and Strauss predicted that grounded theory would continually evolve, and invited researchers to adapt the method as needed for various research topics (Charmaz, 2014). My research will incorporate Glaserian grounded theory, as the goal is to expose the emergent themes within the data and allow that to tell the stories.

Coding. Data analysis is the fundamental piece of grounded theory. Exploring the data, creating categories, and discovering similarities and differences within the data is known as coding (Walker & Myrick, 2006). This is an iterative, inductive process that leads to the establishment of themes and theories. In grounded theory, compared to other qualitative methods, the data analysis process is different, in regard to development and specificity. Coding starts with basic description, then conceptual ordering, and finishing with theorizing (Walker & Myrick, 2006). Glaser and Strauss have slightly different coding processes, although recognizing these differences can be challenging. They both "gather data, code, compare, categorize, theoretically sample, develop a core category, and generate a theory" (Walker & Myrick, 2006, p. 550). The language and general processes are essentially the same, however the difference is how these processes are executed which will be discussed in the next section.

For both Glaser and Strauss, the first phase in the coding process is open coding (Walker & Myrick, 2006). However, Glaser considers open coding to be the first part of what he refers to as substantive coding. In open coding, data is coded in as many ways as possible and memos are used to record conceptual and theoretical ideas that emerge. When the analyst starts to see the opportunity for a theory to emerge that can encompass the data as a whole, open coding is complete (Walker & Myrick, 2006). Glaser's open coding was followed and applied in this research. Glaser's second step is selective coding, which he refers to as the second part of substantive coding. Selective coding involves establishing the coding process around a core category, and this process was applied in this research. There is one fundamental difference between Glaser and Strauss in this section, although both show forms of selectivity. Strauss uses the coding paradigm

to select categories to inspect, rather than selectively coding around a fundamental category. The coding paradigm is a perspective taken toward the data (Walker & Myrick, 2006). In the last stage, the analyst attempts to create a theory by integrating the data around a central theme. Glaser refers to this process as theoretical coding, a process suggested to reveal more than the coding paradigm, with the larger assortment of perspectives that it can produce (Walker & Myrick, 2006).

Procedure. Glaser's coding process was used to guide the coding in this research, using an excel spreadsheet to match themes to data. Being reflexive was crucial, given personal experience with the topic of dementia and Alzheimer's. Open coding was used to code the data in as many initial ways that emerged, using memos to record any concepts or ideas that arose along the way. An example was making records of any references made to dementia. Selective coding was used to narrow in on the three core categories or themes, which could then be further coded for the development of the subthemes. Theoretical coding was used to develop a potential theory by integrating the data around a central theme and conceptualizing the interconnection of each theme. Within the three themes there was overlap between at least two. For example, several references were made to the opportunities for communication during activities. With the help of these themes and their connection to one another, a theory was developed on what influences relationships in LTC. This interconnection will be discussed further in chapter 6. Examples of the coding process are included below.

Table 4: Example of the initial coding process template for the transcripts using excel

Resident-Resident Relationships		
	Traditional Home	New-Augmented Home	New-Full-scope Home

Theme 1: Communication			
Theme 2: Staffing			
Theme 3: Activity			

* No differences were found among the homes, so separation by homes was eliminated

from coding.

      After inserting all of the applicable quotes into the appropriate theme,

relationship, and model of home, subthemes were developed. Each quote was broken

down into potential descriptors which ultimately led to a subtheme that represented each

of descriptors. This process is represented in tables 7 and 8 which were modified from

Burnard, Gill, Stewart, Treasure, & Chadwick. (2008).

Table 5: An example of an initial coding framework for creating a subtheme under the

theme of communication

Interview Transcript	Initial Coding Framework
Interviewer: 'Do they (staff) have any chances to maybe sit down and talk with you or more?	
Participant: 'Occasionally, but I don't think, I, I don't think there's a lot of that, but occasionally you'll have that. I was sitting out there in the lobby down by the elevator area there and that was where I find some of the staff stop by and sit down there and talk.'	• Conversations in the lobby • Conversations in common spaces • Sitting in the lobby • Sitting down and talking

Table 6: An example of an initial coding framework for creating the subtheme of

"conversations" under the theme of communication

Subtheme	Initial Coding Framework
Conversations	• Conversations in the lobby • Conversations in common spaces • Sitting in the lobby • Sitting down and talking

Table 7: An example of a final coding framework for the theme of communication after reduction of the categories in the initial coding framework

Final coding framework	Initial coding framework
Physical Space and Design	• Conversations in the lobby • Conversations in common spaces • Sitting in the lobby • Sitting down and talking

When initially analyzing the transcripts, there was frequent reference among residents, staff members, and family members, to contributors and barriers involving communication, staffing, and activity. The first set of subthemes for communication were conversations, feelings of closeness, and lack of communication. Upon further analysis it became clear that the findings in conversations could be condensed further. Examples of conversations were explained through gatherings in the lobby with residents and staff, as well as through conversations with residents, residents and staff, and staff and family (via in-person, telephone, and/or email). Residents frequently mentioned the lobby of the nursing home as a space that they collected in with other residents and staff on a daily basis. As a result, this became a location that fostered conversations and allowed residents to mingle and communicate with others. Conversations then became two new subthemes: physical space and design, and communication technology and policy. The subtheme, feelings of closeness, consisted of examples of residents, staff members, and family members feeling comfortable, at home, like a family, and part of a community. Conversations that involved discussion of family, likes, dislikes, shared interests, laughter, and playful humour all contributed to these feelings. These lead to the development of newly revised individual subthemes of homelikeness, common interests, and humour, each of which contribute to developing meaningful relationships in LTC.

Feeling at home, sharing interests with others, and engaging in playful humour means that residents feel comfortable enough to engage with others in a meaningful way. The third subtheme, lack of communication, involved examples that pertained to the inability for communication among certain residents, staff members, and family members. A large reason for this lack of communication was the physical health of residents. Physical health became the modified subtheme, representing the difficulty that comes from trying to communicate with someone who has Alzheimer's and dementia. These six factors, originally three, are contributors to meaningful relationships in LTC, and become barriers when they are inexistent.

The two subthemes for the theme of staffing were originally being shorted staff and staff rotation. Generally these two themes stayed the same through the development, in terms of the content within each, but became amount of staff and continuity of staff to fully represent their meaning. Being short staffed involved the consensus that in these particular situations, there are not enough staff on duty to provide sufficient care, to go above and beyond, and to spend quality time with residents and family. In the end, it comes down to the amount of available staff. Staff rotation represented the amount of staff that frequently work on different units from week to week, creating an unfamiliarity among residents. Without that continuity, it can be difficult for residents to develop and nurture relationships with staff. It can also cause frustration among residents when having to continually explain care preferences. With that being said, staff rotation developed into continuity of staff. These two factors are barriers to meaningful relationships in LTC and help to showcase what would contribute.

The three subthemes under the theme of activity were group activities, staff involvement, and lack of activities. Group activities later developed into shared experiences from group activities. Residents often mentioned the various activities that they take part in throughout their days, including mention of those residents that also attend. Aside from discussion around the various types of activities such as bingo, exercise, and crafts, there was a sense of shared experiences and spaces with these residents. Engaging in these group activities appears to allow for the ability to form relationships that are based and built from shared participation. The second subtheme, staff involvement addressed the experiences of some residents engaging in activities with staff such as card games together. This subtheme developed into individual activities between residents and staff in order to clearly address the context and meaning. The third and final subtheme started as lack of activities, which in the title itself did not fully capture the point of the subtheme. What this subtheme is truly trying to convey is the ability to form relationships with others when there are more options and spaces for activities to occur. Functional ability varies among residents leading to their inability to attend certain events. With that being said, relationship development can be difficult in this case. These three factors can be both contributors and barriers to meaningful relationships in LTC.

Analysis and Framework. The PCC framework and grounded theory worked appropriately together for this research. PCC seeks to meet the individual needs of those receiving the care. This can include involving them in their own care decisions and having a relationship with them. Researchers are encouraged to learn and understand what is most important to the care receivers as well as their families, and apply this new

knowledge in practice. The same idea can be applied to grounded theory, a method that is

invested in learning and understanding situations, and creating something new from the

data. In grounded theory, the analyst allows the data to tell the story. The same can be

said for PCC, as it allows the person to tell their story and have a level of control over

their decisions. In a way, PCC and grounded theory are both interested in discovering

something new and something valuable about the perspective of the participant. They are

both concerned with learning what is important to individuals, and what contributes to

their experiences.

PCC and grounded theory guided this research in discovering what we know

about the barriers and challenges to meaningful relationships in LTC. We know that

relationships are important to residents, family, and staff, and their experiences with

LTC, but it is significant to know what enables and disables the development of these

relationships. Applying PCC could assist these relationships in being exercised. On the

other hand, these relationships could also enable the employment of PCC. Both the

framework and the analysis helped to frame the research, and assisted with understanding

these relationships between family and staff in LTC.

Secondary Analysis. Secondary analysis of qualitative data is encouraged to

make best use of previous research (Redman-MacLaren, Mill, & Tommbe, 2014).

However, there are several epistemological and ethical challenges. Qualitative

researchers can have differing epistemological and methodological positions when

generating their data. The researcher's epistemological and methodological positions may

be inconsistent with the manner in which the data was collected (Redman-MacLaren et

al., 2014). Also, depending on the purpose of the research, different methods can be used

to conduct a secondary analysis of data. Redman-MacLaren et al. (2014) describe two out of five types of secondary analysis of qualitative data, which apply here. These are supra analysis, which examines new empirical, theoretical, or methodological questions, and supplementary analysis, a more in-depth investigation of an emergent issue (Redman-MacLaren et al., 2014). The research questions that I sought to understand were newly created from the Care and Construction findings, representing a supra analysis. A significant and emergent finding from Care and Construction was the importance of relationships in LTC, which has been further investigated for the purpose of this research project.

Chapter 5: Findings

Three themes emerged during analysis of transcripts of the resident interviews and the family focus groups: (a) communication among residents, family, and staff, (b) staffing within the LTC facility, and (c) activity among residents, family, and staff. These themes, communication, staffing and activity are interpreted as both contributors and barriers to the development of meaningful relationships in LTC facilities. Subthemes or factors of communication that emerged are physical space and design, communication technology and policy, homelikeness, common interests, humour, and physical health. Subthemes of staffing include amount of staff and continuity of staff. Activity subthemes consisted of shared experiences from group activities, individual activities between residents and staff, and options and choice. The voices of resident's and family members are presented as illustration of these themes.

Communication

There was significant agreement among residents, staff members, and family members that communication between residents, residents and staff members, and staff members and family members was an important contributor to the development of meaningful relationships in LTC. Conversations that often take place in the lobby or lounge between residents and residents and staff, the closeness of everyone, feeling "at home", and being treated like "family" by residents and staff was clear in the data. Residents and participants also referred to communication between staff members and family members, such as the importance of contacting each other to discuss and receive updates on a resident's care and conditions. Residents and family members spoke about feeling as though their voices were not being heard when raising concerns with staff members, and that these opportunities were limited, creating barriers. Further, when family members were unable to communicate with staff members about a resident's condition, it caused frustration and worry. Factors that arose from this information include physical space and design, communication technology and policy, homelikeness, common interests, humour, and physical health.

Table 8: Summarized meaning of subthemes emerging under communication

Communication	
Physical Space and Design	Collective spaces in the facility fostered communication.
Communication Technology and Policy	Staff and family interaction via in-person, telephone, and/or email enabled communication.
Homelikeness	Feeling like part of a family and feeling at home facilitated communication.
Common Interests	Sharing common interests between residents and staff strengthened communication.
Humour	Feeling comfortable enough with other residents and staff to use playful humour enhanced communication.

Physical Health	Being unable to communicate with other residents due to physical / mental health conditions (dementia, stroke) was detrimental to communication.

Physical Space and Design

Residents frequently mentioned the importance of conversations between themselves and other residents as a contributor to meaningful relationships in LTC. The lounge and the lobby were two spaces that enabled them to communicate and engage in friendly discussion with the residents who were passing through. In response to a question about the lobby, an 88-year-old male widow states "I can watch people coming in and out and sit and meet with some friends down there". (NR5) It was a part of their day that meant a lot to them, and was mentioned by several of the residents during their interviews. Conversations between residents and staff members were mentioned, also taking place in the lobby. The same resident continues to explain:

I was sitting out there in the lobby down by the elevator area there and that was where I find some of the staff stop by and sit down there and talk. (NR5)

Residents appeared to appreciate this time that they were able to share with staff members in a common space. They emphasized that the lobby was a place that allowed for frequent opportunities to meet and communicate with both residents and staff. Common spaces may also provide an area for residents to feel as though they are on an equal footing with staff. They are persons staff know, and will stop to chat with in a common space rather than clients or patients who are dependent on staff for care. The normalcy of the lobby reduces the hierarchy or power relations that may characterise other interactions. When residents gather in the lobby or lounge with other residents and

staff members, perhaps they share a common space, but also a common purpose in life. A

94-year-old female widow refers to the opportunities for conversation that are presented

in the lounge:

> Well there's nine of us to a group- a house. So I know we spend quite a bit of our
>
> time at the table talking, that way. Then…we go in say in the afternoon and we'll
>
> sit there. And we just sit there and they call it "chinwag" for an hour. (TR3)

Social support, an outcome of having positive relationships with other residents and staff

members is suggested as important to residents. Those who have a positive experience

with their daily contact with others throughout spaces in the home reportedly feel a sense

of belonging, togetherness, respect, and satisfaction with their social support (Lung &

Liu, 2016). These feelings are suggested to be important factors for developing and

nurturing meaningful relationships in LTC and appreciated by residents. Evidence from

the resident interviews point to them spending a great deal of time talking in groups. This

may mean that they are comfortable with those who surround them and value the

opportunity to continue sharing their time with them. In a previous study by Bonifas and

colleagues (2014), living in a LTC was found to impact the quality and process of social

interactions. With respect to QOL, friendships with residents and staff were considered

highly important. Further, residents consider staff members to be their friends, and one of

their primary sources of social support (Bonifas et al., 2014).

When asked what types of things residents do to get to know other residents, the

94-year-old female widow referred to the conversations that evolve from musical

entertainment in the lounge. They state that "they have special music come in and

everybody gets together in one room and something will happen and then you'll turn and

say well that was pretty good wasn't it?" (TR3) and that "people have a conversation" (TR3) as a result of what they experienced together. Social interactions and conversations are likely to occur following events held in the recreation areas. Having receptions after these events may influence connections through the discussion of shared experiences, and therefore an opportunity to learn more about each other (Bonifas et al., 2014). This overlap of communication and activity will be addressed later.

While LTC facilities exist in a larger external neighbourhood that is often closed off from the home, there is also a more small-scaled environment that exists within that neighbourhood. We are seeing a shift towards environments in LTC that are focused on enabling a sense of "place" and creating a more homelike environment. Instead of using terms from the medical model language like "floors" and "units", some choose to use the term "neighbourhood". Residents who have explained feeling at home have often referred to perceptions of freedom of movement and placement, allowing them to "come and go as they please". The development and sustainment of social relationships in LTC are suggested to be influenced by this feeling of freedom, sense of community, and "home". Understanding this has the potential to influence resident well-being (Bonifas, Simons, Biel, & Kramer, 2014).

Communication Technology and Policy

When discussing the relationship between family and staff, residents often described the importance of communication and the different types used between them. This was particularly important during situations where residents have a change in the condition of their health or care, and seek updates from staff members. A 73-year-old female widow states:

We have 2 main nurses on this floor, and the one that I really like is called [Name of nurse], and she knows all my kids and if anything goes wrong, if I'm really sick and need some help, she will get in touch with [Name of son], who's my power of attorney and, uh, tell him what the latest is. (NR3)

Family members also felt that their relationships with staff members were greatly influenced by their conversations regarding resident care. They voiced that it was important to discuss changes in resident behaviour, care, and health conditions, as explained by one family member:

I try to get here twice a week, sometimes it doesn't always happen and if it can't for certain reasons I make a phone call and see what's doing, how my sister's doing, I get all the answers I want and assurance that everything's fine or if she's not feeling well, whatever. And they're very good to call-.

Family members are appreciative of the opportunity to call and speak with staff members on days where they were unable to find the time to visit. Residents also share an appreciation for the relationship between their family members and staff members. Further, staff reported that successful and quality communication was influenced by different types of communication (face-to-face, telephone, email, letter mail, etc.). Good communication, teamwork, and a positive attitude is suggested as a contributor to providing high-quality care. Therefore, good communication is encouraged between family and staff (Shenk, 2012).

There was also a consensus that staff members willingly contact family when something happens with the resident. Another family member goes on to further explain:

F1: Yeah. Lots of times I get emails from [Name] who is our head RN. And I also have uh I talk to her whenever she has a problem with my husband or she sends me off a quick email saying you know [Name] is OK so don't worry. But blah, blah, blah happened today. OK fine. And also, also uh doctor [Name], he who's the doctor on that floor is also uh I have his own number at home so I can call him at any time, which I did initially.

F2: The cost for calling, making a phone call or an email is nothing [F3: Yeah]. They have the communication, they listen to what you have to say, if you're down they listen to you, they comfort you, um they keep you abreast as to what's going on with your family member, they keep you abreast with what's going on in this facility if you wanna attend, it's up to you.

Another family member also described the level of support s/he receives from staff members:

Now when he both times was very ill, they called me to come in the night, they made me tea, they hugged me, and they talk with me. And um they will call you um maybe two or three times a day to say he's just the same no change. And every night before I went to bed they told me I could call any time at all.

Previous research has pointed to the importance of keeping family members up to date on resident's daily behaviour. By so doing family are reassured that the residents are receiving sufficient personal care (Wilson & Davies, 2009). Such interactions contribute to the development and nurturing of meaningful relationships between staff members and family members. This is suggested to influence the development and nurturing of

meaningful relationships between staff members and family members (Wilson & Davies, 2009).

When a resident needed to be transported to outpatients, for conditions that require immediate hospital attention, a staff member consulted the relative beforehand and involved them in the decision-making process. This family member states:

> They said do you want to come and take her or do you want her to go by
> ambulance, do you want us to tell her that uh she can go by ambulance and you'll
> meet her there? I said well you ask her what she wants to do so they went and she
> said she'd rather go by ambulance because she was in her nightie and everything
> already and, she just didn't wanna get changed again. So I said alright [clears
> throat] tell her to go by ambulance and, and I'll meet her there and they said OK
> that's the way it'll be.

These findings support previous literature on staff and families (Keefe et al., 2015). It has been suggested that families who have a relationship with staff feel part of a care team and influence the QOL of residents by monitoring their needs, both medical and personal. It has also been suggested that understanding the needs of residents becomes easier if there is a positive relationship between staff and family (Keefe et al., 2015). After all, despite their decision to place their family member or friend in a LTC facility, relatives still desire the opportunity to remain involved in the decisions that concern the residents care (Graneheim, Johansson, & Lindgren, 2013). As well, open communication and a collaborative relationship between staff and family that focuses on the wellbeing of the resident leads to comfort among families (Bauer & Nay, 2011). This communication and cooperation is very much appreciated by the majority of residents

and family who participated. Both family and residents were grateful to have that mutual

relationship with staff that kept their minds at ease during times of worry.

Difficulties with communication was often mentioned among relationships

between residents and staff members and staff members and family members. These

opinions contradict feelings above where residents were satisfied with the amount of

interaction between the three parties. A 48-year-old divorced resident explains their

experience:

> They just shove everything I say to the back it's like ok that's fine I'm not saying
>
> anything and there they're not listening. It's like I give up. Doesn't make me
>
> wanna continue on. (SR3)

This feeling is also shared with a 60-year-old single resident who explains that she is

"always stuck by the, by the fact that staff members do not socialize with residents, staff

socialize with staff" further clarifying that "that's a definite blockage". (NR1).

When asked about how the staff members interact with their family members, this

same resident sheds light on that experience from their point of view. S/he describes the

sad reality of the separation between their family members and staff members; two parts

of their life that are important to them. They refer to feelings of sadness several times,

describing their preference for a relationship between their family members and the staff

members in their life. The resident states "…I mean the staff are, they're really part of my

world now." (NR1). This helps capture the reality that they are not a part of their family's

world, despite how important they are to the resident.

Homelikeness

Feeling close and comfortable with everyone in the home, and essentially feeling like they were "home", was often mentioned by residents, staff members, and family members as a factor that contributes to relationships. In response to questions about what makes the place feel like home, a 75-year-old female widow referred to strong relationships among residents and between residents and staff members. They stated that it was "the closeness of everyone" and further explained "it's more like a family" (TR2). Closeness in the context of LTC is been based on physical proximity, as well as frequent and regular contact. This is suggested to influence the formation of relationships, but also nurture them in terms of developing trust and empathy (Munn et al., 2008). Residents share this feeling with other residents, but also with staff members through the conversations that brought them closer together.

Family members share this feeling of closeness with staff members. They shared feeling of being treated as if the facility is their home, like they are family, and that they are known by staff members on different levels when they walk in. Other examples of closeness that were described among participants included "that sense of connection" and being treated "like a queen". A family member, along with agreement from others, also shares the importance of closeness between residents and staff members:

P1: I find it very, very family oriented. Um, they always say hi to [Name of Resident] when they walk by [P2: Mmhmm], um they always speak to her, they never just, they never just, they're not ignoring people, they're always interacting with them.

In response to questions on the important factors that enable residents to maintain relationships with others, another family member explains their specific situation and how important it is that their mother is so close to a certain staff member:

Well I can start that one easily because um, being the baby of the family, I'm very close to my mother and um…so, my mother and I have a terrific relationship and I can't imagine my life without my mother in it, although it's coming I know. But, and with the staff she's just like, they're just like children to her. Uh, she's getting hugs, she gets a hug from everyone from…the cleaning staff right up to uh, management, you know she's…that's all I can say.

Staff echoed feelings of home and community in the sense that the facility often felt more like home, creating a sense of "family" between themselves, residents, and family members.

Common Interests

Conversations often consisted of common interests. This factor is explained further by the 73-year-old female widow:

We talk cats all day long! *Laughs* But, uh, one of them has 4 cats and she lives on a farm outside of Truro and, uh, they're farm cats, really, but she has a name for them all, and they've all got different personalities, so, she loves them she talks about her cats all the time. (NR3).

This statement is especially helpful for understanding how important common interests are to the development of relationships at any level in LTC. Previous literature supports this, such that commonalities, interests, and connections define meaningful relationships in LTC (Nova Scotia Centre on Aging, 2015a). When asked about what contributes to

making it feel like home, residents made reference to conversations that they have with

staff members about their families. For example, a 57-year-old divorced female resident

states:

> Um…they make sure, you know, chatting about this and that. And when I gave
>
> them a question- how's your kid doing today? Oh good, the other one lost a tooth,
>
> he's in grade 7, now he'll be…you know little things like that. (TR1).

The types of conversations that residents engage in with staff members are

supported by previous research. If residents, staff, and family are able to learn

biographical knowledge of each other, it is suggested to influence better quality care,

particularly PCC (Johansson et al., 2014). This is not necessarily limited to physical care,

but also the emotional care and support that can develop from learning about the lives of

those individuals whom you interact with on a daily basis, those you rely on, and those

you care for. Lung & Liu (2016) have also found that both residents and staff show their

understanding and mutual concern through social interaction, with a common goal of

improving their relationship with each other.

Humour

The presence of humour shared between residents and staff members was also

expressed as a contributing factor. A 78-year-old female widow shares their experience

and helps to capture how comfortable they are with a staff member, to the point where

they are able to playfully joke around with one another from day to day. Being

comfortable with someone is helpful and provides the ability to nurture the relationship

further. They say,

Yeah and one of the girls, two of the girls cook good. This one here she don't

cook, thank God. I said who cooked that? They said [name of staff] did I says

good and now she's getting a new car I says tell me when you're goin' out on the

road. (SR1).

Humour has been suggested as a contributor to the development of relationships through

the atmosphere that it brings to the home. Staff members have also acknowledged that

through the relationships that residents develop, they are contributing to this "sense of

life" in the home (Wilson & Davies, 2009). Staff members in previous studies have

commented on joking around with residents, and its ability to reflect a mutual friendly

relationship (Lung & Liu, 2016). For residents, this is also important, as it means that

they are able to engage in socialization with staff members that is not all "serious" and

medically focused.

In response to the question on whether or not staff members are familiar with

resident's family members, there was a general consensus on the appreciation for staff

and family relationships. Resident acknowledged their gratitude for staff members

knowing who their family are, as well as their ability to make them feel as though they

are part of a community. Wilson & Davies (2009) advocate for the importance of

residents, staff, and families, in recognizing that they are members of a community and

that they have the opportunity to make valuable contributions within the LTC home.

Physical Health

Physical health arose as a factor that prevented the development of relationships.

A family member provides an experience, unique from the rest, which describes

challenges in relationships between residents – in this case between their aunt and their

aunt's roommate. They explain the negative experiences and frustration her aunt felt from

not being able to physically communicate with the woman she shared a room with:

> I think that the relationship opportunities um are there for the people that, that
>
> want and need them. Um I found that you do take the next available room I think
>
> is how you're put in there. So my aunt went in there, and you know her and
>
> [Name of Resident] didn't   really hit it off at the beginning [others laughing],
>
> she didn't understand why [Name of Resident] wouldn't speak to her and I had to
>
> keep trying to explain to her [Name of Resident] couldn't speak, and that
>
> frustrated her [Name of Resident] couldn't speak; she was in a ward of extremely
>
> verbal social person used to going to Tim Hortons twice a day and yakking with
>
> people and all of a sudden was sitting with people where no one could speak and
>
> that frustrated her.

This can be explained with the help of Bonifas et al. (2014). The health conditions

of residents has been suggested as a barrier to the development of relationships. Bonifas

et al. (2014) found that functional limitations and health decline have the greatest impact

on the context, quality, and nature of social relationships. Health conditions of residents

limit the ability to socialize, and therefore disrupt or hinder relationship-building. While

resident's value friendships and connection, the medically compromised nature of the

resident population creates challenges for building and maintaining relationships. Further,

the dynamics of spaces in the LTC facility are suggested to be influenced by the

psychosocial characteristics of the individuals who occupy these spaces (Bonifas et al.,

2014).

Another family member states that their mother, as well as other residents, are at a stage in their life where they are unable to fully participate in initiating or maintaining relationships. It is their belief that staff members should be doing more to spend time with these individuals, conversing either verbally or non-verbally:

My mother can't maintain, she's at the point now where she can't maintain a relationship with anyone.

They further explained that staff members "should be doing more in general to…for people that are no longer able to take care of themselves. They should be more respectful, recreation should be doing more, even maybe sitting and holding their hand if you're not able to be here." They further illuminated that the only time they finds anyone with their mother "is if they are giving her personal care or if they're feeding her"

Given the above literature on the importance and appreciation for mutual conversations in LTC (Bauer & Nay, 2011; Graneheim, Johansson, & Lindgren, 2013; Keefe et al., 2015; Lung & Liu, 2016; Shenk, 2012; Wilson & Davies, 2009), it is fair to say that physical health can impact the ability to engage in conversation, and the lack of communication can be detrimental to the development of meaningful relationships. Feelings of frustration from being ignored or simply not having the opportunity to speak to someone who will listen, can create a barrier to creating relationships with others, given the immense feedback on communication from residents and family.

In summary, there were six factors that arose within the theme of communication. These were physical space and design, communication technology and policy, homelikeness, common interests, humour, and physical health. Various types of conversations that took place in the lobby or lounge; feelings of closeness including

feeling like family, feeling at home, feeling comfortable, and communication issues all offered valuable insight. Each of these factors shed light on what goes into developing meaningful relationships in LTC, whether it be between residents, residents and staff members, or staff members and family members. When we think of relationships, it is not unusual to reflect on the conversations that we share with our friend's day in and day out, and the level of comfort that allows us to feel that sense of closeness and family. In turn, each factor plays a significant role in the experiences of residents living in LTC and their ability to develop meaningful relationships.

Staffing

The issue of staffing ratios and the lack of staff members available in LTC settings emerged as a significant barrier to the development of relationships. This suggests that a sufficient amount of staff can contribute to better quality relationships in LTC, especially between residents and staff. Two factors that emerged include amount of staff and continuity of staff. These include topics such as the need for more staff, listening to residents and family, the consequences of staff rotating such as unfamiliarity, and having to explain preferences and requirements to every new staff member.

Table 9: Summarized meaning of subthemes emerging under staffing

Staffing	
Amount of staff	A short-staffed facility hinders the staff member's capacity to spend quality time with residents and their families.
Continuity of Staff	Continual staff rotation disrupts the ability of individual staff to have consistent interactions with residents and become familiar with them and their individual needs.

Amount of Staff

An insufficient amount of staff members was frequently mentioned among residents and family as a barrier to developing relationships between residents, resident and staff, and staff and family. From the resident perspective, it was heard that more staff are needed in the home. The 57-year-old divorced female resident states:

> We need some more staff to help, and if we had another staff that they can have our own games and get people out of their bedrooms and have games on the dining room table. Or watch a movie together. (TR1).

This overlap of staffing and activity will be addressed later.

When describing the staff members on a typical day, a 78-year-old divorced female resident explains the types of things they do for residents, such as dressing them and helping them on and off of their commodes. Referring to staff, they further state that "…that's all you're gonna have time for". (NR6). When asked "do you feel that staff help you live the way you want to here?" they simply responded with "well they, they don't have the time" and "when you get the short staffing thing it's they're rushing rushing rushing rushing". (NR6). The issue of staff shortages and high rates of turnover in LTC, and its ultimate affect the ability to develop relationships is recognized (Ball et al., 2009). According to Curry (2015), current staffing plans are not efficient enough to serve the needs of the increasing number of residents in LTC. In fact almost two-thirds of Canadians (64%), reported by a recent national survey, state that the amount of qualified staff available in LTC is inadequate (Curry, 2015).

When referring to staff members who "float" through various floors of a LTC facility, the 57-year-old divorced female resident supports this when discussing the

workload of the staff. They say, "we need [laughing] more floats. Yeah that's a lot of work for 9 residents per 1 CCA". (TR1). McGilton et al. (2014) found that heavy workloads prevent the development of meaningful relationships between residents and staff. Several family members further support Curry (2015) and McGilton et al. (2014) through their mention of the need for more appropriate staffing ratios:

> F1: And on that note I have quizzed staff…over my years, and uh…the majority um feel that one more staff on each unit would make a world of difference [F2: Oh certainly] [F3: I'm sure it would]. And uh- F3: Especially if it's a heavy carry unit. P1: Especially a heavy carry unit, which our unit is now; that one more person would make a big difference. F1: And many of the staff members say to grandma, well we're short staffed today, we're short staffed today, we're short staffed today [F4: Yep. Hear that all the time]. You don't have to tell my grandmother that you're short staffed, she doesn't need a whole lot you know what I mean, and she's not asking for a whole lot.

Family members provides some conflicting opinions on how the staff are doing in terms of encouragement. One participant states that "there's not enough recreation staff". In Nova Scotia and the other Canadian provinces, excluding Quebec, government does not make it mandatory to have standard staffing ratios (Harrington et al., 2012). There are recommendations and guidelines to follow if desired, but no regulated policy. In fact, the *1989 Homes for Special Care Act* in Nova Scotia pays little attention to staffing requirements (Curry, 2015). This has created inadequate working conditions and outcomes for staff members and the residents they care for (Harrington et al., 2012). Combine the staff shortages with previous research on staff members often spending an

overwhelming amount of time completing administrative tasks, and you find that time that could be spend nurturing relationships with residents is compromised. The ability to effectively deliver PCC is also compromised, as it is rich, personal relationships that contribute to its administration (McGilton et al., 2014).

Continuity of Staff

From the resident and family perspectives, it was found that the continuity of staff is often a barrier. In response to a question on what it is like when staff rotate, for example, the 60-year-old single resident states that it's "hard because it means telling someone that new all the time" and "it's a matter of them being a good listener really, hearing you and so they, they do not grab, and do things automatically, they're quite knowing, they hear, and if they do not know, then they would ask". (NR1). They further explain that this does not happen nearly enough, and that the amount of help that staff provide is the "bare minimum".

Research supports this finding, suggesting that staff members are in a better position to deliver PCC and develop positive relationships with residents if they take the time to learn about the resident during their care routines. Residents, staff, and even families have appreciated the development of these relationships (Wilson & Davies, 2009). However, as we have seen above, having that time to engage fully with residents when providing care is not always possible.

The 73-year-old female widow explains how staff rotation affects the ability to develop relationships with staff members:

It's terribly under-staffed, terribly! And you don't get the chance to build much of a relationship with the staff members because they change all the time! And if

there are certain foods and certain things that you can't eat or don't want, you

have to go through the whole story every five minutes. (NR3).

When asked, during a conversation, "you're suggesting that, because again you feel that

the size of the staff they're not getting to know your relative on an individual basis", a

family member responded:

No. That nurse has been working, the one that's bothered with the book yesterday,

she's been working now for probably its 2 and a half years. Uh she finally light

bulbed in and say…said, um [Name of Resident] likes you to sing. That's right

dear I said. And if you sing to her in the bathroom she will cooperate better, and

it's over quickly. Now I mean, 2 and a half years, she, light bulb moment, right?

Staff members in previous studies have described how engaging in personal care

routines has allowed them to learn more knowledge about each resident they care for.

Wilson & Davies (2009) suggest that in order to ensure individualized care, it is vital that

staff get to know the residents. Family members share this knowledge in response to a

question on whether or not the staffing model or scheduling supports relationships:

F1: I think it does but I think like these folks are saying there's always a benefit to

having more staff and my, I hear um other families in [Name of Town] saying

similar to what you're saying that, that um that you can never have too much

staff- Um…I guess it just doesn't give consistency of people around her, that she

could trust- F2: They get frustrated I think. At [Name of Nursing Home] I find

that there isn't so much switching around, it's it is mostly the same 6 or 7 people

that, that rotate around, but my mother gets frustrated uh with her speech, trying

to explain to uh a new staff person.

In response to a question on how often residents see the same staff member, the 57-year-old divorced resident offered their experience with one staff member that she gets along with:

> So we have 12 CCAs and they rotate, so it might be another you know, 8 days later before I see her again. (TR1).

This captures the reality that residents are recognizing their attachment to certain staff members, and that they are not given the necessary time to nurture those relationships that they have developed.

Both residents and family mentioned dementia, Alzheimer's, and staffing. Family members appeared to agree on the fact that resident with Alzheimer's receive more consistent care:

> F1: Yeah. And that, that I always had a problem with that because people with Alzheimer's…they get better consistent care, they see the same person all the time [F2: Yup], so it's not a strange person coming in and giving them a bath, or directing them here. They know that persons' voice, they know that demeanor and everything like that. When they have to change, and you have to, but when they do change the staff it does throw people off [agreement] that has brain injuries and Alzheimer's.

When interpreting these findings, there was a sense that those residents who do not have dementia are at a disadvantage. While family members who have a relative with dementia appreciate the staff consistency, those who do not have a relative with dementia perhaps feel frustrated by the lack of staff consistency. Though it is important for the care of residents with dementia, there was a sense that it is also important for those without,

not just for care but for relationship building. One resident from the interviews expressed the reality that residents without dementia are often familiar with some staff members over others, given staff rotation, but may not always see them. This can act as a barrier to the development of relationships. Residents with dementia, particularly Alzheimer's based on discussion, require and receive more care than those without.

As Shenk (2012) suggest, interactions that are essential for high-quality caregiving, are even more so for individuals with dementia. It is also a reality that, often times, residents are more familiar with certain staff members over others as a result of staff continuity. This has been described as difficult for relationship development, but especially difficult for residents with Alzheimer's due to confusion, unfamiliarity, and discomfort. Both residents and family members mentioned dementia and Alzheimer's, particularly with respect to resident-staff relationships. Family members explained the importance of staff consistency when caring for someone with dementia and Alzheimer's.

In summary, the amount of staff and the consistency of staff was heard as a large barrier to not only developing those relationships with staff, but also fostering them and keeping them. Both themes affect QOL of residents. Amount of staff is affected when a facility is short-staffed and consequently, when staff members have difficulty completing all of their job duties. A limited amount of staff members means that staff do not always have enough time to interact with the residents causing them to feel rushed. This also means that often, staff have to rotate between units, floors, and residents, creating inconsistency of care. This is an issue that is recognized by residents, staff, family and friends.

Activity

Participation in meaningful activity in LTC is identified, for the most part, as a significant contribution to the development of relationships. Shared experiences from group activities, individual activities between residents and staff, and options and choice are three subthemes that emerged in the data. Shared experiences from group activities consists of descriptions on the types of activities residents share together, such as bingo, card games, and musical entertainment. Engaging in these types of activities with not only residents, but also with staff members, is also important. In regard to options and choice, when there is less opportunity for engagement with others, such that activity options and space are limited, it is less likely that residents are able to nurture relationships with residents and/or staff members.

Table 10: Summarized meaning of subthemes emerging under activity

Activity	
Shared experiences from group activities	Group activities provide the opportunity for socialization and connection between and among residents.
Individual activities between residents and staff	Staff involvement in activities with resident(s) provide the opportunity for socialization and connection.
Options and choice	Having options and choices in activities emerged as important, such that everyone has the opportunity to participate with others in some way and socialize regardless of their physical and cognitive abilities

Shared experiences from group activities

Exercise was an activity that residents often participate in together. A widowed resident whose age they would not disclose captures the interaction that takes place:

We sit down and we have uh, little, you maybe called dumbbells, and we do

exercise with that. And then we have, uh, a bat and a balloon and we chase

around. We hit that around and we have a great time with that. (SR5).

Playing games together was another activity that the residents mentioned to be

important to them and nurture the develop relationships. The 57-year-old divorced female

states:

Well in the afternoon depending on activities, if I go to another house or the

[Name of Center], they have Bingo and games and…um, that's when

everyone gathers…the Center. And some of the houses they'll have different

things, you know if I wanted a game of Wii bowling and we'd go with another

house so we'd have a little crowd to do that. (TR1).

Brandt & Paniagua (2011) found that participation in activities (Wii bowling is

referenced in their study) was a result of adherence to staff encouragement and the desire

for social interaction with other residents and staff members.

The 75-year-old female widow explains the closeness they feel from supporting

their friend, who is blind, at bingo:

Every Thursday I go to Bingo, and I have a good friend and she's blind, so

whatever prizes I win I give to her. And she- we became very close. But she

always goes to Bingo, they always make a point to bring her in so she can sit- she

has a wheelchair- so she can sit with me and if I win anything for her then I'll

describe to her what it is and- like having a set of eyes for her. (TR2).

Group events have been found to help bring residents together, promote social

interaction, and create shared experiences (Bonifas et al., 2014). Sharing activities with

others has great potential to being people closer together and help find those people who

you can build a meaningful relationship with.

The 94-year-old female widow commented on the opportunity to enjoy musical

entertainment together:

> We go down- like I said- to the lounge. We go down and we have exercises and
>
> we have sing-songs. And then there's four- three or four girls- that uh, they have
>
> the doing of bringing in country music. And they'll bring three or four of them in
>
> and one of the ladies be the singer and for the afternoon you get that. And there's
>
> other things we do…exercises. (TR3).

This is shared among the majority of residents who state that they enjoy going "to the

music room." Various other activities that residents participate in together consist of

"discussing books", "crafts", and "getting your hands in the dirt" when referring to

planting flowers.

When analyzing the ways in which activities were discussed, residents always

spoke about the activities they participated in with others. Previous literature shows that

two factors, positive peer relationships and participation in meaningful activities,

contribute to thriving in LTC (Bonifas et al., 2014). Research has highlighted the

importance of relationships with residents, family, and staff with respect to positive

experiences. Sharing similar interests has been suggested to nurture a sense of

camaraderie and support from peers. Engagement in recreational activities within the

facility also foster relationships among residents (Bonifas et al., 2014). Group activities

often take place in late spaces, such as facility dining halls, and therefore represent major

locations where socializing and relationship development takes place. Group activities

have the potential and are suggested to bring residents together, promote social

interaction, and provide the opportunity for conversations and personal exchange. These

opportunities are not always sought out, but can arise from routines such as sitting at the

same tables during activities or events (Bonifas et al., 2014).

Individual activities between residents and staff

Among the residents, there were conflicting opinions on whether or not staff

involve themselves in activities with residents. The 75-year-old female widow explains

their experience with bingo and card games with staff members:

I go down to the center down the hall and uh, play Bingo every Thursday they

have Bingo. And, uh, I play 'Skipbo' with the nurses in the evenings. Card game,

they like to play that. (TR2).

This is agreed upon by another resident who states that in the evenings they enjoy playing

Skipo and scrabble with the nurses. A family member also notices staff's involvement

with residents:

I find a lot of times when you come in that the staff are sitting watching TV with

the clients, or they're talking with the clients, or they're serving the client a cup of

coffee, would you like a cup of coffee? Like, it's very respectful, it's very laid

back, it's not loud, it's quiet, and uh, they certainly encourage the client's that

can have the input to have it and even if they can't.

When referring to a quieter and introverted resident when it comes to social interaction,

one family member appears happy with the staff's attitude towards their mother:

The staff are very good to her. Yeah they'll go in and she'll have a puzzle sitting

out there pretending she's working on it but they all come in and do some, some

of the puzzle for her, with her, in her room and she, that's good enough.

There were also conflicting opinions on the reality of staff members encouraging

them to participate in activities. A 79-year-old divorced female resident highlights the

fact that, in her case, staff are encouraging when it comes to involvement in activities:

She'll come in my room and she'll say, "this or that is going on, now are you

gonna go?" You know? "Yes, I'll go". (NR4).

While the residents talked highly of their involvement with staff, the family

members had a different perspective to offer. They felt that more could be done:

F1: Um, recreation in my opinion, yes they try and put on little Halloween socials,

yes they grab a few people and stick them in front of a tea pot, recreation should

be doing more to individually encourage you know [F2: Yes] [others lowly

talking] coming around room to room, and I mean even if it's providing people

with you know buttons to sort and things like that, or you know, having a game of

cards you know with individual people and stuff like that [F3: Match the socks].

[laughing] F1: Yes match the socks; get people matching the socks.

A study by Casey, Low, Jeon, & Brodaty (2015) found that staff assist many

residents when attending social activities. Positive interactions are said to potentially lead

to relationship building, so the importance of assisting residents to attend those activities

is known, especially those with limited mobility, impaired communication, and decreased

social functioning (Casey et al., 2015).

Some participants shed light on how far staff members will go to be involved with not just residents, but with family as well:

> F1: The nineteenth was our anniversary so they took that little table and just the
> two of us and a cake and, and they make him a birthday cake, make everybody
> birthday cake. F2: Yeah that's true. F1: So they make us feel at home, you know.

Options and Choice

The 79-year-old divorced female resident refers to the lack of mall outings as a barrier to fostering relationships; an activity that a large number of residents would enjoy participating in:

> Me and a lot of people in here like to get out to the malls but, so we understand
> it's expensive. We don't push it. (NR4).

Family members also stated that activities do not always have to cost money to organize:

> F1: For a while, especially when my mother was still able you know to do things,
> someone would colour with her, or you know, one of the things they would do is
> they would go into the linen room and they'd bring out a bunch of hand towels
> and facecloths and things and there would be several ladies sitting there and
> folding facecloths and towels and having a lovely time. F2: We need more of it.
> F1: Yes, yes that's what's really important.

Family members focused on space, such that they felt that there is not enough space for activities:

> F1: There was a little activity room they call it [F2: Mmhmm]. Well they have
> now converted that to um a little bedroom area where if somebody is coming in to
> sit with their relatives who's dying or whatever, they can stay there overnight. So

that room is gone, it's locked. The ladies that would continuously have people in

to play cards; if there's not a little board meeting going on maybe you could go in

that room, but otherwise whatever. And I'm saying, what's wrong with them

going in and using the stupid dining room? [F2: Mmhmm]

Engaging in activities other than primary care routines in LTC has been considered

important to QOL, such that they amount to something, like the development of

relationships (Tak, Kedia, Tomgumpun, & Hong, 2015). As we have seen, they provide

ample opportunity to bring residents, as well as staff members, closer together.

The importance of activities was supposed by the staff focus groups. Staff

members, when possible, will try to entertain residents informally, whether this is

physical or mental stimulation such as games, puzzles, walking, exercise, and dance.

However, staff suggest that more staff are needed to help increase such activities. The

themes that emerged from the staff focus groups were generally consistent with those

arising from the resident interviews and/or the family focus groups.

Interconnection of Themes

Although the three themes are separate and have sufficient data to individually

support them, they are also interconnected with one another.

Figure 4. A visual of the overlapping or interconnected relationship between the themes of communication, staffing, and activity.

A finding from the theme of communication referenced a situation where a resident mentioned the conversations that arise between residents from musical entertainment in the facility. This conversation is a result of residents expressing their opinions and thoughts of the performances. This particular situation represents the interconnectedness between the themes of communication and activity. An additional finding from the theme of activity also brought to light the overlap between communication and activity. This situation involved a family member expressing the conversations that residents and staff engage in while watching television and having tea together in the lounge. While they are engaging in an activity together, they are also communicating with one another.

This interconnection becomes deeper when staffing is involved. A sufficient amount of staff members need to be available in order to organize activities for residents to engage in, and for themselves to engage in with the residents. In order to participate in these activities with residents, there needs to be enough staff and they need to have enough time. The same goes for meaningful conversations between residents and staff. Staffing greatly impedes having the time to properly speak with residents.

Across and within the three relationships and models, the three themes of conversation, staffing, and participation in activities brings about contributors and barriers to meaningful relationships within LTC facilities. The subthemes for each provide a closer look at different ways that these themes provide or prevent a positive experience with others in the home. Having sufficient communication among residents,

family members, and staff members from both perspectives appears to contribute to the

development of meaningful relationships in LTC, whereas a lack of communication can

act as a significant barrier. Adequate staffing has also been described as a contributor to

these relationships, whereas staffing is largely described as a substantial barrier. Lastly,

the availability of activities that foster relationships are a large contributor, whereas a

lack of activities that foster interaction and/or a lack of staff involvement can act as a

barrier to developing meaningful relationships. These three interconnected themes affect

the development of relationships between residents, family, and staff.

Chapter 6: Discussion

Relevance to Research Questions

The goals of this research sought to explore meaningful relationships in LTC

between residents, residents and staff members, and staff members and family members.

The main research question that was analyzed was "What are contributors and barriers to

meaningful relationships among residents, staff, and family in LTC facilities?" The

second question was "In what ways are these influencers similar or different when

understanding meaningful relationships with residents with dementia?" Given the limited

discussion on dementia, it became more of a perspective rather than a question, because

there was not enough information to generate contributors and barriers. When possible, it

was examined with respect to the existing themes.

Understanding the relationship between residents and staff members is central to

the framework of PCC. With the cooperation of staff and the level of comfort residents

feel towards them, a relationship can develop. This can result in the application of PCC

and an increased QOL and quality of care of the resident. The relationship between

family members and staff members also plays a large role in the ways in which care is

person-centred. A positive relationship between family and staff has the great potential to

ultimately lead to a more PCC approach, due in part from teamwork and shared

knowledge. The analysis reveals the centrality of the resident's needs, for care,

socialization, and activities, and that close attention needs to be especially paid to the

needs of those residents and their families who are experiencing dementia. If this can be

achieved, better care can potentially be applied and meaningful relationships can be

developed.

Communication is essential for meaningful relationships in LTC

There are certain factors in the physical and social environment that enable and

enhance the capacity to have authentic communication. These factors emerged from the

interviews and focus groups and help to understand the process and the ways in which

communication contributes to the development of meaningful relationships. These factors

include physical space and design, communication technology and policy, homelikeness,

common interests, humour, and physical health. These are important because they

influence the initial and continued communication in LTC. Frequent communication in

LTC allows for the ability to become comfortable with others. This comfort can be

further enhanced through the option for preferred spaces for communication, such as

lobbies. Learning about other residents through communication essentially means that

residents are better able to understand and receive a form of PCC from each other. This

can be through the ways in which conversations take place with residents (knowledge of

appropriate context and location preferences of others), the ways in which staff provide

daily and social care to residents, and/or the ways in which family and friends can work

together with staff to provide the best and most preferred care to residents. This theme of communication came up frequently during each phase of the grounded theory analysis as an important concept to explore. It has assisted with understanding the process of communication; specifically the important and essential ways that it contributes to developing, nurturing, and sustaining relationships in LTC. Furthermore, this theoretical concept of communication, regardless of the number of reviews of the data, was frequently prominent to the process of developing meaningful relationships in LTC.

Further, the continuity of conversations within the LTC facility and the location in which they take place is captured in the analysis and informs the meaning of conversations. Intimacy is represented by homelikeness, common interests, and humour, and reciprocity is desired where there are complications with communication from physical health. Relationships are not always reciprocated due to the inability to exchange, which is an important factor in developing and nurturing relationships. Continuity, intimacy, and reciprocity all represent factors of communication that determine an overall idea of whether or not residents, staff members, and family members feel like they are part of a family in the LTC facility. Family, in this research, is not defined as biological or represented by the number of visits to the facility, for example. Rather, it is the continuity, intimacy, and reciprocity between and among residents, staff members, and family members within the home that makes them feel like a family. Family, in this case, means continuity, intimacy, reciprocity, and produces a situation that contributes to the development and nurturing of meaningful relationships. Dodson & Zincavage (2007) state that staff members have described the best model of care for residents as creating family-like bonds with them. Staff members have also

indicated that they often build strong attachments to residents and speak of them as if

they are family (Majerovitz, Mollott, & Rudder, 2009).

Without consistent and familiar staff, meaningful relationships cannot happen.

Relationships among residents and staff members put staff in a better position to

provide PCC to residents. Two factors emerged from the interviews and focus groups that

help to understand how staffing contributes to the development of meaningful

relationships. These factors include amount of staff and continuity of staff. Having a

relationship means that residents can feel comfortable expressing their wants and needs to

staff. With that being said, being familiar and having frequent, consistent encounters with

a resident means that staff are better able to remember the wants and needs of certain

residents without having to be reminded. Therefore, PCC can be more readily applied

with the strong help of a meaningful relationship. As well, relationships between staff

and family are important for PCC, given that family can contribute greatly to the care

being applied to their relative or friend. Working together as a team means that staff and

family can contribute knowledge that the other may not be aware of or be an expert in.

This combined knowledge as a result of relationships creates the theory that there is an

opportunity for PCC. As well, this theoretical concept of staffing was frequently

noticeable to the process of developing meaningful relationships in LTC.

Additionally, the relationship between amount of staff and continuity of staff

helps to understand the process of how staffing creates a barrier to the development of

meaningful relationships. Having the time to spend with residents is captured in the

analysis of amount of staff and assists with understanding what it means when a LTC

facility is short-staffed. When a facility is short-staffed, staff members do not have the

time to spend with residents outside of basic care delivery. As well, when staff are constantly rotating between units, there is an unfamiliarity between residents, staff members, and family members. Without that continuity, it is hard for residents and staff to get to know each other in a meaningful way, especially if they are only in a certain facility or unit once every couple of weeks. Time and unfamiliarity represent factors of staffing that produce an overall idea that residents and family members desire a relationship with staff where they feel more like friends, rather than patients, and therefore receive more sufficient care and support. A resident council in a LTC facility is concerned with creating a community that meets everyone's needs. A vote by the council determined that rather than being called residents by staff members, they preferred to be called "friends" (Hoban, 2010).

When staff do not have the time to sit with residents and their families, or when residents, staff members, and family members are unfamiliar with one another, the relationship resembles more of a patient-caretaker relationships, rather than a friendship. Further, a staff members becomes someone who simply gets residents ready for the day and moves onto the next. Unfamiliarity creates conversations around preferences, which happen frequently, creating distance and even frustration among residents, and a decreased opportunity to develop a friendship and further, a meaningful relationship. Staff members are likely to signal to residents and family members that they do not wish to spend time with them when they feel pressured to quickly complete care tasks. This creates tension, as residents and family members expect staff to provide residents with the daily interaction that they used to have with family and friends prior to nursing home admission (Majerovitz et al., 2009).

Subsequently, with dementia, staff rotation is almost non-existent and contributes to the care they receive, and perhaps the relationships they are able to develop. When understanding how staffing contributes differently to the development of meaningful relationships with residents with dementia, analysis shows that, unlike other residents, those with dementia receive more consistent care. Residents with dementia are cared for by the same staff members and spend significant time with them. Therefore, staff members are more familiar to those who are still cognitively able to recognize them. Given this consistent and familiar care routine, these residents and their staff members are in a better position to develop meaningful relationships in their own way and in their own capacity. The difference in care practices frustrates those who are essentially cognitively inclined and receive irregular care.

Activities strongly support relationships in LTC.

Shared activities in LTC foster socialization, as well as the opportunity to get to know individuals, develop meaningful relationships, and enjoy the company of others. Three factors emerged from the theme of activity that enhance the capacity to develop meaningful relationships. These factors include shared experiences from group activities, individual activities between residents and staff, and options and choice. Having choice and options for activities is important because all residents are able to participate in one way, and choose what works best for them - whether it be physically, cognitively, or personal preference - representing PCC. Staff member's involvement with residents is significant, because residents can feel as though they are on the same level playing field as staff, and feel supported in the activities they choose. Staff taking the time to participate in activities with residents means they are putting the interests of residents

first and respecting that they enjoy their company, their contribution, and their interests in

their social life, not just routine care activities. They are essentially providing PCC. This

theoretical concept of activity, regardless of how many reviews of the data, was

frequently found as important to the development of meaningful relationships in LTC.

      Further, the relationship between shared experiences from group activities,

individual activities between residents and staff, and options and choice helps to

understand how activity contributes to the development of meaningful relationships.

Shared experiences from group activities encourage and provide the opportunity for

socialization and connection between and among residents, and is captured in the

analysis. Individual activities between residents and staff embodies cohesion, in the sense

that residents and staff members participate in activities together, and that staff encourage

and support residents to participate when possible. Options and choice refers to the

availability of activities, including both sufficient options for activities and the

appropriate spaces for which they can take place. Socialization, cohesion, and availability

represent factors of activity that produce an overall idea that without activities in the LTC

facility that involve both residents and staff members, there is less opportunity for

residents, staff, and even family members to engage with and learn about each other.

Participating in an activity and essentially sharing something together allows for feelings

of unity. Without this engagement, there is less of an opportunity for relationships to

develop or to grow. Hoban (2010) states findings from resident and staff satisfaction

surveys that have received high scores as a result of a partnership between residents and

staff members. This relationship involved residents and staff working together to plan

and participate in activities based on individual interests and abilities (Hoban, 2010).

Having this relationship is appreciated by both residents and staff members.

Implications for Policy

Given the emphasis and importance of the theme of communication, the LTC

sector would benefit from a communication strategy that supports the development of

relationships between and among residents, staff members, and family. Knowledge of the

family towards the resident's care is valuable. An enhanced and mutually respectful

relationship between staff and family, will go a long way to improving the relationship

with residents. A communication policy could value this involvement of family and

assess how information is conveyed to both residents and family members. Policies that

encourage this communication, as well as communication between other parties is

necessary to influence the development of relationships.

Currently, it has been found that staff do not always, if at all, have enough time to

socialize with residents. A shift in the working environment and staffing policy would

benefit everyone involved. Enforcing a policy and regulations that outline sufficient

staffing ratios and standards would allow residents and staff members more time to spend

with each other. This may also eliminate the number of different staff members that are

caring for residents each day, with the exception of residents with dementia. The voices

of residents, staff members, and family members should be reflected in these new

policies. The way that staffing ratios are presently structured leaves little room for staff to

find the time to engage with residents outside of basic care. It is important that staff are

allowed the time to socialize and get to know the people with whom they work with.

It may also be important to pay attention to building designs when developing new LTC facilities, or renovating older ones. The findings show the residents appreciation for having a space to engage in conversations with others, like the lobby or lounge. Incorporating these spaces into the designs would guarantee a common space for residents and staff. Having the appropriate amount of space for activities is also a design feature it pay attention to. Findings from this research show that having enough space to play games with residents and staff was limited at times. This affects the amount of time that residents spend engaging in activities, as well as the types of games that they can engage in.

Implications for Best Practices

Given that communication appears to be a large contributor to the development of meaningful relationships in LTC, positive communication between residents, staff, and family should be encouraged. Perhaps a family ambassador program would assist with supporting and offering opportunities for communication and communication workshop programs. This could perhaps outline various types of communication, as well as how and when to appropriately apply them. Ultimately, this would help to encourage and develop positive relationships.

The findings from this research have provided an opportunity for change. The information that has been discovered on relationships can transform the ways in which care is applied to residents by staff members within LTC facilities. Often times, staff do not have enough time to engage with residents. However, even a simple greeting from staff to residents and their families would have the potential to change the way that each party interacts with one another, and create an environment that is less task-oriented and

more person-centred. Perhaps having time set aside in their day to sit with a certain number of residents would help to ensure the residents feel cared for, as appose to just receiving basic care. Ideally, enforcing recommended staffing ratio standards can improve the amount of staff that are available to accommodate conversation and activities with, and among, residents, and therefore be in a better position to develop relationships. Residents would also benefit from more activity options, and activities that involve staff. This will help facilitate relationships between residents and staff. Engaging family members in these activities could also have the potential to strengthen the relationship between staff and family. These changes and attitudes are an important step in the right direction.

Implications for Education

Residents, staff members, and family members could all benefit from understanding the importance and benefit of PCC; a type of care that is even more readily applied when everyone is able to work together. Perhaps a workshop involving all three parties, and even management, would assist with increasing this understanding and awareness. A workshop explaining the findings from this research would also be a valuable experience for residents, staff members, and family members. In order to successfully develop and sustain meaningful relationships, sufficient communication, staffing, and activities are crucial. Providing residents, staff members, and family members with these findings is important for change particularly among staff and family. Based on the resident perspective, there is value in staff and family having a relationship in the facility.

Awareness of PCC has the potential to produce conversations between staff and management on how to structure their days to meet this need. Residents and family stated that communication and involvement in activities with staff were important to residents, but they also stated that staff do not always have the time to fulfill this need. Perhaps educating management on the importance of relationships will influence the decision-making in the facility around staffing. In time, this education and awareness could have the potential to change the policies within this industry on the way that staff operate and the role of family and friends within the home. After all, the ultimate goal is relational development and therefore better quality care and QOL of residents in LTC.

Limitations

Completion of a study using secondary data comes with several limitations to consider. The first limitation concerns the differing perspectives, particularly with respect to the residents and their family members. Research suggests that the preferences of residents is often mistaken by family members and care staff, therefore the voice of the resident should be considered for planning interventions (Moyle, 2014). A second limitation involves the data collection. As I was not a part of the data collection process, this could have interfered with my ability to properly interpret the feelings and information in the focus groups. However, careful and sufficient effort was made to interpret the texts. I also had no control over the information collected. Lastly, there were only three family focus groups involved, with a limited amount of discussion on residents with dementia. A small sample size can create limits within the findings. There were, however, 15 resident in-depth interviews, which assisted with broadening the sample size. Although I had resident-staff relationships as part of this study, I did not have

transcriptions of the conversations that took place in the staff focus groups, but rather summarized themes that were similar to the other data sets. Including questions from staff will increase the quality of future studies in this area.

Future Research

Completing this study has allowed for the opportunity to look forward to future opportunities. With that being said, exploring the relationship between staff and family on their own and in more detail would be interesting, because the discussion was not always guided in their direction with as much detail as I would enjoy seeing. Previous research recognizes the value in staff members and family members getting along, therefore exploring what contributes to that dynamic will be beneficial for future developments. Another relationship worth exploring is one that was not explored here; the relationship between residents and their family and/or friends. A limited, but intriguing, amount of discussion was drawn to what role staff play in the relationship between residents and their family. There were a couple of participants who mentioned that staff support the role of this relationship by inviting them to the home and to participate in events. Future research could explore the ways in which staff influence continued relationships with family and friends in a new space they may call home. More of an initial focus on dementia will also be beneficial. Although family and friends in the focus group had relatives with Alzheimer's and dementia, it was not a requirement for participation. Completing a study that directly addresses the contributors and barriers to the development of relationships when a resident has dementia will be valuable, specifically to the ways in which residents, staff, family, and even management operate and assist with enabling this development.

Conclusion

With the increasing need for LTC, the time is now to improve the QOL is LTC

facilities. This grounded theory study sought to explore the meaning of relationships in

LTC between residents, staff, and family. Further, it looked for any contributors and

barriers involved in the development of those relationships, and paid particular attention

to PCC and the ways in which residents QOL and wellbeing are at the centre of these

relationships. As suggested previously in the literature, relationships have been

considered an important factor in QOL. However, research on how these relationships

develop has been limited. It was found that across all relationship types, residents and

residents, residents and staff, and staff and families, and across each of the models of care

homes, traditional, new-augmented, and new-full-scope, communication among

individuals, the amount of staff that are present, and the activities that are available to all

parties can be both contributors and barriers to the development of meaningful

relationships in LTC facilities.

Communicating with others, whether that be verbal or non-verbal, means that

individuals are better able to form connections and even feel more like a family. This

feeling of family significantly contributes to the development of relationships. Support

has been found for communication between residents, staff and residents, and staff and

family. Having a sufficient amount of staff in the LTC facility means that residents and

family are able to become familiar with staff in a way that enhances the care that

residents receive and a peace of mind for families. When staff are shifted around or have

a large number of residents to care for at one time, being able to spend quality time with

them is difficult and therefore stands in the way of being able to form a relationship with

them. At the end of the day, residents seek a relationship with staff members where they are considered friends, rather than patients and caretakers. Having the opportunity to participate in various activities allows residents, and also staff, the ability to enjoy time with both parties. It gets residents out of their rooms to socialize, ultimately sharing experiences with others that bring them joy and have the potential to bring them closer together. Unfortunately, families are not always a part of these activities, but would serve as a great opportunity to form relationships with everyone involved.

The findings suggest the importance of taking the time to develop relationships in LTC. It is crucial that staff are aware of this when going about their days, encouraging the development of relationships not just among residents, but with residents and their families. If everyone feels comfortable with each other, there is potential for residents to be well taken care of in what is ultimately their home.

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APPENDIX

Appendix A: Family Focus Group Questions

The questions from the family focus group that will be analyzed are as follows:

1. What is it like for you to have a family member or friend living in this nursing home? What are some positive things about this home and what are some things that are not so positive?

2. Can you tell me about the aspects of the nursing home that you feel have had a positive impact on your family member's quality of life? *Probes: Space and physical features of nursing home*; ***Care team***

3. Can you tell me about the aspects of the nursing home that you feel have had a negative impact on your family member's quality of life? *Probes: Space and physical features of nursing home*; ***Care team***

4. Apart from the physical features of the nursing home and how staff interact with your relative, is there anything else about this home that you feel makes a significant contribution to your relative's quality of life? Provide examples. [Positive, negative]

5. We've talked about a lot of areas and elements of nursing home life. At the end of the day, what do you feel contributes to good quality of life for your family member or friend living in the nursing home? Why?

6. Do you feel you get the kind of support you need in your role as a family member or friend? Why, or why not?

7. In your experience, what constitutes good quality of life for your family member or friend living in the nursing home?

8. Does anyone have any closing comments or thoughts they'd like to share?

Appendix B: Staff Focus Group Questions

The questions from the staff focus group that will be analyzed are as follows:

Focus Group Part 1: Discussion

A. Staffing Model:

- What are your impressions of the staffing model in the nursing home where you work?

- As you know, the ultimate goal of the staffing model is to improve resident quality of life. How would you say the staffing model at your nursing home is impacting the quality of life of your residents?

  o Can you share any specific examples of positive impacts?

  o Can you share any specific examples of negative impacts?

B. Physical Design:

- Just as a closing question, we'd like to get some sense of how well supported you feel in your role? Do you feel you are getting the support you need to be effective in your job and to provide the best possible care to your residents?

  o If yes, probe as to what kind of support they are receiving, when and where.

  o If not, probe as to what other support might be helpful, when and where?

- Does anyone have any closing comments or thoughts they'd like to share on either the staffing model or the physical design of continuing care facilities?

C. Quality of Life:

Based on your experience and relationship to residents living here, what do you feel constitutes (makes up) resident quality of life?

- What elements would you use to measure quality of life for residents?

- Why would you use these elements?

Focus Group Part 2: Review of Themes in Current Employee Survey

"Now we'd like to get your reaction to some possible themes we've identified from the survey and see if you have any additional suggestions or thoughts to ensure that we are gathering information about all aspects of your staffing model and experiences."

1. Staff Perceptions of Resident Autonomy and Control: i.e. *"The residents and families participate in decision-making"*

2. Meaningful Relationships: Relationships between Staff and Family: i.e. *"I am comfortable bringing my concerns to a family member"*

Appendix C: Resident In-Depth Interviews
Section II: Experiences Living Here

1. Please tell me about what you do in a typical day (weekday vs weekend).

    Note to Interviewer: Following cues from the participant's responses, guide the discussion to cover each of the theme areas and the questions there.

    Themes:
    > ***Staff (p. 4)***
    > Choices/Autonomy (p. 5)
    > Layout/design (p. 6)
    > ***Relationships (p. 7)***
    > Homelikeness (p. 8)

Staff Theme
When discussing this theme with the resident note the range of staff roles (includes care, therapy, recreation, cleaning, laundry, administration, spiritual care, etc)

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11. Describe the staff who work with you through a typical day
    - e.g number of people; the types of things they do for/with you
    - How well you know them/how well they know you?

12. How do you feel about the interactions you have with staff?
    - What helps/hinders you to interact/communicate with staff the way you want?
      (Probe: Feedback vs friendly/casual conversation; Care vs. companionship (caring for/caring about?)
    - What is important to you about how staff work with you here (e.g. communication, interactions, way they help with care/activities)?
      (Probe: delivered with dignity, privacy, safety, security)

13. In what ways do staff influence/help/hinder you to live the way you want?
    - How do you feel about the amount/type of help that you get?
    - Tell me about other types of services that help you live the way you want
      (e.g. nursing care, eating healthy foods, exercise programs, access to equipment

that helps you move, transportation to see your family or to go out on outings with your family)

| Choices/Autonomy Theme |
| To be able to "live the way you want" |

14. How much choice do you have about what you do?
    - When? (Time of day; frequency during day/week/month)
    - Where? (in own room, shared spaces, off-site (transportation options))
    - Are there activities that you would like to do but don't? Why?

15. How does the amount of choice about what you do, and when you do it, affect the quality of your experience here (i.e, your quality of life)?
    - How important is it to you?

16. In what ways do staff affect the choices you have about what you do?

| Relationships Theme |

18. How do you feel about your interactions with other people who live here (i.e., other residents)?
    - Are you able to develop friendships with people who live here the way you would like to? Why? Why not?
    - As often as you want? Why? Why not?

19. Are you able to interact with family and friends who live in the community the way you would like to? Why? Why not?
    - As often as you want? Why? Why not?

20. How important are your friends/family to you and your life here?

21. In what ways do staff help you interact with friends/family?

22. How does the layout of name of nursing _home_ (rooms, furnishings, lighting, rules, location, safety, comfort) affect the way you interact with friends/family?
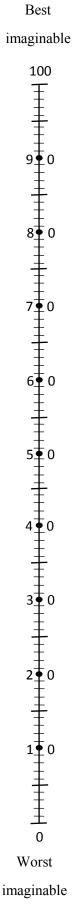
Section III: Overall Impression of Experience/QoL

26. How would you describe your overall quality of life? [Check one]
    o Very poor
    o Poor
    o Neutral
    o Good
    o Very good

27. To help people say how good or bad their state of health is, we have drawn a scale (rather like a thermometer) on which the best state you can imagine is marked 100 and the worst state you can imagine is marked 0.

We would like you to indicate on this scale how good or bad your own health is today, in your opinion. Please do this by drawing a line from the box below to whichever point on the scale indicates how good or bad your state of health is today.[1]

**Your own
state of health
today**

Best

imaginable

100

9 0

8 0

7 0

6 0

5 0

4 0

3 0

2 0

1 0

0

Worst

imaginable

28. Given your health status, how would you describe your overall experience of living in this nursing home? [Check one]
    o Very poor
    o Poor
    o Neutral
    o Good
    o Very good

29. Are there things you would like to change about your life here?
    • What they do you like overall? dislike?

30. Would you recommend *name of nursing home* (this site/this organization) to others? Why/why not?

31. Is there anything else you would to share with me about living here?

Appendix D: Family Survey Questions

Family Survey on Nursing Home Quality of Life - Relevant Questions/Sections for

Context

Section 1: Resident Quality of Life

- 2.6 Respect Items: *Now let's consider how your family member feels about staff in the nursing home. For each statement please answer with one of the following choices: 0) Never 1) Rarely 2) Sometimes 3) Most of the time 4) Always DK) Don't Know NA)Not applicable*

  _____ a. Staff pay attention to my family member.

  _____ b. My family member can express his/her opinion without fear of consequences.

  _____ c. My family member is treated with dignity by the people involved in his/her support and care.

  _____ d. My family member is careful about what he/she says around staff.

  _____ e. Staff respect what my family member likes and dislikes

- 2.7 Responsive Staff Items: *These items deal with how responsive staff are to your family member's needs*

  _____ a. Staff respond quickly when my family member asks for assistance.

  _____ b. My family member's services are delivered when he/she wants them.

  _____ c. The care and support my family member gets help him/her live their

life the

  way he/she wants.

  _____ d. Staff act on my family member's suggestions.

- 2.8 Staff-Resident Bonding Items: *Next, let us consider the relationships between staff and your family member. For each statement please answer with one of the following choices:*

  0) Never 1) Rarely 2) Sometimes 3) Most of the time 4) Always DK) Don't Know NA) Not applicable

  _____ a. Some of the staff know the story of my family member's life.

  _____ b. Staff take the time to have a friendly conversation with my family member.

  _____ c. Staff talk to my family member about how to meet his/her needs.

  _____ d. My family member considers a staff member his/her friend.

  _____ e. Staff are open and honest with my family member.

Appendix E: Staff Survey Questions

Questions from quantitative analysis that may be helpful in this study to give context

Staff Survey on Nursing Home Quality of Life - Relevant Questions/Sections for Context

Focuses on how their experience of the work environment impacts resident quality of

life; Staff Perspectives of Relationships with Family

Section 1: Staff Employment Experiences

- 1.9: *Interpersonal behaviour at work.* In the last year, how often have the people
  listed (Family Members & Residents/Clients) engaged in the follow
  behaviours…. yelled at you in anger, cheered you up, cursed at you (used
  obscenities), complimented you, called you names, told you that you were
  incompetent, thanked you, treated you with disrespect, went out of their way to
  help you, made fun of you, physically assaulted you (e.g., hit, kicked, shoved,
  used a weapon), sexually harassed you, racially discriminated against you, praised
  your job performance

- 1.10: Do you work on a dementia unit?

Section 3: Impacts on resident quality of life

- 3.2 *Resident Autonomy/Control*: Families are involved in decisions about care as
  often as they want to be.

- 3.9 *Meaningful Activities*: Residents and family have opportunities to participate
  in activities that are meaningful for them.

- 3.15: What are the strengths/key features of the nursing home that support good
  quality of life for residents?

- 3.16: What are the challenges/limitations of the nursing home that do not support

  good quality of life for residents?