Université de Sherbrooke

Étude des fondements managériaux des difficultés d'amélioration des centres d'hébergement et de soins de longue durée

Par
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Doctorat en gérontologie

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Résumé

Cette thèse par articles vise à contribuer à la compréhension des difficultés d'amélioration des centres d'hébergement et de soins de longue durée (CHSLD) d'une perspective managériale. Le premier article qui la compose présente les résultats d'une étude rétrospective de cas multiples de projets d'amélioration ayant produit des résultats contrastés dans quatre CHSLD publics. Les deux autres articles présentent les résultats d'une recherche-action portant sur un processus d'engagement d'une intention d'amélioration dans un regroupement de CHSLD privés conventionnés. La contribution de cette thèse se réalise par une analyse des modalités de gestion du changement favorables à la production d'améliorations significatives et pérennes, mais surtout par la mise en lumière de dynamiques systémiques entravant le recours à celles-ci. L'exposition de liens entre les dynamiques macrosystémiques des CHSLD et les incapacités microsystémiques à soutenir leurs intentions d'améliorations permettent aussi un apport au champ plus large de la performance organisationnelle. Plus spécifiquement, l'étude des fondements managériaux des difficultés d'amélioration des CHSLD rend possible une explication de la sous-performance organisationnelle durable d'une perspective de gestion du changement. Les résultats de cette thèse soutiennent qu'une révision des principes et des valeurs qui gouvernent l'engagement d'intentions d'améliorations est requise pour permettre aux organisations durablement sous-performantes, que représentent une majorité de CHSLD, de sortir de leurs cercles vicieux. Une gouverne de l'amélioration sensible et adaptée aux capacités d'amélioration courantes, mais aussi passées de l'organisation apparaît être requise pour progressivement, mais exponentiellement construire sa performance organisationnelle. La disposition d'une organisation à adopter des intentions d'améliorations conséquentes à ses habiletés et capacités à les réaliser serait une composante

essentielle à l'amélioration organisationnelle et permettrait cette capacité d'amélioration exponentielle.

Tables des matières

Introduction

La présente thèse par articles fût orientée par une question fondamentale, soit pourquoi est-ce que les centres d'hébergement et de soins de longue durée (CHSLD) ont autant de difficultés à s'améliorer? Cette question motiva un parcours académique qui lia des projets de recherche réalisés dans le cadre des programmes de maîtrise et de doctorat en gérontologie par la voie d'un passage accéléré. Des connaissances proprement gérontologiques, mais aussi issues des disciplines faisant des organisations leur objet d'étude, soit la sociologie des organisations, la psychologie organisationnelle, la gestion, la théorie des organisations, le développement organisationnel et l'administration publique, furent mobilisées pendant ce parcours.

Les prochaines sections de ce rapport seront consacrées à bonifier le contenu des trois articles qui représentent le cœur ce cette thèse. Une problématique plus étoffée, un retour sur la pertinence des objectifs définis, des discussions supplémentaires sur les résultats des trois articles, des recommandations finales ainsi qu'une conclusion seront présentés. Les méthodologies propres aux deux projets de recherche intégrés à cette thèse par article seront plutôt présentées de façon structurée dans les trois articles.

Problématique

Organisations aux multiples problèmes

Les centres d'hébergement et de soins de longue durée (CHSLD), tout comme leurs équivalents dans le monde industrialisé, sont décrits comme des organisations ayant de multiples problèmes. En effet, les organisations d'hébergement et de soins de longue durée (OHSLD) sont dépeintes comme des organisations ayant plus de difficultés que tout autre type d'organisation de services à produire des résultats de qualité (Yeatts et al., 2004). Les OHSLD présentent de nombreux problèmes de nature clinique, managériale et réglementaire.

Les problèmes d'ordre *clinique* qui affligent les résidents des OHSLD sont nombreux, alors que la qualité générale des soins dispensés en OHSLD est faible (O'Connor, 2009). Ces problèmes sont des conséquences de l'incapacité des OHSLD à mettre en application des pratiques de soins reconnus efficaces (Levenson, 2009b). Elles comprennent notamment l'utilisation injustifiée de contentions physiques (Johnson, Ostaszkiewicz, & O'Connell, 2009; Kato *et al.*, 2008), la constipation et les impactions fécales (Howard, West, & Ossip-Klein, 2000; Lenhoff, 2005), les chutes engendrant des blessures (Kato, et al., 2008; Lenhoff, 2005), les plaies de pression (Horn *et al.*, 2010; Rosen *et al.*, 2006; Rust, Wagner, Hoffman, Rowe, & Neumann, 2008) et le sous-diagnostic et la sous-prévention de la douleur (Lenhoff, 2005; Levenson, 2009b; Swafford, Miller, Pao-Feng, Herr, & Ersek, 2009). Plusieurs de ces problèmes sont interreliés et peuvent engendrer une variété de conséquences néfastes pouvant aller jusqu'au décès (Horn, et al., 2010). Les conséquences psychosociales de ces défaillances de soins comprennent les problèmes comportementaux et d'agressivité (Horn, et al., 2010; Rust, et al., 2008) les problèmes dépressif et d'anxiété (McKenzie, Naccarella, & Thompson, 2007) ainsi que la diminution de la participation

sociale (Kato, et al., 2008) et de la qualité de vie (DuBeau, Ouslander, & Palmer, 2007). Pourtant, la majorité de ces maux peuvent être évités par la dispensation de soins infirmiers de base (Lenhoff, 2005).

En termes psychosociaux, la qualité des relations humaines liant le personnel au résident est faible de façon générale (DeLaHunt, 2005; Masso & McCarthy, 2009). Il est en de même pour les relations entre les familles des résidents et le personnel (Austin *et al.*, 2009). Celles-ci sont décrites, autant par les uns que par les autres, comme des relations viciées par un manque de confiance mutuelle (Austin, et al., 2009). La vie dans les OHSLD est fréquemment prédictible, routinière et permet peu d'intimité, de dignité ou d'occasion de faire usage d'autonomie décisionnelle (Ragsdale & McDougall, 2008). Aussi, la maltraitance physique et psychologique dirigée vers les résidents est courante dans les OHSLD (Benbow, 2008; O'Connor, 2009). La négligence des résidents est responsable de maints de leurs problèmes comportementaux (Levenson, 2009b), émotifs, dépressifs et de solitude (Lenhoff, 2005).

Sur le plan *managérial*, les OHSLD sont reconnues être des organisations fortement hiérarchisées et autocratiques (Benbow, 2008). Leur hiérarchie fait en sorte que le personnel ayant le plus de scolarité et les plus hauts salaires sont les plus distants des résidents, et que ceux ayant le moins de formation et les plus petits salaires dispensent entre 80-90 % de tous les soins (Caspar, O'Rourke, & Gutman, 2009). Les milieux d'hébergement et de soins de longue durée sont fortement cloisonnés, ce qui nuit à l'établissement de relations de confiance et de réciprocité (Sbordone & Sterman, 1983). Le manque de communication entre le personnel soignant et le personnel de gestion est un thème récurrent des écrits portant sur les OHSLD (Ragsdale & McDougall, 2008). La majorité d'entre elles sont caractérisées par des relations gestionnaires-personnels déficientes, soit par un manque de respect des superviseurs, un manque de

reconnaissance du travail du personnel, une faible autonomie du personnel et peu d'occasions de contribuer à la définition des plans de soins (Kinjerski & Skrypnek, 2008). Une telle philosophie de gestion paraît être ancrée dans les OHSLD depuis plus de 30 ans, considérant que l'étude de Sbordone et Sterman (1983) identifie l'emploi de renforcements négatifs et de punitions comme le principal mode de contrôle des employés. En effet, la culture organisationnelle des OHSLD est typiquement une culture de gestion *top-down* au sein de laquelle les décisions sont prises par les gestionnaires et où la participation des résidents et du personnel soignant est rare (Kelly & McSweeney, 2009; Robinson & Rosher, 2006; Rosen, et al., 2006). Le personnel de première ligne, incluant les infirmières, est fréquemment oublié dans le cadre d'efforts d'amélioration de la qualité, et ce, même s'il est celui qui passe le plus de temps auprès des résidents (Horn, et al., 2010).

Selon Presutti (2006), la propension des gestionnaires des OHSLD à la microgestion, soit à l'application du principe voulant qu'on ne soit jamais aussi bien servi que par soi-même, émane d'une peur de ne pas répondre aux exigences de ses supérieurs. Cette inclinaison engendre donc un climat de dépendance et affecte négativement le moral du personnel (Presutti, 2006). Les OHSLD sont considérés être des organisations qui « empower » insuffisamment leur personnel soignant (Yeatts, Cready, Ray, DeWitt, & Queen, 2004). Selon Kane, les préposés « *have at least one thing in common with their clientele: perceived and actual lack of power* » (1994, p.71). Les OHSLD ont été étudiées en tant que milieu propice à l'épuisement émotif, la dépersonnalisation, la réduction de l'accomplissement professionnel et l'insatisfaction professionnelle délétère à l'engagement (Tellis-Nayak, 2007). Dans son étude ethnographique portant sur les différences entre les OHSLD ayant un roulement de personnel élevé et celles ayant un roulement bas, Eaton (2001) fait foi de la grande réciprocité entre le bien-être des résidents et celui du personnel soignant

de proximité des OHSLD. Selon cette étude, les OHSLD ayant un roulement de personnel bas sont identifiables par les plus faibles odeurs d'urines et de selles, par la propreté des vêtements des résidents, par le degré d'hygiène corporelle supérieur des résidents, par les problèmes comportementaux moins nombreux des résidents, par des résidents appelant le personnel par leur prénom, et par la plus grande confiance générale des résidents à l'égard d'autrui. Les endroits où il fait bon travailler sont donc aussi des endroits où il fait bon vivre.

Sur le plan de la gestion des processus de travail, la collecte et le partage d'informations cliniques sont problématiques dans les OHSLD (DeLaHunt, 2005; Nace, 2008). La faible qualité du travail d'équipe et le manque de communication interdisciplinaire nuisent au développement, à l'application et au partage de bonnes pratiques en OHSLD (Benbow, 2008; Schruijer, 2006). Les différentes parties du corps des résidents sont assignées à des individus de disciplines variées, faisant en sorte que les plans de soins représentent des ensembles d'interprétations parallèles plutôt qu'intégrées (Levenson, 2009a). Le manque de communication nuit aussi aux interrelations entre les divers réseaux informels se créant dans les OHSLD (Sbordone & Sterman, 1983; Schruijer, 2006). De surcroît, la communication entre le personnel et les résidents est pauvre (Masso & McCarthy, 2009). Les OHSLD sont caractérisées par une déconnexion générale des désirs de leurs résidents et de leurs représentations par le personnel (White-Chu, Graves, Godfrey, Bonner, & Sloane, 2009).

Au-delà du manque de communication et d'intégration caractérisant les processus de soins en OHSLD, les processus effectifs sont focalisés sur les problèmes de santé au détriment des besoins psychosociaux des résidents (Boyd, Luetje, & Eckert, 1992). Selon Kelly et McSweeney (2009), une culture de soins autoritaire en OHSLD fait en sorte que les routines de travail sont fréquemment organisées au bénéfice de l'organisation et du personnel plutôt que du résident. La

centration sur le maintien des routines de travail se fait au détriment d'une réponse personnalisée aux besoins des résidents (Benbow, 2008). Plusieurs organisations tiennent des horaires d'alimentation, de bain, de sommeil et d'activités privilégiant l'efficacité de la tâche au détriment des choix de l'individu. (Robinson & Rosher, 2006). De façon générale, le personnel favorise les comportements produisant de la dépendance et ignore les comportements d'indépendance des résidents, en adoptant une logique de « faire pour » plutôt que d'« être avec » (Masso & McCarthy, 2009). Considérant qu'il est plus facile de « gérer » des résidents passifs qu'actifs, les OHSLD tendent à renforcer la passivité. Les résidents d'OHSLD sont fréquemment encouragés à jouer le rôle du malade, à accepter de faire montre de passivité et d'impuissance (Sbordone & Sterman, 1983). Il est utopique de croire que les OHSLD peuvent répondre aux préférences personnelles de tous les résidents, mais il est certainement possible et souhaitable que leur organisation soit davantage guidée par l'intention de répondre en priorité aux besoins des résidents (Kelly & McSweeney, 2009).

Les problèmes des OHSLD sur le plan *réglementaire* sont largement reconnus. Tout d'abord, les critères employés pour contrôler la qualité des pratiques en OHSLD ne sont pas des indicateurs valides de services d'hébergement et de soins de longue durée de qualité (Dellefield, 2007; Horn, et al., 2010; Levenson, 2009b). Ces critères de qualité tirent plutôt les OHSLD vers un modèle médical ayant comme prémisse que la qualité des soins est plus importante que la façon de les dispenser (Koren, 2010). Les lois et réglementations régissant le champ de l'hébergement et des soins de longue durée sont centrées sur l'efficacité et les résultats et non sur les processus et les définitions de tâches propices à leurs atteintes (DuBeau, et al., 2007; Levenson, 2009b; Schruijer, 2006). Ensuite, les organisations réglementaires focalisent leurs regards sur l'évaluation clinique et le développement de plans de soins au détriment d'une évaluation de la capacité des

OHSLD à subvenir à l'ensemble des besoins biopsychosociaux des résidents (Levenson, 2009a). Aux États-Unis, une large majorité des évaluateurs mandatés par les états pour évaluer la qualité des OHSLD estiment que leur priorité est d'identifier des lacunes en termes de soins (Koren, 2010). Tel que décrit par Ragsdale et McDougall: « *Traditional nursing home care has historically been provided to accommodate regulatory requirements without consideration of meeting the resident's individual needs* » (2008, p. 993). Selon ces mêmes auteurs, le système réglementaire actuel est non seulement inadéquat, mais impossible à respecter faute de ressources. Conséquemment, très peu d'OHSLD correspondent au modèle construit par cette structure réglementaire (Koren, 2010). En cherchant à respecter les réglementations établies par ce cadre institutionnel, les OHSLD détournent leur attention des occasions de remettre en question les fondements de leurs systèmes actuels tel qu'appelé par le *culture change movement* (Steven A. Levenson, 2010).

En somme, bien que les OHSLD représentent une institution majeure et coûteuse consacrée à la dispensation de soins et services aux personnes en grande perte d'autonomie, elles faillissent largement à cette tâche (Rosenfield & Branch, 2005). Les OHSLD ne réussissent ni à assurer le bien-être de leurs résidents, ni la satisfaction professionnelle de leurs employés (Yeatts, et al., 2004). Elles contribuent plutôt au déclin fonctionnel de leurs résidents (Koren, 2010). Dans ce contexte, elles sont l'objet de nombreux appels à l'amélioration, mais elles ont beaucoup de difficultés à leurs répondre (Yeatts, et al., 2004). Présentement, la majorité des *nursing homes* sont des *homes,* voire des *nursing homes* que de noms (Koren, 2010).

Approches d'amélioration éprouvées

Au cours des dernières décennies, des efforts significatifs ont été déployés pour améliorer les soins et services offerts par les OHSLD (Levenson, 2009c). Au travers des initiatives

individuelles ou conjointes, des organisations de soins, des institutions académiques, des associations caritatives et des agences gouvernementales ont développé des protocoles, des recommandations et des modèles visant à améliorer la qualité des OHSLD (Levenson, 2009c). Plusieurs projets d'amélioration ou de réforme du champ de l'hébergement et des soins de longue durée ont découlé de ces efforts (Levenson, 2009a). Selon Levenson, (2010a) les différentes avenues ayant été explorées pour améliorer la qualité des services et des soins dans les OHSLD comprennent le développement de protocoles et de recommandations cliniques, la formation de la main d'œuvre, l'« empowerment » des résidents, l'éducation publique, les systèmes d'assurance de la qualité, l'augmentation des ressources ou les systèmes de récompenses liés à la performance et les réformes fondées sur l'approche du changement de culture.

La formation ou le développement des compétences du personnel est la réponse la plus communément adoptée pour répondre aux difficultés vécues en OHSLD (Stolee et al., 2005). Ces formations portent autant sur les fondements de la pratique géronto-gériatrique (Sbordone & Sterman, 1983), les particularités des nouveaux modèles d'organisations des soins (Mitty, 2005) que sur les bonnes pratiques de gestion (Shanley, 2007b). Le développement de protocoles et de recommandations cliniques est aussi une avenue populaire (Rosenfield & Branch, 2005). Des recommandations pour la pratique clinique ont notamment été conçues pour l'évaluation de résidents, les soins de plaies, l'incontinence, les contentions physiques et chimiques, la douleur, les soins d'hygiène, la dépression, les soins palliatifs, les soins spécialisés pour les résidents souffrant de démence (Lenhoff, 2005), les plaies de pression et l'immunisation (Nace, 2008). Maints programmes visant quant à eux l'implantation de recommandations pour la pratique clinique ont été mis en œuvre pour la réduction des contentions physiques, la réduction de l'incontinence urinaire, la prévention de la constipation, la prévention des chutes (Etheridge,

Couturier, Denis, Tremblay, & Tannenbaum, 2014), la réduction de la malnutrition (Pearce, 2010), l'amélioration des soins de fin de vie (Hill et al., 2005) et la prévention des plaies de pression (Horn et al., 2010).

Les systèmes d'assurance ou de contrôle de la qualité dans les OHSLD représentent l'ensemble des mesures visant à développer des d'indicateurs pour permettre des décisions et des actions bien informées (S.A. Levenson, 2010). Plusieurs pays occidentaux ont mis en place de telles mesures dans les OHSLD, notamment les États-Unis, la Grande-Bretagne et l'Australie (O'Connor, 2009; Shanley, 2007a). Aux États-Unis, depuis le début des années 1990, des réglementations obligent les OHSLD à évaluer et documenter l'évolution de la condition de santé de leurs résidents en employant un outil standardisé nommé le Resident Assessment Instrument/Minimum Data Set (RAI/MDS) (Dellefield, 2007). L'emploi du RAI/MDS est une responsabilité formelle des infirmières certifiées et une compétence centrale de leur profession (Dellefield, 2007). Cet outil permet de produire des informations détaillées sur l'état de santé fonctionnelle, cognitive et émotionnelle des résidents (Ikegami et al., 2001). Au cours des dernières années, de nouveaux paramètres d'évaluation ont été ajoutés au RAI/MDS afin de mener les OHSLD à porter attention à de nouvelles facettes de la santé de leur clientèle (p. ex. immunisation, Nace, 2008). La complétion du RAI/MDS permet conséquemment le développement et l'évaluation des plans de soins des résidents, mais aussi l'établissement de mesures de qualité et de supervision du respect des réglementations fédérales et étatiques (Dellefield, 2007; Ikegami, Hirdes, & Carpenter, 2001). Aux États-Unis, les droits des résidents d'OHSLD sont inscrits dans le Nursing Home Reform Act du Omnibus Budget Reconciliation Act (1987) au niveau fédéral, et fréquemment dans le cadre de lois étatiques (Lenhoff, 2005). Les règlements régissant le champ de l'hébergement et des soins de longue durée américains

comprennent notamment des niveaux minimums de scolarisation du personnel soignant, des protocoles de pratiques cliniques relatifs aux contentions et cathéters (DuBeau, et al., 2007; Stolee et al., 2005) et des ratios personnel-résident minimums dans certains états (Lenhoff, 2005). Les OHSLD qui ne respectent pas les réglementations peuvent subir des pénalités financières, être interdites d'admettre de nouveaux résidents ou voir leur certificat d'opération retiré (Lenhoff, 2005). Ce système d'évaluation et de certification est chapeauté par le Center for Medicare and Medicaid Services (CMS), mais est géré par des organisations de contrôle d'améliorations de la qualité mandatées par le CMS dans chaque état (Heldenbrand, 2008; Lenhoff, 2005). Ces mesures ont eu un effet positif sur le nombre d'OHSLD commettant des défaillances, même si un nombre beaucoup plus élevé d'OHSLD commet des infractions graves (Lenhoff, 2005). Cette augmentation peut également n'être que le produit d'une plus grande capacité à déceler ces infractions (Lenhoff, 2005). Ces problèmes sont dus à une faible application, voire même un déclin de l'application des mesures coercitives par les états à l'égard des OHSLD défaillantes. Ces défaillances ne sont pas surprenantes considérant le sous-financement de ces mesures (Lenhoff, 2005). En fait, seulement 0.05 % des 90 milliards consacrés aux milieux d'hébergement et de soins de longue durée en 1999 a été réservé à la supervision des OHSLD au regard de l'application des réglementations (Lenhoff, 2005). Une nouvelle mesure, soit le Nursing Home Quality Initiative, a été lancée en 2002 avec l'intention de contourner ces défauts de supervision en permettant aux futurs résidents des OHSLD et à leurs familles de « voter avec leurs pieds » (Lenhoff, 2005, p. 26). Ce projet a rendu publics les résultats d'évaluation des OHSLD par la voie de l'Internet afin d'inciter les OHSLD à améliorer la qualité de leurs services pour maintenir leurs parts du marché. Cette mesure d'assurance de la qualité représente ainsi un moyen de responsabiliser les OHSLD, mais aussi une forme d'information publique. Les campagnes d'éducation publique à propos de ce

que constituent un hébergement et des soins de longue durée de qualité, ainsi que les contributions des ressources médiatiques à la dénonciation des actes de maltraitance, permettent aux consommateurs de défendre leurs droits et de faire pression sur les décideurs de l'institution de l'hébergement et des soins de longue durée (Lenhoff, 2005). Au-delà de ces mesures, ayant comme but d'« empowerer » les résidents des OHSLD et leurs familles, certaines mesures ont été établies pour octroyer plus de pouvoir à leurs résidents actuels tels que les conseils des résidents et les cercles d'apprentissage (White-Chu et al., 2009).

En ce qui a trait aux changements managériaux, les OHSLD sont des organisations ayant expérimenté très peu de solutions de gestion (Yeatts et al., 2004). En effet, nous n'avons recensé qu'un petit nombre d'articles faisant état de projets visant à implanter de nouvelles modalités de gestion en OHSLD. Des programmes visant l'établissement de nouvelles méthodes de gestion des ressources humaines (Gilster & Dalessandro, 2008) et l'implantation de dispositifs de mobilisation et de mise à profit des compétences du personnel soignant sont parmi ceux-ci (Bishop et al., 2008; Yeatts et al., 2004). Plus largement, des changements destinés à implanter des systèmes d'amélioration en continu de la qualité ont été entrepris au cours des dernières années en OHSLD (Heldenbrand, 2008). Une étude de Yeatts et coll. (2004) décrit une stratégie de gestion participative nommée « équipes autogérées », en tant que modèle d'amélioration en continu de la qualité dans les OHSLD. L'étude de Rosen et coll. (2005) expose une stratégie d'amélioration en continu de la qualité misant sur l'empowerment du personnel, des incitatifs financiers et de la rétroaction des gestionnaires. Certaines interventions de développement professionnel peuvent également être conçues comme des entreprises d'amélioration en continu de la qualité. L'étude de McCormack et coll. (2009) rend compte d'un projet de développement professionnel en OHSLD ayant permis au personnel soignant d'explorer leurs professions d'une perspective critique et de «

prendre contrôle » de leurs pratiques afin d'intégrer à leurs routines de travail des modalités d'apprentissage en continu (McCormack et al., 2009, p. 93).

Enfin, plusieurs articles scientifiques (p. ex. Kelly & McSweeney, 2009; McCormack et al., 2009; Ramarajan et al., 2008; Robinson & Rosher, 2006; Shanley, 2007a) font état de projets ayant comme objectif de changer la culture d'une OHSLD. Certains projets ont employé des modèles préfabriqués alors que d'autres ont opté pour le développement local de stratégies de changement de culture (Caspar et al., 2009). Les modèles « clé en main » les plus fréquemment cités sont le Wellspring Model qui mise sur la collaboration entre OHSLD, l'Eden Alternative qui met l'accent sur l'amélioration de l'environnement physique des OHSLD (Rosenfield & Branch, 2005) et le GreenHouse Movement qui favorise l'hébergement au sein de plus petits établissements (Ragsdale & McDougall, 2008). L'existence de ces différents modèles et la variabilité caractérisant les initiatives locales de changement de culture illustrent que la réforme d'une OHSLD peut être appréhendée par différentes dimensions d'une organisation et abordée par différentes portes d'entrée.

En somme, toutes ces initiatives d'améliorations entreprises dans les OHSLD ont été amorcées dans l'espoir de contribuer à l'amélioration effective des soins et services offerts par les OHSLD. Certaines ont opté pour une amélioration incrémentale par l'implantation de nouvelles pratiques ciblées, d'autres pour une amélioration plus transversale en investissant les compétences managériales de leurs gestionnaires et d'autres pour une amélioration plus globale par l'implantation de systèmes d'amélioration continue ou de modèles de changement de culture. Les raisons ou motivations des décisions d'engager leur amélioration par l'une ou l'autre de ces approches ne sont que très rarement abordées au sein des écrits scientifiques recensés. Il semble toutefois reconnu que ces efforts n'ont pas réussi à produire des améliorations suffisamment

significatives pour répondre aux attentes contemporaines à l'égard des OHSLD. Comme nous le décrirons dans la section suivante, les diverses parties prenantes des OHSLD se retrouvent fréquemment désillusionnées par le peu de changement produit au cours des dernières décennies (Dixon, 2003).

Difficultés et obstacles au changement

Tout d'abord, il est important de reconnaître que le changement est requis à l'amélioration (Damanpour & Evan, 1984), mais aussi que le changement est difficile au sein d'une grande majorité de secteurs d'activités. Les processus de travail tendent à s'institutionnaliser et leur altération engendre toujours, sauf exception, des résistances parmi les divers groupes composant une organisation (Boyd et al., 1992). Dans le secteur de la santé, les processus de changement sont reconnus pour être des entreprises complexes qui engendrent majoritairement des échecs (Masso & McCarthy, 2009; Narine & Persaud, 2003). Les OHSLD ne font pas exception à la règle. Les structures organisationnelles établies dans les OHSLD sont remarquablement résistantes au changement. La plupart du temps, les programmes de changement conduit en OHSLD échouent, engendrent une série de conséquences négatives inattendues, provoquent des résultats modestes ou ne sont même pas évalués (Johnson et al., 2009; Kato et al., 2008; Masso & McCarthy, 2009; Shanley, 2007a). Les OHSLD se sont montrées historiquement résistantes aux changements incrémentaux et encore davantage au changement de grande échelle (Rosenfield & Branch, 2005; Sbordone & Sterman, 1983). En termes de résultats, les développeurs de recommandations pour la pratique clinique ont beaucoup de difficultés à les faire adopter et à les implanter et, conséquemment, à produire du changement (Rosenfield & Branch, 2005). Pour ce qui est des réglementations plus rigoureuses, elles n'ont pas permis de responsabiliser les OHSLD

suffisamment pour que les pratiques douteuses soient éradiquées (Wiener, 2003) ou que le nombre d'infractions graves diminue (Lenhoff, 2005). En ce qui a trait au mouvement de changement de culture, la recension des écrits de Masso et McCarthy (2009) remet en doute l'efficacité des initiatives menées en Australie et aux États-Unis depuis plus de 20 ans. Même les OHSLD les plus performantes sur le plan de la transformation de leur culture sont loin d'incarner la vision promue par le mouvement du changement de culture (Patterson, Dannefer, & Siders, 2009). De façon générale, le personnel adopte toujours une logique de doing-for plutôt que de being with (Masso & McCarthy, 2009). Les OHSLD ne semblent pas avoir trouvé de moyens pour améliorer la qualité de leurs organisations (Wiener, 2003); la gestion du quotidien semble prédominer sur la gestion à long terme depuis plusieurs années (Sbordone & Sterman, 1983).

Des défaillances en termes de gestion sont énoncées comme l'obstacle premier au changement. Bien que la gestion du changement soit considérée comme une fonction importante du rôle de gestionnaire en OHSLD, très peu d'attention est accordée à son inscription véritable et explicite dans son mandat (Shanley, 2007a). Le manque de leadership dans les OHSLD est délétère à l'implantation de nouvelles pratiques (Rosenfield & Branch, 2005). En termes de stratégie d'implantation, les projets d'amélioration de la qualité dans les OHSLD sont fréquemment impulsés du haut et ne sont pas accompagnés d'une supervision adéquate ou d'un apport significatif des gestionnaires (Rosen et al., 2006). Dans leur étude portant sur la formation en OHSLD, Stolee et coll. (2005) indiquent que la majorité des initiatives se limite à la diffusion d'information, sans offrir de stratégies de renforcement des acquis. Le manque de prise en compte des facteurs organisationnels, systémiques et sociopolitiques caractérisant les OHSLD est à la source de maints insuccès d'implantation de nouvelles pratiques (Sbordone & Sterman, 1983 ; Stolee et al., 2005). Par exemple, les formations offertes pour promouvoir l'utilisation de nouvelles

pratiques inondent le personnel d'informations non adaptées aux niveaux de scolarité variables du personnel des OHSLD (Stolee et al., 2005). Ces dernières n'ont pas les capacités organisationnelles ou gestionnaires requises à la mise en œuvre des changements proposés dans les écrits scientifiques, que ce soit de répondre aux exigences réglementaires, d'implanter des recommandations pour la pratique clinique ou de procéder à la transformation de leur culture (Wiener, 2003). Faire en sorte que les idées produites par la recherche soient reconnues comme des solutions viables au sein des milieux d'hébergement et de soins de longue durée demeure un défi (Dannefer, Stein, Siders, & Patterson, 2008)

Ensuite, il appert que les nombreux problèmes qui affectent la qualité des soins et services dispensés en OHSLD représentent des obstacles à leurs propres résolutions. Premièrement, les problèmes de recrutement et de roulement du personnel nuisent au leadership et à l'engagement envers le changement (Koren, 2010; Rosenfield & Branch, 2005). Les OHSLD offrent un faible soutien général à l'amélioration, quant aux incitatifs à la mise en application de nouvelles pratiques, aux apports d'équipes interdisciplinaires inclusives des médecins et gestionnaires et à l'informatisation des processus de soins (DuBeau et al., 2007; Stolee et al., 2005). L'inadéquation entre l'environnement réglementaire de l'hébergement et des soins de longue durée et la réalité des organisations crée aussi une tension délétère à la transition vers une nouvelle philosophie de services et à l'établissement d'une nouvelle culture (Dixon, 2003). Par exemple, certains paramètres réglementés empêchent l'organisation personnalisée des chambres des résidents (Rosenfield & Branch, 2005). Selon Davies et coll. (2007) les OHSLD peuvent être étiquetées en tant que *communauté contrôlée* au sein desquelles les valeurs importantes sont relatives à la minimisation du risque, au maintien du statu quo et à la centration du travail sur les tâches à accomplir. Au sein d'une telle communauté, le personnel apprend à garder ses idées pour soi et à

suivre les directives. Les gestionnaires y sont plutôt frustrés de voir le personnel ne pas profiter des rares occasions qu'il a de participer à des comités ou des forums lui permettant d'exprimer ses opinions. Le personnel des OHSLD est ainsi représenté comme étant composé d'individus valorisant le maintien d'une routine, réticents à employer des traitements non familiers, ayant des attitudes négatives à l'égard des personnes âgées, et plus résistants au changement à mesure qu'ils gagnent en nombre d'années en poste (Heldenbrand, 2008; Stolee et al., 2005). Les prérogatives professionnelles de la profession infirmière et les règles syndicales contribuent également à l'inertie des OHSLD (Dannefer, et al., 2008).

Le manque de ressources fait également obstacle au changement en OHSLD. Selon Feldman et Kane (2003), plus d'efforts de transfert de connaissances en pratique échouent par manque de volonté des bailleurs de fonds qu'en raison de toute autre raison. Les OHSLD manquent de financement en comparaison avec les milieux de soins aigus, tout comme d'espaces et d'équipements utiles à la formation (Stolee et al., 2005). De plus, les conséquences des failles devant être comblées engendrent des coûts trop importants pour que les OHSLD disposent des marges de manœuvre financières requises à l'entreprise de changement (Levenson, 2009a). Certaines mesures de gestion ayant prouvé leur utilité, notamment l'embauche de consultant clinique en mesure de coacher l'application de nouvelles pratiques sur les unités de soins, sont conséquemment non viables en OHSLD en raison de leur coût (Rosen et al., 2006). La capacité des OHSLD à gérer des changements est en fait en déclin considérant le manque croissant de ressources (Kelly & McSweeney, 2009). L'accroissement de la complexité des besoins de leurs résidents et le roulement élevé des résidents qui en découle exigent une période d'adaptation de plus en plus importante de la part du personnel, ce qui est délétère au changement (Stolee et al., 2005). Les OHSLD devront aussi composer avec une réduction escomptée de 50 % de leur main-

d'œuvre potentielle en parallèle d'une augmentation de 50 % de leur clientèle potentielle (Rosenfield & Branch, 2005). Il s'agit donc d'opérer des organisations de plus en plus larges tout en offrant des services de plus en plus personnalisés (Gibson & Barsade, 2003). L'importance, intrinsèque aux milieux d'hébergement et de soins de longue durée, de trouver un équilibre entre le respect des choix personnels des résidents et le devoir de les protéger, entre leur qualité de vie et leur sécurité, augmentera la pression à l'amélioration en OHSLD (Rust et al., 2008; White-Chu et al., 2009). Pourtant, il semble que les gestionnaires des OHSLD sont léthargiques devant les problèmes auxquels ils sont confrontés (Rosenfield & Branch, 2005).

En somme, il est juste de considérer les OHSLD comme étant généralement incapables d'amélioration. Le manque de ressources mis à leur disposition et leur manque d'expertise généralisé expliqueraient la stagnation qui les caractérise trop souvent. Toutefois, comme le démontrera la section suivante plusieurs cas d'améliorations réalisées en OHSLD sont documentés.

Améliorations réalisées

Paradoxalement, les articles scientifiques qui exposent les résultats de projets d'amélioration ayant produit des effets mitigés, nuls ou négatifs sont plutôt rares. Ceci correspond au « biais pro-innovation » décrit par Greenhalgh et coll. (2004, p. 10) comme une conséquence de la plus grande facilité à expliquer la transformation que la stagnation. Il semble que les insuccès au changement en OHSLD sont plus fréquemment décrits en tant qu'état de fait général qu'analysé à travers des cas uniques. Plusieurs écrits font en effet état de la possibilité de mener de réaliser des améliorations dans les OHSLD. Des projets d'implantation de dispositifs électroniques de collecte d'informations cliniques (DeLaHunt, 2005) et de dossiers cliniques informatisés

(Alexander, Rantz, Flesner, Diekemper, & Siem, 2007; Gruber, Darragh, Puccia, Kadric, & Bruce, 2010) ont engendré des résultats positifs en termes d'efficacité des processus de soins, d'économie de ressources et de valorisation du personnel. En ce qui a trait aux interventions cliniques, des programmes de soins aux plaies de pressions (Horn et al., 2010), de réduction de l'utilisation des contentions (Johnson et al., 2009), de prévention des chutes (Kato et al., 2008), d'amélioration de la nutrition (Pearce, 2010), de gestion de la douleur (Hill et al., 2005; Swafford et al., 2009) et de dispensation de services de dialyse (Yang & Campbell, 2009) ont eu des effets cliniques, professionnels et organisationnels positifs. Sur le plan psychosocial, Sbordone et Sterman (1983) indiquent qu'il est reconnu que des résultats positifs notamment eu égard aux problèmes de dépression, de confusion, d'isolement, d'errance et d'apathie peuvent être atteints. McKenzie et coll. (2007) ont quant à eux mis en lumière la possibilité d'augmenter la qualité de vie des résidents des OHSLD grâce à un programme d'amélioration de l'alimentation et d'augmentation de l'activité physique. De même, des interventions ayant comme objectif d'améliorer l'expérience professionnelle du personnel soignant ont eu du succès. L'étude de Bishop et coll. (2008) a démontré l'influence positive de l'établissement d'une relation gestionnaire-préposé plus respectueuse et aidante sur l'engagement du personnel envers leur OHSLD. Kinjerski et Skrypnek (2008) ont aussi démontré qu'il est possible d'augmenter l'engagement du personnel et de diminuer le roulement et l'absentéisme par l'implantation d'un programme de développement professionnel. Une étude de Sbordone et Sterman (1983) portant sur la dispensation d'une formation de gestion promouvant l'adoption d'une représentation des employés des OHSLD comme des êtres ayant des besoins complexes et variés a plutôt permis des gains appréciables en termes de moral et de roulement. Enfin, une intervention de consultation auprès d'une organisation problématique employant une approche de recherche-action permit d'améliorer le taux

d'absentéisme et la qualité des soins dispensés dans l'OHSLD en misant sur l'établissement de relations de confiance par des réunions interdisciplinaires et interdépartementales (Schruijer, 2006).

La thèse de Heldenbrand (2008) révèle quant à elle la possibilité pour des OHSLD d'implanter des modèles d'amélioration en continu de la qualité ayant une influence significative sur la qualité de leurs services, et ce, surtout lorsque ce modèle est adapté à leur contexte local. La thèse non publiée de Limeberry (2001), cité par Heldenbrand (2008), démontre aussi qu'un modèle d'amélioration en continu de la qualité peut avoir une influence positive sur plusieurs d'indicateurs de qualité d'une OHSLD. Le recours à des équipes de soins autogérées pour favoriser l'apprentissage organisationnel en continu a eu des effets positifs sur le plan des relations interpersonnelles, de la coordination des soins, de l'absentéisme et de la compréhension des politiques organisationnelles (Yeatts et al., 2004)

Pour ce qui est du mouvement de changement de culture, malgré son insuccès largement documenté (Shanley, 2007a), plusieurs articles relatent le succès de certaines initiatives locales. Le programme de changement de culture étudié par Boyd et coll. (1992) a permis d'améliorer la personnalisation des soins ainsi que la communication, le moral, l'autonomie et l'engagement du personnel envers leurs équipes de travail et l'organisation. Brush (2008) a décrit les effets positifs préliminaires d'une initiative de changement de culture abordant le défi par l'entremise d'une transformation des services alimentaires. Une étude portant sur l'effet du changement de culture sur les infirmières auxiliaires a plutôt souligné l'effet positif de l'adoption d'une approche de gestion plus humaine sur leur engagement et leur satisfaction du travail (Tellis-Nayak, 2007). Une gestion plus respectueuse des ambitions et compétences du personnel, promu par le mouvement de changement de culture tel qu'étudié par Ramarajan et coll. (2008), a un effet positif sur

l'épuisement professionnel. En d'autres cas, des interventions très simples et sous-tendues par les principes du changement de culture sont documentées pour avoir produit des effets mesurables chez les résidents, le personnel et les organisations. Par exemple, l'augmentation de la température dans les salles de bain rend la situation du bain moins stressante pour les résidents et le personnel et engendre conséquemment des gains de temps (Koren, 2010). En ce qui a trait à l'efficacité des modèles préfabriqués de changement de culture, il appert que le Green House Movement, bien qu'incompatible avec les grandes infrastructures institutionnelles qui sont la norme actuelle dans le champ de l'hébergement et des soins de longue durée (Caspar et al., 2009), est le seul à avoir démontré des gains multidimensionnels : pas de perte ou de gain financier, déclin du roulement de personnel, déclin des problèmes d'alimentation, diminution du nombre de signalements de défaillances, diminution du nombre d'accidents de travail liés aux déplacements, moins de dépressions, moins d'utilisation d'antipsychotique et ralentissement de la perte de capacité à vaquer à ses activités de la vie quotidienne (Rabig & Rabig, 2008; Ragsdale & McDougall, 2008). Toutefois, selon une étude canadienne, les entreprises de changement de culture développant leurs propres modèles localement sont plus fréquemment fructueuses que les entreprises employant les modèles préfabriqués (Caspar et al., 2009).

Le recours aux mesures réglementaires a aussi permis des améliorations. Aux États-Unis entre 1987 et 2007, soit depuis l'instauration des nouvelles normes régies par l'OBRA, des progrès significatifs ont été réalisés dans le domaine de l'hébergement et des soins de longue durée (Levenson, 2010a). L'implantation du RAI/MDS permet aux organisations de recueillir et de détenir de l'information systématique et détaillée à propos de leurs résidents. Cette information peut être utilisée pour planifier les plans de soins, pour mesurer les améliorations et les détériorations de santé chez les résidents et pour identifier les problèmes de qualité (Levenson,

2010a). Ensuite, les exigences législatives instituées relativement à la formation minimale des préposés ont engendré certaines améliorations (Levenson, 2010a; Stolee et al., 2005). Des législations plus récentes ont contribué à diminuer l'utilisation de contentions physiques, à altérer la culture soutenant leur utilisation, à diminuer l'utilisation de cathéters et à améliorer la prévention et la gestion des plaies de pressions (Levenson, 2010a; Stolee et al., 2005). Il appert ainsi que l'effet de stratégies d'amélioration des pratiques en OHSLD est potentialisé par des politiques systémiques et du soutien réglementaire (Stolee et al., 2005).

Objectifs

Comme exposé par la section précédente, bien que la majorité des OHSLD de réussissent pas à répondre aux attentes contemporaines à leurs égards, l'amélioration est possible en OHSLD. Toutefois, aucune approche ou stratégie de changement ne s'est révélée produire des résultats positifs de façon constante dans les OHSLD (Levenson, 2009b). Malgré l'énorme pression au changement à laquelle sont confrontées toutes les OHSLD, les objectifs et les moyens entrepris par les OHSLD pour y répondre varient selon les idées prévalant au sein de chaque organisation (Kalliola, 2009). C'est dans ce contexte que nous avons décidé de tenter de réaliser cette thèse sur les fondements managériaux des difficultés d'amélioration des OHSLD québécoises, nommées CHSLD. Pour y arriver, comme nous l'avons exposé en introduction, nous avons défini deux grands objectifs de recherche pour structurer notre travail.

Le premier est de comprendre ce qui distingue les stratégies de gestion du changement qui permettent des gains pérennes de ceux qui n'en permettent pas en CHSLD. Cet objectif vise spécifiquement à valider l'applicabilité de connaissances propres aux caractéristiques bénéfiques

de stratégies de gestion du changement dans le contexte des OHSLD et à approfondir la compréhension de ces caractéristiques bénéfiques.

Le second est de comprendre les fondements de l'incapacité reconnue des CHSLD à s'améliorer significativement ainsi que leur maintien durable dans un cercle vicieux de sous-performance. Ce second objectif fut appréhendé en portant notre regard vers l'amont des processus de changement. Cette décision est légitimée intuitivement, voire culturellement, par les nombreuses expressions soulignant l'importance de « prévenir plutôt que de guérir », mais surtout par de maints appels à une meilleure compréhension des activités se déroulant en amont des processus d'implantation de changements provenant du monde scientifique. Pettigrew (1990a) met notamment de l'avant l'importance de ne pas traiter les processus de changement comme des épisodes détachés des contingences actuelles et antécédentes donnant sens à leur impulsion. Greenhalgh et coll. (2004b) soulignent quant à eux la pertinence d'efforts pour mieux comprendre le processus par lequel les organisations capturent des idées et les manipulent pour en faire des changements plus ou moins efficaces. D'une perspective plus ciblée, Simon (1997) aborde la problématique en explicitant l'importance de mieux comprendre les processus organisationnels employés pour évaluer la « fonction de production » d'une activité innovante, soit le potentiel d'amélioration relatif d'un objectif de changement, et pour allouer les ressources disponibles à l'activité désignée. Finalement, le Department of Health de la Grande-Bretagne (1998) explicite l'existence de connaissances fiables sur les pratiques favorables à la conduite de changement au même moment que le faible recours à ces pratiques par les organisations du secteur de la santé. Cet énoncé met en lumière que la difficulté à transposer en pratique les connaissances existantes ne concerne pas seulement les sphères cliniques des organisations du champ de la santé, mais les sphères managériales également. Ainsi, en étudiant les processus par lesquels les OHSLD

engagent des changements, et les déterminants qui orientent leurs décisions et actions, nous escomptons répondre aux appels de ces auteurs en contribuant au développement d'une meilleure compréhension de l'interface entre le « cours normal des choses » au sein d'une organisation et le début de la phase implantation d'un processus d'amélioration. Ce second objectif escompte donc plus précisément comprendre ce qui empêche les OHSLD d'engager plus régulièrement de façon à produire des améliorations effectives et participer à une compréhension plus générale de l'amont des processus d'amélioration.

Premier article

L'étude présentée dans le cadre de ce premier article fut consacrée à comprendre ce qui distingue les projets d'amélioration qui permettent des gains pérennes de ceux qui n'en permettent pas en CHSLD. Cet objectif se réalisa par la conduite d'une étude de cas multiples de projets d'amélioration ayant produit des résultats contrastés dans quatre CHSLD. Les résultats de cette étude furent publiés en 2014 dans le *Journal of Applied Gerontology* dans un article qui s'intitule: « Explaining the Success or Failure of Quality Improvement Initiatives in Long-Term Care Organizations From a Dynamic Perspective ».

Explaining the Success or Failure of Quality Improvement Initiatives in Long-Term Care Organizations From a Dynamic Perspective

Abstract

The purpose of this study was to better understand why change initiatives succeed or fail in long-term care organizations. Four case studies from Québec, Canada were contrasted retrospectively. A constipation and restraints program succeeded, while an incontinence and falls program failed. Successful programs were distinguished by the use of a change strategy that combined "let-it happen", "help-it happen" and "make-it happen" interventions to create senses of urgency, solidarity, intensity and accumulation. These four active ingredients of the successful change strategies propelled their respective change processes forward to completion. This paper provides concrete examples of successful and unsuccessful combinations of "let-it happen", "help-it happen" and "make-it happen" change management interventions. Change managers can draw upon these examples to best tailor and energize change management strategies in their own organizations.

Keywords

change management, long-term care, change dynamics, innovative care program

Background

Knowledge on how to motivate, disseminate and sustain quality improvement in long-term care organizations (LTCOs) is lacking (Feldman & Kane, 2003). Change in LTCOs remains a complex endeavor based mainly in intuition and anecdote (Masso & McCarthy, 2009). To date, change management research carried out in LTCOs has produced one-dimensional lists of factors

that enable or hinder new innovations (e.g. Etheridge, Tannenbaum, & Couturier, 2008; Horn et al., 2010; Swafford, Miller, Pao-Feng, Herr, & Ersek, 2009; Yeatts, Cready, Ray, DeWitt, & Queen, 2004). Theories produced within the field of organizational studies contend that change can be better explained by the more or less skillfully managed interactions between the content of the change, the context of the change and the process of the change (Pettigrew, McKee & Ferlie, 1988; Masso & McCarthy, 2009).

Few studies have attempted to describe the dynamic attributes of change processes that lead to successful organizational innovation, particularly in LTCOs (Greenhalgh, Robert, Macfarlane, Bate, & Kyriakidou, 2004; Van de Ven & Rogers, 1988). What is known is that the use of a single educational intervention is less effective than the simultaneous application of multiple change management interventions for achieving desired outcomes (Bero et al., 1998; Kitson et al., 2008). The concept of applying a change strategy that combines multiple interventions, rather than implementing a single intervention, is therefore attractive. However, the best approach for integrating multiple change interventions to yield an effective change strategy remains poorly understood.

From coherent perspectives, multiple authors shed light on this matter. Paton and McCalman stress that successful change managers are the ones who are able to juggle with the ability to "have the answers" and "allow the organization to find its own" (2000, p. 197). Kitson et al. (2008) extend the principle by stating that the effective transfer of knowledge into practice requires a combination of change management interventions ranging from "doing for others" to "enabling and empowering". Shanley (2007) specifies that managing change in nursing settings necessitates fostering "bottom-up", "top-down" and "sideways" contributions. The potential applicability of this principle in LTCOs is supported by a systematic review of pain management

conducted in long-term care settings (Swafford et al., 2009). This review sustains that combining participative problem solving, to supportive coaching from a pain management expert and rigorous supervision will favor the implementation of the most effective pain management programs. In sum, these recommendations recall the three types of "influences that help spread the innovation" in service delivery organization (Greenhalgh et al., 2004, p. 601), which are "let-it happen", "help-it happen" and "make-it happen", and propose that their combination in a given change process is beneficial. Doing so, their authors insinuate that the three types of change influences are not only different conceptual bases from which to explain the spread of innovations, but also representations of complementary vectors of change.

Inadvertently, managers of LTCOs typically favor authoritative approaches to bring about change, rather than participative approaches that allow staff empowerment (Kelly & McSweeney, 2009). The fear of losing control over processes which may lead to regulatory infractions or hinder their LTCO's already fragile public image exacerbates this inclination towards authoritative management (Levenson, 2010; White-Chu, Graves, Godfrey, Bonner, & Sloane, 2009). LTCOs are described as controlled communities in which staff members learn to keep their ideas to themselves and do as they are told in order to minimize the risks of leaving the status quo (Davies, 2001). The highly controlled and structured environment of LTCOs stifles the autonomy and creativity of their staff (Ragsdale & McDougall, 2008). The overwhelming lack of resources (Feldman & Kane, 2003; Stolee et al., 2005) and a tendency towards working in silos (Brownlee, 2010) augment LTCOs' difficulties to improve.

Practically speaking, how can change managers in LTCOs break out of their authoritative stance and go about "making things happen", "helping things happen" and "letting things happen"? What are examples of change management interventions that "make things happen", "help things

happen" and "let things happen"? How does each type of change influence contribute to the progression of a change process? How does a change process evolve when change management interventions effectively elicit and combine each type of change influence? What happens when they are not?

The objective of this study was to analyze whether the success or failure of change processes in LTCOs can be explained by the distinct combination of "make-it happen", "help-it happen" and "let-it happen" change influences fostered during their course. The study also sought to identify the resulting mechanisms that propel successful change processes forward.

Methods

We conducted a retrospective multiple case study (Yin, 2003) guided by a realist approach (Pawson, Greenhalgh, Harvey, & Walshe, 2004).

Table 1. Characteristics of the Four Long-Term Care Organizations

Case 1: Restraints reduction program (success)	Case 2: Continence program (failure)
Number of beds: 387 Type of clientele: 3.8 mean hours of care Year of initiation: 1998 Proportion of residents targeted: 65% Success rate: 97% Years of sustainability: > 6 years	Number of beds: 452 Type of clientele: 3.5 hours of care and more Year of initiation: 1998 Proportion of residents targeted: 100% Success rate: Not evaluated Years of sustainability: Un-sustained
Case 3: Constipation prevention program (success)	**Case 4: Falls prevention program (failure)**
Number of beds: 124 Type of clientele: minimum of3 hours of care Year of initiation:1988 Proportion of residents targeted:100% Success rate:75% Years of sustainability: > 20 years	Number of beds: 42 Type of clientele: Mobile elderly residents Year of initiation: 1996 Proportion of residents targeted: 100% Success rate: Not evaluated Years of sustainability: Un-sustained

The realist approach aims to enable understanding of the "mechanisms that connect events in a way that changes them either in the desired direction or in an unexpected way" (Kitson et al., 2008, p. 10). Four LTCOs in Québec were selected based on their having undertaken the recent implementation of an innovative care program. A continence program, a falls prevention program, a restraints reduction program, and a constipation prevention program were selected. These programs aim to humanize care, favor autonomy through behavioral and organizational transformation, are founded on scientific evidence, and share dynamic similarities (Markwell, 2005; Mueller, 2004; Pålshaugen, 2009; Phillips, Roberts, & Hunsaker, 2008; Selig & Boyle, 2001).

To be able to contrast the results (Yin, 2003), we recruited two LTCOs that gauged their change initiative to be successful and two that did not. Success was defined as the sustained implementation the program for more than 24 months. The success or failure of the initiatives was determined by the perspective of the managers currently employed by the LTCOs and validated using documentation. The four LTCOs retained for the study (Table 1) were purposefully recruited (Yin, 2003) from the list of public LTCOs governed by the Quebec Ministry of Health and Social Services. LTCOs were selected based on their ability to guarantee access to individuals involved in the implementation of the innovative program in their organization. A contact person from each LTCO was responsible for recruiting four key players involved in the change process, i.e. two change managers and two change users, for a total of 16 participants.

Semi-structured individual interviews with four persons in each organization were conducted, lasting between 45 to 90 minutes each. To direct the documentary analysis and carry out the interviews, we used an interview guide derived from the main concepts in our theoretical

framework. The interviews were recorded using a numerical recorder and were transcribed verbatim.

Our observations and analyses were framed by our theoretical stance, i.e. by our representation of the outcome of a change initiative as the product of the interactions between: 1) the content of the change (the innovative program), 2) the context of the change (the inner and outer context of the LTCOs), and 3) the process of the change (actions, reactions and interactions of the various actors of the LTCOs) (Pettigrew et al., 1988). The "let-it happen", "help-it happen" and "make-it happen" typology of influences of innovative processes (Greenhalgh et al., 2004) was utilized to define the change influences elicited by change management interventions. Finally, in order to create comparable patterns of "let-it happen", "help-it happen" and "make-it happen" influences, we focused on five different phases of the change processes, i.e. initiation, development, communication, implementation and sustainment (Van de Ven, Angle & Poole, 2000; Fixsen, Naoom, Blase, Friedman & Wallace, 2005).

Table 2. Definition of the Three Types of Influences by Which an Innovation Can Spread

Types of influences	Description
Make-it happen	Influences the change process through planned, scientific, orderly, regulated management.
Help-it happen	Influences the change process through social and technical enabling, negotiation and influence.
Let-it happen	Influences the change process through unpredictable, unprogrammed, uncertain, adaptive and self-organizing emergent sub-processes

For the analysis of each case, we favored a *process-focused* coding, inspired by grounded theory (Strauss & Corbin, 1998). First, we categorized the change influences as "let-it-happen", "make-it-happen", and "help-it-happen". Each change influence was matched to the type which *best* defined its influence on the change process as they were described by the participants. To enhance the reliability of the coding, a coding check was performed (Miles & Huberman, 1994). Second, we identified relationships between the phases of the change process and the types of change influences that marked their course. During this analysis phase, we developed a process oriented explanation, i.e. based on the interactions between content of the change, the context of the change and the process of the change, for the degree of sustainment achieved in each case. In other words, we utilized our data to answer the realist question of "what is it about this program that works for whom in what circumstances?" (Pawson, 2004, p.2). Third, we performed a cross-case analysis to identify core similarities and differences between the four cases. We conducted this last step in the realist intention of identifying the change mechanisms created by the singular combinations of change influences put forward in the successful and unsuccessful cases.

Findings

Each case is described as a function of the "let-it-happen", "make-it-happen", and "help-it-happen" influences that shaped the initiation, development, communication, implementation and sustainment phases of the change processes. A description of contextual influences and a process oriented explanation for the outcome of the change process are provided at the end of each case. Supporting citations from the change managers' (CM) and change users' (CU) experiences are provided as examples to explain why the programs succeeded or failed.

Case 1: Falls Prevention Program (failure)

Implementation of the falls prevention program in the LTCO was mandated by the regional health agency in response to a recommendation from the Quebec Ministry of Health and Social Services. From the users' perspective, the program was initiated out of the blue: "It fell from the sky. Someone suddenly appeared with a falls prevention program (*make-it happen*)." [CU] The project manager expressed concern that the program was not developed in view of the context of the care units at her LTCO, but attempted to rectify the situation using guidance from scientific documentation rather than input from potential change users (*make-it happen*). In terms of communication, both the users and the managers recognized that solely offering single training sessions was inadequate: "The little 15-minute periods weren't enough. The resources provided were not enough to take the program seriously." [CM] Consequently, the bulk of the information and training mandate fell upon assistant head nurses, who considered the situation irritating and overwhelming (*let-it happen*). The implementation interventions consisted primarily of providing standardized assessment tools (*help-it happen*) and integrating the new practices into the patient's care plan based on the results of the assessment (*help-it happen*). The eventual failure of the program to be integrated into routine care and sustained was blamed on a lack of supervision and the absence of measurable process outcomes: "I think it started off very well! But we weren't really looking at the program's effects. We saw it was losing speed, we weren't able to do much (*let-it happen*)." Users expressed feeling left on their own: "It was a beautiful project, but we did not have the means to apply it. The day-shift nurse had to shoulder the entire burden of both the assessment and the treatment on her own." [CU] As input from the change users was not sought in advance, there was a lack of buy-in and sense of accountability for the successful implementation of the program: "They put it together, they developed it. Then, they dropped it on

us. […] They said: 'Do what you have to do to make it work'." [CU] Still, managers and users stressed that their efforts were not futile: "It's not respected at all, but I see the personnel with the residents, making them walk every day." [CU] New mandates dictated by the regional health agency led the falls program to fall down the organization's priority ladder: "Meetings gave way to other topics, like patient centered care, and the falls program was no longer on the agenda." [CM]

In sum, the falls prevention program failed because the change managers did not draw upon the users' knowledge and skills at the beginning of the change process, provided no oversight for the program's widespread implementation in the LTCO, and dismissed the importance of the program over time.

Case 2: Constipation Program (success)

The constipation program was initiated by the nurses' recognition of the severity and high prevalence of constipation among the organization's residents: "We had our own ideas: 'That's what we want, we're going to do it this way.' When we said: 'Ok, let's start this', we, the assistant head nurses, we sat down with the head nurse and shared our thoughts (*let-it happen and help-it happen*)." [CU] The nurses then convinced a medical doctor to champion the cause and act as its project manager (*help-it happen*). Yet, the development of the program was essentially ensured by the nurses before being formalized by higher level management: "We did our work, we gave it to the management and then they developed it (*let-it and make-it happen*)." [CU] Both an organization-wide conference hosted by the project manager (*make-it happen*) and a series of meetings with each level of the personnel were used to inform the users about the program, encourage uptake, and obtain feedback (*help-it happen*). In the early stages of implementation, the program benefited from all the resources it required to grow: "We were testing it out, but we

needed the management's help for the medication part and the collective prescriptions. We could not do it completely on our own (*help-it happen*)." [CU] The components of the intervention were also made mandatory: "We wouldn't say: 'If you have time, make him walk,' which is what we did before. With the new program we would say: 'You need to make him walk 15 minutes to 30 minutes today (*make-it happen*)." [CU] Yet, the change users' opinions were valued: "We did not have a head nurse that said: 'You are not doing it properly!' It was the opposite, she would say: Ah! That's good, new ideas! Go ahead, you have our support (*let-it happen*)." [CU] To ease the burden of the new practices, working environments were reorganized to allow the staff to spend more time on the unit with the residents (*help-it happen*). Efforts were made to highlight the causal link that existed between the users' efforts to implement the program and the evaluated improvements in the residents' bowel habits "We would say, 'Hey! He looks less confused; he's less agitated.' Then we would look at the bowel movement calendar and it was becoming more regular (*make-it happen and help-it happen*)." [CU] Measuring and appreciating these results rapidly ensured that the program became the new norm for this organization. Managers maintained their openness to the users' suggestions, their support and their supervision up until the personnel integrated the new practices into their routine in a sustainable manner (*let-it, help-it and make-it happen*). At the tail end of the process, approximately one year after the project's debut, consultation between the head nurses allowed the best practices from each care unit to spread across the entire organization (*make-it happen*). In retrospect, the managers perceived that the program underwent significant changes since the beginning of its implementation because of the input of the users: "When I re-read the initial program I thought: 'Oh my goodness! If I could rewrite it, let me tell you I would know how to do it better now and it would look a lot more polished than this." [CM] The fact that the organization had only recently acquired status as a

LTCO was conceived as a receptive context for change: “We were a majority of young people, from 20 to 30 years old. I think we wanted to develop a new philosophy of care right from the start.” [CM]

In sum, the constipation prevention program surpassed its objectives because the process was initiated at the change users’ level, received support from management, and was guided by a respectful and bidirectional collaborative approach between the users and managers. This change management strategy tapped into the users’ strong desire for change, offered an appropriate balance of support and ensured that incremental successes gradually led to sustained engagement towards the constipation prevention mandate.

Case 3: Continence Program (failure)

The continence program was initiated by a nurse clinician as part of the organization’s mandate to ensure leadership in the field of geriatric medicine: “We aim for excellence and quality of care. Incontinence, constipation, falls program; we developed programs for all of them at the same time (*make-it happen*).” [CM] Although incontinence was recognized as a significant problem, the program never made it into the spotlight: “I don’t remember us saying, ‘This year is the year for incontinence.’” [CM] The program was developed by the nurse clinician based on an evidence synthesis from the scientific literature, and expert contributions from two medical doctors (*make-it happen*). At no point in time were the change users consulted: “We never asked them, ‘Do you think the program is valuable? Does it make sense?’ Because obviously it made sense.” [CM] Once the program was approved by the nursing director, it was introduced to the users through informal training sessions on the care units: “We never held a formal day of training. The staff was informed, had access to the program and was shown how to use the bladder diaries (*help-*

it happen)." [CM] Compared to a wound care program, which was implemented around the same time as the continence initiative, the managers admitted that they did not sufficiently supervise the continence program, monitor the outcomes or promote collaborative decision-making (*let-it happen*). Nor did the users feel particularly engaged in the process: "…they did not get everybody's cooperation. No one said: 'I won't participate; I will leave all my patients in pads.' But our commitment was only half-hearted. We said, 'I'm sorry, I will do what I can when I can.'" [CU] Sustainability was poor, primarily because the continence initiative was initiated simultaneously with other programs and had a low level of priority attached to it since continence was one of the organization's quality care indicators.

In sum, the continence program was a failure for three main reasons. First, the introduction of the program got buried among other change initiatives that were started at the same time. Second, implementation of the program never achieved buy-in from the participants, since their opinion and feedback was never sought. And third, the managers did not follow through with proper measurement or dissemination of the outcomes.

Case 4: Restraints Reduction Program (success)

The restraints reduction program was initiated by a nursing director, inspired by a seemingly anecdotal event: "All this started one day when my son harmlessly asked why all these people were tied up." [CM] This nursing director had been requested to lead a pilot project at the organization, and she chose restraint reduction as the theme of the project (*make-it happen*). She initially met with resistance from members of the pilot team: "One head nurse, who was very skeptical at the time, said: 'I read plenty of articles stating that restraints are good.'[So] I told her to present a case in favour of restraints: 'Listen, if you're able to convince me, then we will keep

the restraints (*help-it happen*).'" [CM] The pilot project therefore evolved as a review of the evidence for and against restraints, with the case against restraints winning. Based on the evidence, the staff began to remove restraints (*make-it happen*) and the success attained by the pilot-project fueled the program's diffusion across the organization: "It became contagious, it was good news. The other floors were asking themselves: 'Why them and not us?' Slowly, it contaminated the other care units (*let-it happen*)." [CM] This informal implementation phase lasted five years: "The teams got together informally to discuss alternatives to restraints (*let-it happen*)." [CM] Restraints reduction became a care priority before any formal program was developed: "The innovation came from the people who look the client and their families in the eyes every day." [CM] The rehabilitation personnel took on an active role in the process and supported the nursing staff in their efforts: "At some point, the leadership changed. Occupational therapy really took the lead, probably because they held the solutions (*help-it happen*)." [CM] The change process was eventually vetted by the board of directors: "This was extremely helpful because it said, 'It's not your personal decision, it is an organizational decision' (*help-it happen*)" [CM] Subsequently, an organization-wide communication strategy was launched, using all available media (*make-it happen*) and several 15-minute training sessions offering feedback opportunities dispensed by middle managers and other professionals (*help-it happen*). The change managers ensured that the outcomes of the new practices were monitored, measured (*make-it happen*) and communicated (*help-it happen*): "There were presentations with boards, graphs. They did that for a while, it was really intense." [CU] The board of directors also followed-up on the program's implementation and success (*make-it happen*). Encouragement and celebration of positive results occurred: "At first there was a table on the unit that indicated the results and presented congratulation letters. We don't do that anymore, now it is relatively stable, but at that time it was important (*help-it*

happen).” [CM] Today, the users consider the practices developed through the restraints reduction initiative as routine. While managerial efforts have greatly diminished (*let-it happen*), the application of alternatives to restraints must still be supported and supervised to avoid a return to the old habits (*make-it happen and help-it happen*). Subsequent legislation that obliged LTCOs to reduce restraint use further reinforced an already solid enterprise.

In sum, the restraints reduction program was an overwhelming success because a growing acceptance of the legitimacy of restraints-free care drove the development of the program. Participation of frontline caregivers, intermediate-level managers and professionals in developing, communicating and implementing the new practices encouraged their engagement in what they conceived as a common enterprise. Nonetheless, “make-it” and “help-it-happen” contributions from higher level managers were key assets in ensuring sustainability.

Cross-case analysis

Our cross-case analysis indicates that the success of change management processes in LTCOs can be explained by the distinct combination of “make-it happen”, “help-it happen” and “let-it happen” change influences elicited during their course. As illustrated by Table 3, the successful and unsuccessful change processes were not distinguished by the presence or absence of the three types of change influence, but rather by their distribution across the five phases. While we expected that doing more would be more conducive to sustained improvements than doing less, this analysis highlights the significance of the interactions between multiple change influences. In both the falls and incontinence cases, which were unsuccessful, the three types of influence were engendered, but resulted in a poor level of engagement, mediocre efforts to change, a half-hearted sense of cohesion, and a sense of sluggishness. On the other hand, the constipation and restraints

programs showed that each type of change influence must be integrated in a winning combination to reveal its singular value. In the successful cases, "let-it happen" influences promoted creativity, allowed adaptation of the programs to each individualized setting, and encouraged engagement of the end users; "make-it happen" influences orientated the change efforts and showed the change users that the LTCO had an unwavering commitment to quality improvement; and "help-it happen" influences offered technical, social and motivational resources to the change users for engaging in the change process. The complementary interactions between "make-it happen", "help-it happen" and "let-it happen" change influences in turn created the senses of urgency, solidarity, intensity and accumulation that propelled the successful change processes forward to completion.

Urgency to change was created by simultaneously disturbing the change users' routines through the communication of firm change intentions (*make-it happen*) and providing them with the autonomy to use their expertise to find solutions (*let-it happen*). As one change user described, "There was a vision from above. That was step one. Then there was the identification of a particular pilot team. That was step two. The pilot team said: 'Let's challenge ourselves and prove that we can find a way to make it work. Let's try to put new practices in place see if we can succeed in changing one case at a time.'" [CU] In the unsuccessful cases, the inability to pair change intentions to opportunities to contribute resulted in a feeble tension for change.

Table 3. *Synthesis of the Change Management Influences Elicited During Each Phase of the Change Processes*

Program	Initiation	Development	Communication	Implementation	Sustainment
Falls (failure)	Make-it	Make-it	Let-it	Let-it Help-it(x2)	Let-it
Constipation (success)	Let-it Help-it(x2)	Let-it Help-it Make-it	Make-it Help-it	Make-it(x2) Help-it(x3) Let-it	Make-it (x2) Help-it Let-it
Incontinence (failure)	Make-it	Make-it	Let-it	Let-it Help-it	Let-it
Restraints (success)	Make-it Help-it	Make-it Help-it Let-it	Make-it Help-it Let-it	Make-it(x2) Help-it(x3) Let-it	Make-it Help-it Let-it

Solidarity was fostered by establishing directive (*make-it happen*), participative (*let-it happen*) and supportive (*help-it happen*) influences to ensure timely and complementary contributions for troubleshooting and problem solving. Change users reported feeling valued in this process and adamant to contribute to what they conceived as a common and worthwhile goal: "We all worked together; we wanted to do it. It was important for all of us; it was important to do it for the resident. It was a success because we were a team." [CU] By pushing down their change intentions and essentially relying on the good will of the change users, the change managers of the unsuccessful cases instead prompted the change users to experience a sense of abandonment.

Intensity was fueled by ensuring a heightened level of change management interventions (*make-it, help-it, let-it happen*) across the change process, but notably during the outmost important implementation period. This intensity served to clearly distinguish between the "before" and "after" program: "Everyone was focused on one thing and one thing only and that really made the program stand out, it really got us excited and involved in it!" [CU] This intense period of

oversight was necessary for extraordinary efforts to be devoted to the change process and for the change users to gain a sense of confidence and competence in their ability to run the new program. Conversely, the minimalist strategies put forward in the unsuccessful cases led their respective change objectives to gather feeble amounts of "change energy" and thus to fade away from their LTCO's crowded change agenda.

Accumulation was engendered by favoring change management interventions that were more effective at building on the strengths of the change users (*let-it and help-it happen*) than confronting their limits (*make-it happen*) early in the process: "We found more and more practical ways of doing things. The more we found solutions to problems, the more time we had to focus on new ways to improve the program." [CU] These cumulative and incremental gains in experience built a solid foundation to support an ongoing and dynamic organization-wide commitment to change. By opting for a reverse approach, that made things happen before changing abruptly to letting them happen, the change managers of the unsuccessful cases led change users to view the new practices as inadequate and to feel disrespected.

The successful cases also demonstrated that an appropriate change management strategy can overcome contextual challenges. In the restraints case, the lack of initial buy-in was addressed by prolonging the initiation of the project until everyone was convinced of the necessity and legitimacy of the process. In the constipation case, the program was spearheaded by the younger members of the personnel, who were encouraged to learn by trial and error and perfect the program before boasting its success to the older employees. Conversely, in both unsuccessful cases, the innovative programs were "left to disappear" when other newer programs took on precedence.

Discussion

In contrast to other literature pertaining to change management in LTCOs, our study did not produce a list of favorable factors to change or a recipe of change management interventions. Instead, the cases explored in this manuscript uncovered four potentially active ingredients of successful change processes conducted in LTCOs. While future research methods are needed to measure and ensure the fidelity of implementation of these dynamic ingredients across different long-term care organizations, concepts developed in the wider field of organizational studies lend credibility to our results.

The need for a sense of urgency to accompany the introduction of a new program can be compared to the concept of "creative tension" drawn from the theory of the learning organization (Senge, 1990). Creative tension contends that a change process should be experienced as an opportunity to close the gap between an unfavorable current reality and an enticing future state. The value of solidarity rather evokes the concept of "team learning" proposed by the same theory (Senge, 1990). Team learning occurs when the energy of colleagues is aligned towards a common objective, when the sum of resources at a team's disposition is greater than the sum of resources of its individual members. The importance of creating a sense of intensity is implied by Friedberg (1997) who advises organizations to undertake change initiatives one at a time to prevent dispersing their "slack resources" (Simon, 1997). The concepts of "short term wins" and "consolidating improvements" (Kotter, 1995), which advance that experiences from early successes create the competence and confidence to progressively tackle bigger problems, sustains the potential validity of the accumulation concept. In more general terms, the idea that various types of change management interventions will only reveal their potential when combined with adequate complementary interventions is supported by Friedberg (1997) who posits that the

potential of any change technology to energize a change process depends on the measures that accompany it.

From the specific perspective of LTCOs, we believe our results can be considered as good news for change managers. Our cases suggest that lasting improvements can be achieved without supplementary resources when the full potential of resources at hand is mobilized. The successful change strategies allowed frontline caregivers, professionals and managers alike to put their knowledge and competencies to the service of the change processes. Favoring the contribution of the various stakeholders of a given change process to the extent of their competencies was favorable to prompt the "organizational respect" (Ramarajan, Barsade & Burack, 2008, p. 4) required for their engagement. Such inclusive approaches allowed respecting change users, but also developing the most efficient means of reaching change intentions (Friedberg, 1997; Rosenfield & Branch, 2005). In this view, the central role of change managers becomes the identification, solicitation and exploitation of the pertinent pools of expertise contained within their organization. Seeing people as a way of solving organizational problems rather than as sources of the problems needing to be more rigidly controlled (Iles & Sutherland, 2001) appears to be essential in LTCOs. As highlighted by our cases, fostering contributions from the various stakeholders of a change process may be insufficient; their interactions outside of their respective horizontal and vertical silos could be even more important. Only through such interactions were senses of urgency, solidarity, intensity, and accumulation elicited to create sufficient dynamism to plow though forces of inertia.

Finally, the notion that contextual attributes cannot exclusively explain the outcome of a given change process is supported by the variable size and mandate of the participating LTCOs. Success and failure was achieved in large and small facilities dispensing care to residents requiring

more and less care. The contrasted outcomes and change dynamics that characterized the successful and unsuccessful cases appeared to be the product of change strategies that were more and less adapted to their context. Success in the 387 bed facility was achieved incrementally over a period of many years while success was achieved more drastically in the 124 bed facility in approximately one year. These variable timeframes resulted from change management strategies that considered the favorable and unfavorable elements of their context.

Implications for Practice

We believe that change managers could benefit from planning a change management strategy when considering implementation of a new clinical program. Implementation of a new program is a complex process that requires so much more than evidence-based clinical guidelines. Integrating the concepts of urgency, solidarity, intensity and accumulation in this planning phase could help create momentum. Instillation of a sense of urgency during the introduction of a new program, creation of a sense of solidarity and intensity during implementation, and the continuous planning of cumulative gains to stimulate sustained improvements appear to be well-advised. Flexibility in the application of the change strategy should also be considered to adapt it to emerging contextual challenges. Achieving a fine balance between “make-it-happen,” “let-it-happen” and “help-it-happen” influences is key so that the strengths and contributions of the change users will not be undervalued, nor left to evolve without managerial support. The timely involvement of all stakeholders in a LTCO represents an effective method for leading a truly dynamic change process.

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Discussion supplémentaire

Les résultats de cet article exposent que l'amélioration est possible en OHSLD lorsqu'un objectif de changement est soutenu par une stratégie de gestion du changement permettant de générer suffisamment de dynamisme pour ployer les forces d'inertie propres à un contexte donné. Une stratégie de changement propice à générer ce dynamisme serait composée d'interventions de gestion conjuguant trois types d'influence, soit « make-it happen », « help-it happen » et « let-it happen », telles que formulées par Greenhalgh et ses collaborateurs (Greenhalgh, Robert, Macfarlane, Bate, & Kyriakidou, 2004). Les interactions entre ces trois types d'influence stimuleraient des sentiments d'urgence, de solidarité, d'intensité et d'accumulation de compétences chez les acteurs devant changer leurs pratiques pour permettre l'atteinte d'un objectif de changement. Ces résultats peuvent être discutés plus amplement que dans l'article lui-même à la lumière de deux thématiques, soit l'influence déterminante des stratégies de gestion du changement et la composition des stratégies de gestion du changement bénéfiques.

En ce qui a trait à l'influence déterminante des stratégies de gestion sur les résultats de processus de changement, celle-ci fût notamment exposée antérieurement par (Friedberg, 1997; Kitson et al., 2008). Pour ceux-ci, la stratégie de gestion du changement est ultimement responsable de la qualité de l'enracinement de nouvelles pratiques requises à l'atteinte d'un objectif d'amélioration dans un contexte d'action donné. Dans notre article, la prépondérance de l'influence de la stratégie de gestion du changement est associée à sa capacité à générer suffisamment de dynamisme pour ployer les forces d'inertie d'un contexte et s'inscrit ainsi dans le sillon de théories fondatrices de la gestion du changement (p ex. Kanter, Stein, & Jick, 1992;

Lewin, 1951). L'importance de l'adaptation de la stratégie de gestion du changement à des particularités contextuelles soutenue par nos résultats est aussi appuyée par Friedberg (1997). En effet, il soutient que l'inadaptation d'une stratégie de changement à la structuration d'un champ doit être blâmée lorsqu'un changement prend une autre direction que souhaité initialement. Une synthèse des leviers favorables au changement dans les organisations de santé, réalisée récemment par Lévesque et Sutherland (2017), appuie aussi la valeur de l'adaptation locale des stratégies de changement en affirmant la valeur d'une planification sensible aux éléments facilitateurs et aux obstacles d'un contexte.

Deuxièmement, nos résultats valident que le contenu des stratégies de gestion du changement bénéficie de l'inclusion d'intervention de gestion soutenant trois types d'influence, soit « let-it happen », « help-it happen » et « make-it happen ». Par exemple, l'inclusion d'une forme d'adaptation locale, de coaching et de supervision à une même stratégie de gestion du changement serait avisée. Ce résultat appuie des recommandations associées à des études réalisées en OHSLD (p ex. Shanley, 2007a) et en d'autres contextes. Les travaux de Lévesque et Sutherland (2017) ajoutent à la valeur de cette conceptualisation en indiquant que la pression au changement peut prendre la forme de *« hugs, nudges and shoves* » (p.8) ou, écrit autrement, d'interventions ayant comme fonction de soutenir, d'encourager et de bousculer [traduction libre]. La relation interactive des interventions de gestion incluses à une stratégie de gestion du changement soulignée par notre étude est aussi appuyée par ces deux auteurs. Ils écrivent :

> *« a lever rarely operates in isolation—any system, organisation or healthcare professional is subject to multiple levers simultaneously. Meaningful and sustained change is more likely*

to be secured when different levers work in concert—aligning and reinforcing efforts to improve. » (Levesque & Sutherland, 2017, p. 5)

Ils expriment qu'il est du rôle des agents de changement de bien évaluer la fonction des différents leviers utilisés pour faire émerger un changement souhaité et de coordonner leur mise en œuvre. La contribution idiosyncrasique de notre article vise à soutenir ce travail par l'identification de quatre sentiments favorables émanant de combinaisons gagnantes. L'urgence, l'intensité, la solidarité et l'accumulation de compétences se révèlent ainsi comme des cibles à viser prioritairement par les agents qui élaborent les combinaisons et séquences d'interventions de gestion propres aux stratégies de gestion du changement. Ces quatre sentiments peuvent donc être considérés comme antinomiques aux sentiments communément associés au phénomène de résistance au changement (p. ex. anxiété, incertitude, perte de contrôle, etc.) (Carney, 2000). Nos résultats se distinguent également par l'exposition de la capacité interne des organisations à mettre en œuvre différents types d'intervention de gestion et à générer les sentiments mobilisateurs. Alors que Levesque et Sutherland *(2017, p. 5)* indiquent que : « *it would be difficult for a single organisation to have both the internal capacity and the external credibility to operate in a supportive facilitator role and simultaneously act as a coercive 'watchdog' that penalises poor performance »* notre étude démontre que les agents de changement peuvent y arriver "by-design". Par exemple, dans les deux cas de succès que nous avons documentés, les influences "make-it happen" ont été générées localement par un engagement ferme de la direction à réaliser leurs objectifs d'amélioration et la supervision des effets des changements de pratiques attendus. Ainsi, bien que nous convenions qu'il est éclairé pour les agents de changement d'une organisation de mettre à profit des leviers de changement générés par d'autres entités de leurs environnements (p

ex. : syndicats, organisations réglementaires, etc.), nos résultats montrent que des dispositifs coercitifs, de soutien ou d'émergence peuvent être déployés de l'interne.

En somme, nous considérons que les résultats de ce premier article contribuent à valider certaines connaissances issues de l'étude des OHSLD et de la gestion du changement tout en proposant certaines contributions originales qui méritent plus de recherche. Les quatre sentiments, identifiés comme les ingrédients actifs de stratégies de gestion de changement fructueuses, mériteraient notamment d'être étudiés dans d'autres contextes organisationnels. Si ce premier article expose que le changement significatif et pérenne est possible en OHSLD quand une stratégie de gestion du changement appropriée est utilisée, il ne contribue pas à la compréhension des difficultés généralisées des OHSLD à s'améliorer. Le second article de cette thèse a comme fonction de répondre à cette interrogation en proposant une explication à l'indisposition récurrente des OHSLD à élaborer et déployer des stratégies de gestion du changement plus adéquates.

Deuxième article

L'étude présentée dans ce second article engagea l'objectif de comprendre les fondements de l'incapacité reconnue des CHSLD à s'améliorer significativement ainsi que leur maintien durable dans un cercle vicieux de sous-performance. Pour y arriver, une recherche-action portant sur le processus d'engagement d'intentions d'amélioration fut réalisée en collaboration avec un regroupement de CHSLD. Cette recherche-action permit d'exposer les déterminants systémiques de l'indisposition des CHSLD à recourir à des modalités de gestion reconnues favorables à l'amélioration. Ce travail mena à la rédaction d'un article soumis pour publication au *Canadian Journal on Aging* en octobre 2017 et intitulé : « Improvement Engagement as a Prism to Rethink the Fundamental Inhibitors of Quality Gains in Long-Term Care Organizations ».

Improvement Engagement as a Prism to Rethink the Fundamental Inhibitors of Quality Gains in Long-Term Care Organizations

Abstract

Background and objective: Long-term care organizations (LTCOs) have been repeatedly described by scientific literature as inept at generating quality improvement and indisposed to use change management principles. This study aims to explain the general improvement inability of LTCOs by focusing on the precursory phase of their improvement processes.

Methods: An action research with a semi-private LTCO located in Quebec, Canada, was conducted.

Results: Four types of improvement engagement activities were described: 1) authoritarian and disconnected impulsion; 2) intuitive and technical concretization; 3) partial and symbolic diagnosis; and 4) content and communication-focused development. The form of these activities was correlated to a tacit improvement governance system which stemmed from the LTCO's interactions with its internal and external environments.

Discussion and conclusion: In contrast to many studies of improvement in LTCOs, this study identifies systemic dynamics as the fundamental inhibitor of improvement, one that is more considerable than the lack of resources.

Keywords: nursing home, change management, organizational theory, organizational development, governance, action research

Background and Objectives

The immense pressure to improve faced by LTCOs has not led them to reach contemporary expectations (Hockley, Harrison, Watson, Randall, & Murray, 2017; Shura, Siders, & Dannefer, 2011) or to significantly increase their capability to improve (Levenson, 2009). Unlike most organizational improvement processes (Burnes & Jackson, 2011), the ones applied in LTCOs provoke underwhelming results, produce unintended negative consequences, simply fail or are not even evaluated (Johnson, Ostaszkiewicz, & O'Connell, 2009; Masso & McCarthy, 2009; Shanley, 2007a). These failures have been associated with the disposition of healthcare organizations (Bero et al., 1998) and LTCOs (Aylward, Stolee, Keat, & Johncox, 2003; Stolee et al., 2005) to solely employ communication devices (i.e. training sessions, educational pamphlets, etc.) to support their improvement intentions. Such minimalist change management strategies are recognized as conducive to partial gains in LTCOs (Etheridge, Couturier, Denis, Tremblay, & Tannenbaum, 2014), as in other types of organizations (Kitson et al., 2008). Change management strategies that encompass multiple and complementary managerial devices ranging from "making things happen" to "letting things happen" are rather recommended (Etheridge et al., 2014; Masso & McCarthy, 2009; Shanley, 2007b). LTCOs can thus be conceived as struggling to utilize relatively common managerial knowledge to increase their capability to improve. Many studies done on LTCOs focus on contextual attributes to explain these change management defaults. Lack of financing, inadequate regulatory requirements, lack of qualification and high turnover are notably pointed out as fundamental obstacles (Koren, 2010; Ragsdale & McDougall, 2008; Shanley, 2007a). However, knowledge is lacking on the "immediate and more distant antecedents" (Pettigrew, 1990, p.285) that give the change management strategies deployed in LTCOs form, meaning, and substance. To our knowledge, no prior work has specifically studied the precursory phase of

improvement processes in LTCOs to understand the contingencies in which take root their improvement intentions and the means developed to realize them. Therefore, this study intended to understand how LTCO's engage improvement processes by:

1) Characterizing the activities associated with improvement engagement processes in LTCOs;
2) Explaining the determinants of the characteristics of improvement engagement processes in LTCOs.

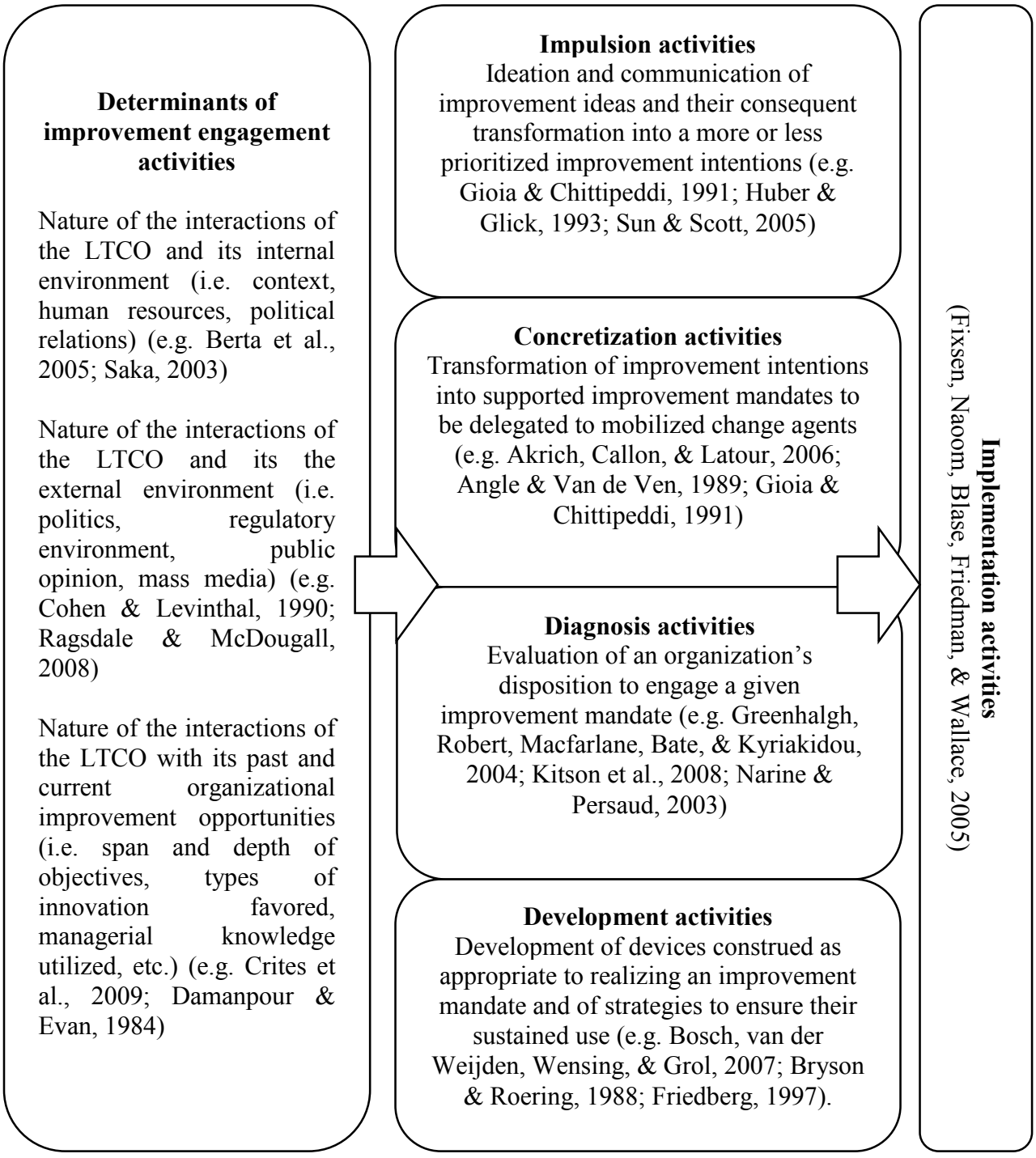
Conceptual Framework

A conceptual framework based on a literature review was elaborated to orientate this study. The review aimed to retrieve literature pertaining to the engagement of improvement processes, i.e. to the precursory phase of organizational improvement processes. Activities commonly carried out prior to implementation, which can be defined as the "specified set of activities designed to put into practice an activity or program of known dimensions" (Fixsen et al., 2005, p. 5), were considered as such. The key words "improvement engagement" and "change engagement" did not allow the collection of any pertinent material. The key words "change initiation" coupled with a snowball method allowed identifying 30 pertinent documents. We nevertheless opted to conserve the term "engagement" in the framework as it represents a *characterizable period* in contrast with the term "initiation" which represents an *objective moment*. We also preferred the term "improvement" to the term "change" as organizational change efforts rationally aim to produce improvement rather than change. As no literature specifically focused on improvement engagement in LTCOs was retrieved, a research using the key words "nursing home or long-term care or residential aged care" as contextual identifiers coupled with the key words "change

management" (91), "organizational development" (25) and "decision-making" (19) allowed the identification of an additional 135 documents containing pertinent material.

The analysis of the 165 retained documents enabled the construction of the components of the framework, which are "determinants of the improvement engagement activities" and "improvement engagement activities" (Figure 1). The first component of the conceptual framework is comprised of three potential determinants of the nature and form of improvement engagement activities. Identifying these potential determinants required distinguishing them from determinants of general organizational performance. The gathered literature was thus scrutinized in order to identify organizational dimensions that influence the onset of improvement processes and that can be acted upon during this process. For example, structural design, organization size, workforce stability, availability of financial resources and organizational culture were described as influential on the improvement engagement by reviewed literature, but were not retained, as they were not specifically associated with the onset of improvement processes or malleable during the engagement process. The second component is rather comprised of four types of activities: impulsion (e.g. identifying an improvement need), concretization (e.g. delegating an improvement mandate to manager), diagnosis (e.g. identifying potential obstacles) and development (e.g. developing a training program).

Figure 1. Conceptual Framework



Research Design and Methods

An action research in collaboration with a semi-private LTCO that encompasses multiple facilities was conducted. Having adopted an interactive research approach (Svensson, Eklund, Randle, & Aronsson, 2007), the study aimed to produce actionable knowledge more than to generate concrete transformation. To do so, the study's first author acted as an action researcher and integrated the LTCO with the explicit objective of accompanying them in engaging an improvement process of their choice. The researcher's integration into the LTCO debuted with the direct observation of a corporate level meeting, which served to orientate the rest of its research path. Other than direct observation (Peretz, 1998), work sessions with a project team (Svensson et al., 2007), semi-structured individual interviews concerning themes associated with the conceptual framework and emerging themes (Rapley, 2004), documentary analysis (Cellard, 1997) and a feedback session (Friedberg, 1997) were used to collect data (Table 1). The action research lasted 18 months and led the researcher to collaborate with the three levels of management that were involved in improvement engagement processes. These levels are the corporate level (i.e. directors overseeing activities of all establishments), facility level (i.e. directors and managers overseeing the activities of a group of facilities) and practice level (i.e. middle managers overseeing the activities of a subunit of a single facility). The action collaboration consisted of the assistance of one project team in engaging a process that aimed to improve the welcoming and integration of new residents. This improvement intention was chosen by the LTCO for reasons detailed in the results section. The researcher's role during the team's work sessions was to experience the engagement activities, observe emerging conflicts and difficulties, as well as to stimulate reflection amongst the team members in regards to said conflicts (Albinsson & Arnesson, 2010).

Table 1. *Data Collected at Each Management Level*

Corporate level	Direct observation: 1 corporate meeting (2 hours of field notes) Interviews: 5 recorded and transcribed interviews of 1.5 hours Feedback session: 1 recorded session of 2 hours Documentary analysis: content analysis of organizational plan, strategic plan, etc.
Facility level	Direct observation: 8 regional meetings (16 hours of field notes) Interviews: 11 recorded and transcribed interviews of 1.5 hours Work sessions: 9 project team sessions (18 hours of field notes) Documentary analysis: content analysis of yearly lists of improvement objectives
Practice level	Interviews: 8 recorded and transcribed interviews of 1.5 hours

The data analysis was guided by the concepts presented in the conceptual framework (Miles & Huberman, 1994). The framework oriented the production of conceptual codes and sub-codes, as well as relationship codes to define the correlation between improvement engagement activities and their potential determinants (Bradley, Curry, & Devers, 2007). Our intent was to produce a middle-range theory (Merton, 1968) that offered insight into the fundamental inhibitors of improvement in LTCOs by focusing on the onset of improvement processes. Coding of the data and line-by-line checking was conducted by the action researcher and checked by the second author (Miles & Huberman, 1994). The discrepancies between "espoused-theories" (principles and values people believe their behaviour is based on) and "theories-in-use" (principles and values implied by peoples' behaviour) represented the primary approach to analyze the data (Argyris & Schon, 1974; Denis & Lehoux, 2009). Theories-in-use were principally uncovered by the work sessions and direction observation, but also by fitting descriptions provided by interviews. The following results section is composed of four subsections, which include written descriptions and in-quote citations. Table 2 triangulates data from work sessions, direct observations, documentary analysis and interviews.

Results

The LTCO's Ability to Generate Improvement

Espoused-theories depicted the LTCO as having made giant strides in recent years: "*Today, we don't have four pages of flip charts [of improvement intentions]. The organization has been radically transformed*" (regional level). Their proponents affirmed that structural improvements (i.e. policies, programs, guidelines, job descriptions, etc.) were needed, accomplished and allowed general quality gains. This view was endorsed by the LTCO's accreditation with honours by a publicly mandated accreditation agency during the data collection. Theories-in-use rather highlighted the frequent disconnections between what is documented and done stemming from strictly top-down communicative implementation strategies: "*Some managers say: 'Yes, it's done. I gave it to my team.' But it's done very partially and superficially, without any serious follow-up, without it being implemented in real life, without it becoming a real change"* (practice level). Theories-in-use thus advanced the LTCO had the capability to produce diffused quality gains, but would be generally incapable of producing significant and lasting improvements. The outcomes of many improvement intentions were described as "*not integrated*" (regional level), "*a float*" (practice level), "*in vegetative states*" (regional level) and needing to be "*recuperated*" (corporate level) or "*reactivated*" (corporate level). In sum, the LTCO was characterized by an important gap between its ability to structurally, and thus, apparently improve and actually improve. The next section will describe the improvement engagement activities that appear to be at the source of this conjuncture.

Description of the Improvement Engagement Activities

Our results characterized and validated the existence of the four types of improvement engagement activities presented by the conceptual framework.

Espoused-theories regarding the impulsion activities highlighted their close ties to the reality of their organizations. They were defined as a prerogative of the top-level actors of the LTCO, but also as rooted in the reality of its practice level: *"I bring our daily realities to the corporate level and it's with them that we agree upon priorities. Everything is linked together* (regional level). Yearly meetings with caregivers and the production of quality indicators (i.e.: number of falls, cost of medical equipment, etc.) would favour the impulsion of improvement intentions that are grounded in the reality of the practice level. Conversely, theories-in-use stressed that the improvement intentions generated at the top of the LTCO were much more consistently prioritized, engaged and associated with resources than ideas sprung from its bottom. Practice level actors expressed feeling an important gap between the intents of their improvement priorities and the ones engaged by the LTCO. Many issues considered as significant nuisances from the perspective of middle managers, notably high turnover amongst caregivers, inefficient recruitment procedures, hazardous work organizations and discontinuous communication, would remain unaddressed or recurrent. The nature of the improvement intentions engaged by the LTCO would generate a sense of incoherence and frustration: *"I try to do what the resident wants, but we are working in the opposite direction. I look at my day and it's more and more orders from the top: `Hey! I work for the residents, not for you!`"* (regional level). In sum, the impulsion activities were characterized as authoritarian and disconnected from the primary needs of the residents or the fundamental deficiencies of the LTCO.

Espoused-theories identified the concretization activities as oriented by the intuitive aim of creating the best pairing of improvement intention and change agents. Important efforts would consequently be devoted to ensuring the intentions are clear and their change agents dedicated. Multiple checkpoints, notably monthly statutory meetings and performance appraisal meetings, would be put in place to ensure the agents are imputable. An important sense of responsibility and accountability would be generated: "*If we write it in our plan, we have an agreement, we are signing a check, we have a deliverable. It makes us responsible, as a team"* (regional level). Theories-in-use confirmed the intuitive nature of the concretization activities, but rather emphasized the difficulties they entailed. The most common concretization difficulties would concern the clarity of the improvement intention and role distribution. Moreover, most improvement mandates would be delegated without precise means of monitoring or evaluating their realization: *"It's not normal, I've been in business a long time and you must measure everything, you must be aware of everything that is happening. Here, we trust people because they are professionals? Professional does not mean anything!"* (regional level). The activities utilized to transform improvement intentions into improvement mandates would leave change agents perplexed and disengaged. In sum, the concretization activities were characterized as intuitive and technical, as they mostly occulted their mobilization function.

Espoused-theories regarding the diagnosis activities described them as essential and consistently carried out: *[The middle manager] must be convinced he can mobilize his troops, because he has little turnover, because his people expressed: 'It's not working anymore, we have to do something about it!' He must grasp that momentum"* (regional level). From this view, insight provided by informal questioning, audits, surveys and various indicators would be analyzed before deciding to engage an improvement mandate. Theories-in-use seemed to communicate the

randomness and casualness of the diagnosis activities. Lack of knowledge on how to perform them and a general indisposition to communicate deficiencies or limitations would engender diagnosis defaults: *"Obviously, we won't tell them it's impossible, that's what you cannot say, OK? Because even though their demands are unrealistic, we have to collaborate"* (practice level). More importantly, many participants expressed that the results of potential diagnosis activities would not be sufficiently valued to overturn a corporate level decision to engage a given improvement intention: *"Unfortunately, we don't do prior analyses, but it would be interesting to do so. That being said, it wouldn't change our orientations"* (corporate level). Diagnosis activities would be inadequate to highlight obstacles and adapt change management strategies accordingly: *"Now, we are back at our starting point, but prior to the changes, at the base, we frequently said: 'No, it makes no sense…'"* (practice level). In sum, the diagnosis activities appeared to be partially and symbolically conducted as the top-down pressure to improve would lead diagnosis activities to be neglected or their results to be disregarded.

Espoused-theories described the development activities as concerning the development of multidimensional implementation strategies. These strategies would frequently encompass the diffusion of information and training sessions, but also participative management devices: *"I go on the floor, I talk with the nursing assistants, I ask questions, I try to understand, so they see that I considered their perceptions, their opinions. I do that at every change"* (practice level). Theories-in-use described the development activities as essentially informal and focused on the content of the improvement devices: "*When we want to plan a change, we also have to plan how we will make it happen. If we only plan what we're aiming for without planning how we will get there, we are way off the track!*" (regional level). Most improvement devices would be developed by groups of change agents using information drawn from other LTCOs' experiences, scientific literature,

but rarely by consulting potential change users. Improvement devices would thus frequently be perceived as inappropriate: *"I aim for the best practices, but I think that we also have to be able to integrate them in simple processes. Now, our procedures are thick like this!"* (regional level). In sum, the development activities were characterized as focused on content and communication as they appeared to be conducted by change agents who considered that prescribing sophisticated new practices equated to their actualization.

Determinants of the Improvement Engagement Activities

The results suggest that the three potential determinants of the improvement engagement activities identified by the conceptual framework, did influence the nature of the improvement engagement activities in the LTCO, but did so through an "in-use" set of principles and values that fundamentally orientate the engagement of improvement intentions. We defined them as forming a tacit improvement governance system rooted in the LTCO's relationship with its external environment and internal environment. The nature of these relationships is defined in the current results section while the tacit governance system is described in the last section.

Table 2. Triangulation of the Data

	Work sessions	**Observation and documentary analysis**	**Interviews (Theories-in-use)**	**Interviews (Espoused-theories)**
The LTCO's Ability to Generate Improvement	The project of improving the welcoming and integration of new residents was not considered as a new endeavour by the project team members. Multiple previous attempts would have failed to generate improved practices.	A group of corporate level directors initiated a tour of their establishments to expose their difficulties to "consolidate improvements" and to encourage employees to "bring to life" the structural improvements achieved in past years.	*"We make the change, but at what cost and how well is it really done? If we would manage change properly, involve people and all that, we could progress step by step. Now, we do it to do it, to check it off our list, rather than doing what we should do."* (facility level)	*"Our organization is completely different from what it was 7 or 8 years ago. In terms of quality of care, we developed guidelines and procedures. It's documented. Our personnel's training is much improved. (…) We have rigorousness."* (facility level)
Impulsion Activities	The intention to improve the welcoming and integration of new residents was formally identified as an improvement priority by the corporate level. The attention to this topic followed its identification as a deficiency by the Ministry of health and social services and the accreditation agency.	A facility-level meeting held at the end of the year served to identify improvement objectives for the coming year. While all middle managers participated, the meeting essentially aimed to communicate the improvement intentions set out by the corporate level.	*"I don't think we start from the individual, we start from the big ideas, the big ideologies and we descend to the individual. We should start at the individual level, look at what is going well, and then take up other things."* (practice level)	*"We go on yearly retreats with all the managers and people that have an influence on our organization to talk about the improvement priorities we want to put forward during the coming year."* (facility level)

Concretization Activities	The project team did not understand the finality of the mandate it was given and some of its members did not understand the value of their involvement. Team members spent multiple meetings debating the width and depth of the improvement mandate. Our advice to carry out a mapping of the welcoming and integration process was not upheld.	During a monthly management meeting, multiple participants criticized not being solicited to participate towards the improvement of the welcoming and integration of new residents.	"*Sometimes, it's like the momentum is not there. Sometimes, you don't have the right people in the right place. Other times, the need to change is not felt by the people at the base or what is expected is not clear enough."* (corporate level)	*"Come to think of it, we ask ourselves who is the best person to reach this objective with the resources on hand. (…) For collaborators, it's pretty much all the people that gravitate around the issue, they must absolutely be involved in the process."* (facility level)
Diagnosis Activities	Informal and imprecise data collection means to describe current welcoming and integration practices were used. Proposals to structure and expand the aim of the diagnosis (i.e. conduct focus groups with residents and family members, conduct a process mapping, etc.) were not upheld.	During our data collection, a facility-level team applied a project aiming to implement a standardized menu for the residents. While multiple difficulties arose during the conduct of the same project in another region, the project was launched using the same change management strategy.	*"It's like they never expect there will be a surprise behind the wall, it's like we expect to take down the wall and everything will be perfect: 'No! We know something always happens, something is always missing…' It's like it's always something new, but it's always like that each time we make a change.*" (facility level)	*"I appraise the situation, I submit my thoughts and I say: 'Listen, we have a decision to take. Do we go ahead with it? Are we ready? Do we have momentum?'"* (facility level)

Development Activities	The project team was overwhelmingly concerned with the content of the device (i.e. handing a FAQ document to new residents, associating new residents to specific nursing assistants, etc.). The outcome of the development activities was thus a new welcoming and integration program to be made available to caregivers in binders to be left at nursing stations.	Data from our observations and documentary analysis revealed the frequent use of the term "communication plan" to represent change management strategies. This terminology symbolizes and orientates the development activities towards the planning of essentially communicative efforts.	*"Often, we do things in half-measures and that's why it doesn't work: 'Oh, yeah, that thing, we gave it, yes.' But `giving` is nothing, you must coach, support, manage, repeat, follow-up…"* (facility level)	*"When we have time, all the planning is not done by a single person alone in her office. It can start at our level, but after it will include managers of all levels and the frontline employees."* (facility level)
Nature of the Interactions of the LTCO and Its External Environment	During the welcoming and integration process, the preparation for the accreditation evaluation was frequently identified as a reason to postpone work sessions. At its tail end, it rather pushed the project team to devote time to the project, but also to botch their work to produce a new program in time.	Preparation efforts to the accreditation essentially aimed to rapidly update or produce programs and guidelines, inform employees of their existence and instruct employees to answer potential questions on their content. All means appeared legitimate to prevent "raising red flags at the Ministry" (facility level).	*"We add pressure on ourselves not to find ourselves in the media, because of the media and new ministerial expectations. And then you say: 'Some of the changes I couldn't do now, I will be forced to do them because if I don't, I may end up in the hot seat, with some reports becoming public…'" (*facility level*)*	*"We give ourselves values, a mission, a vision, so we don't need ministerial, accreditation or any other norms, but some norms or tools are helpful to put some things in place. We also have processes, mechanisms, training associated with the accreditation, but we would put them in place anyways."* (corporate level)

Nature of the Interactions of the LTCO and its Internal Environment	Our recommendations to improve diagnosis operations during the welcoming and integration improvement process were not upheld, as some team members feared caregivers or family members participating in focus groups could "rile themselves up" (facility level).	During multiple meetings, the ethnic diversity of the LTCO's workforce was portrayed as a source of conflict and change resistance. Managers appeared distraught by the situation.	*"As much as when the direction announces something the employees are defensive, when a proposition comes from the base, managers are like: 'What is happening? What do they want to gain?' Paranoia was developed, no one trusts anyone anymore."* (facility level)	*"For me, the nursing assistants are like organizational psychologists, because they are the closest to the residents. (…) Their input is highly valuable, we have to consider them a lot."* (corporate level)
Improvement Governance System	The sole outcome of the LTCO's decision to engage the intention of improving the welcoming and integration of new residents was an ostensible new program. Nevertheless, the project was estimated a success without measuring or auditing practice improvements. A facility-level director expressed: "*I can't believe we made it*!"	During an end-of-year meeting, a middle manager suggested not retaining any new clinical improvement objectives, as most previous ones were not actualized. The facility director responded that new clinical improvement objectives were mandatory, but added to the yearly improvement agenda the objective of actualizing all existing clinical programs.	*"If only you knew how performing we could be in a short period! Not on all of it. We start with this, we go at it hard and we keep at it until it's done. Then we take on another one. That is why our people are exhausted. They don't see the end of it and they say: 'Why did we do this? We don't even integrate it and then we ask us to do something else just for show?'"* (corporate level)	*"Follow-ups are organized, it's part of our culture. That's because we say to ourselves that we prefer digging deep. Because, if not, we scatter ourselves across all the programs and nothing lives on. (…) We really must make sure that the caregivers make it their own. It requires having communication structures, accountable managers…"* (corporate level)

From the perspective of the LTCO, its external environment was composed of multiple regulatory agencies (the Ministry of health and social services, an accreditation agency[1], an ombudsman, a coroner's office, a complaint commissioner and professional orders) and the mass media. The Ministry of health and social services and the accreditation agency were regarded as the most significant as they are the primary quality evaluators of the LTCO. Espoused-theories conceived the LTCO's interactions with these regulatory bodies positively, highlighting the structural and standardization gains they facilitated. Their influence would be beneficial to mobilizing the LTCO's improvement attention and resources. In this view, the evaluation activities conducted by the regulatory bodies were described as supportive of improvement efforts: *"It forces us to evaluate our processes because, often, we don't have enough time to do some things. It forces us to stop and say: `OK, let's take the time to rethink our global functioning'"* (regional level). From this perspective, the LTCO's preparation for the evaluation was deemed continuous and natural. Theories-in-use were much more critical of the influence of the LTCO's interactions with its external environment. Firstly, the deceitful nature of the LTCO's relationship with its accreditation agency was described: *"The accreditation makes me think of old times, when the school director showed up in class. Everybody had their pants well pressed and their hair well groomed, but as soon as he crossed the doorway, all hell broke loose!"* (regional level). Moreover, the eagerness of the mass media to report the negative events and the pressure of the government to avoid negative press would punctually lead the LTCO to adopt a crisis management mode and

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[1] In Quebec, Canada, the provincial Ministry of health and social services finances the clinical services supplied by semi-private LTCOs and defines a normative framework which must be respected and is supervised by a mandated accreditation agency.

drift away from its priorities. The lack of transparency that characterizes the LTCO's relationship with its external environment would blur its improvement priorities and diminish the tension to improve:

> *"How can things change if we never show our true face to the media, the government and all that? We always camouflage our reality. We make a nice little speech to our employees: 'The accreditation agency is coming. You must address the residents politely, you must do this, you must do that…' It's phony, but it's like that everywhere and everyone knows it, the Ministry included."* (regional level)

A cascade of negative consequences were associated with this relationship, notably the disengagement of improvement intentions internally judged important and the deployment of autocratic change management strategies. Organizational resources dedicated to answering external priorities would drain the LTCO's minimal slack resources and prevent it from gradually building actual performance. In sum, the LTCO's relationship with its external environment would be characterized as unidirectional and subservient as externally driven improvement intentions seemed to be considered priorities and strictly ostensible means of reaching them to be valued.

From the perspective of the LTCO, its internal environment would be composed of its human resources, residents and family members. Espoused-theories described the LTCO's relationship with its internal environment as highly influential: "*Our board of directors is very close to the reality of our installations. They are people who are concerned by the quality of the services received by our clientele*" (corporate level). Accordingly, the LTCO would be sensitive to the particularities of their internal context and the insight of their frontline employees would be

valued. Theories-in-use rather highlighted the disconnection of the LTCO with its internal environment: *"I find it utopian. I hear it all the time from other managers, they say: 'They do not have the means to fulfill their ambitions.' I'm fine with their ambitions, but I wonder if they are from another planet"* (regional level). The amount of improvement intentions engaged by the LTCO would scatter its minimal slack resources and render the deployment of proper change management strategies impossible. This incoherence between the heftiness of the improvement agenda, the demands of the usual workload and the slim resources available to carry them out would also foster human resources difficulties, notably high turnover rates of managers and caregivers. A general lack of confidence and communication would also mark the relationship of the LTCO with its internal environment, notably with caregivers, but also with family members:

> *"Our teams are disengaged, stressed and worried because the family members are more and more difficult. They say: 'We can't handle it anymore, we feel spied on, watched!' Some people have recorders, they record conservations sometimes, they take pictures. All that creates an unhealthy insecurity and a general paranoia"* (regional level).

A lack of transparency and honesty would also define the relationships of the LTCO's managers: "*During that committee, what some people are putting forward is nothing but smoke and mirrors. They say: 'Everything is fine', but we know it's not true"* (practice level). These politically motivated behaviours would not be apprehended as problematic, but rather left alone to avoid further confrontation. These power games, just as communication defaults with central stakeholders and high turnover rates, would be conceived as immutable and remain inadequately

addressed. In sum, the LTCO's relationship with its internal environment appeared characterized by a general disconnection and underinvestment that led to the underutilization of its resources.

Improvement Governance Systems

The tacit improvement governance system appeared to function remotely from a formal system made up of espoused managerial models and knowledge (i.e.: philosophies that promote resident and staff centeredness, a local quality management model that promotes integrated improvement efforts, change management training that stresses the importance of coaching and support, etc.). (Figure 2). The four following principles distinguished the tacit and formal systems:

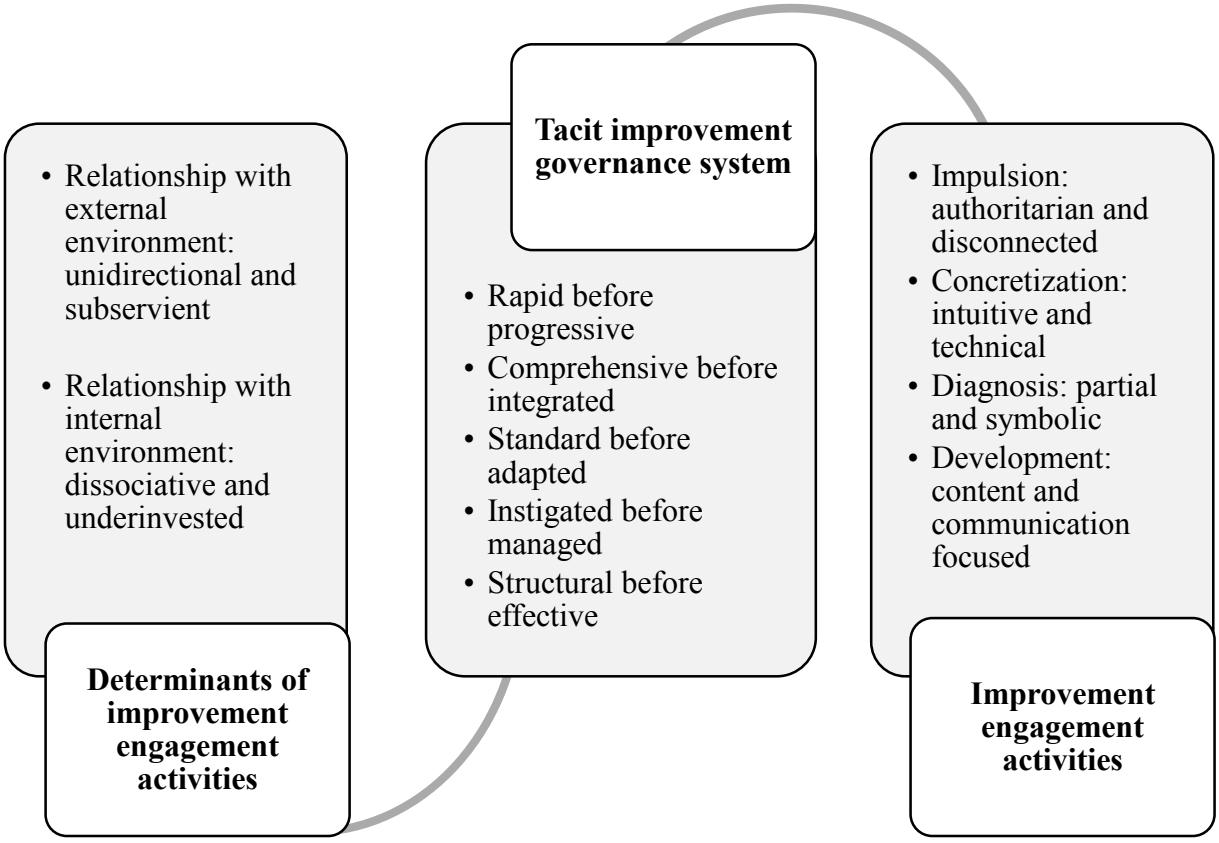
Rapid before progressive improvement. While the formal system valued a steady engagement of a limited amount of improvement intentions, the tacit system promoted the contrary: *"We cannot be taking baby steps because everywhere around us, giant steps are being made!"* (corporate level). Rapidly generating improvements would be owed to the LTCO's residents. This principle stimulated overcharged top-down impulsion activities and a disregard for the outcome of diagnosis activities: "*They are going 200 miles per hour, without looking at what is happening on the ground. It's very problematic. They suffocate us with documents, programs and all sorts of things to be implemented yesterday."* (regional level). In this sense, a regional actor suggested: "*When you think about it, what is so pressing? If we just want to improve, we should do it correctly. Truly, almost everything can wait…"*

Comprehensive before integrated improvement. While the value of ensuring integrated improvement was formally identified as a core organizational principle, the tacit necessity of generating all-embracing improvement seemed to prevent integration. Improvement intentions

would be engaged with minimal regards to similar projects conducted previously, to similar projects conducted in other organizations or to their potential effects on previous or future projects. This principle appeared to lead impulsion activities to be thought out in a temporal and contextual vacuum resulting in unmanageable improvement agendas. Concretization activities would be consequently conducted in a more technical, rather than motivational aim. Participants expressed the need to engage less improvement intentions, but to engage them as united teams: *"I understand what the food service manager does in a LTCO, but what are his projects exactly? And other managers'? Instead of working in silos, we should say: 'Hey! I work for this service and I'm interested in participating'"* (regional level).

Standard before adapted improvement. While the formal system promotes the benefits of allowing improvement engagement processes to be adapted to local and micro-local particularities (i.e.: staffing structure, management turnover, work climate, etc.), the tacit system opposed the possibility of stimulating uneven improvements: *"Two years ago, people chose one or two programs to apply in their region according to their interest. This year, we decided to impose programs because we noticed things were evolving unevenly"* (regional level). Standardization is conceived as a means of cultivating a sense of unicity across the organization, of developing the organization's credibility and of facilitating management. This principle would exacerbate the effects of the rapidity and comprehensiveness principles as standardization necessitates centralized impulsion and a disregard for local particularities emphasized by diagnosis activities. Participants expressed that help was needed in order to find balance between standardized and local improvement.

Figure 2. Linking the determinants of improvement engagement to the characteristics of improvement engagement activities



Instigated before managed improvement. The formal improvement governance system utilizes a yearly improvement agenda to tally retained improvement intentions and structure their monitoring and supervision. In reality, follow-up interventions would be irregularly conducted and lack of positive results remain inconsequential: *"If we don't reach them, there won't be any sanctions. We obviously try to reach our objectives, but sometimes, for reasons beyond our control, we are not able to"* (regional level). Moreover, most evaluation interventions would be imprecise and consider subjective information as fact. This principle appears to allocate more energy and resources to impulsion activities than to the three other types of engagement activities. Dedicating more efforts to the management and supervision of the outcomes of instigated improvement mandates was recommended: "*What is happening with the shareholders? Are they sleeping or*

what?' If it was my money, I would go to see what is happening behind the curtains, I would stop trusting what this guy or that guy was telling me" (regional level).

Structural before effective improvement. While the formal system promotes engaging improvement intentions until potential change users internalize the value of improvement devices and utilize them routinely, its counterpart suggests that structural improvement is a prerequisite to more in-depth change: *"Now that we got our heads out of the water [in terms of program development], we can try to aim for actualization. We want to support our teams, especially our nurses, so they can make the concepts their own"* (regional level). This principle appears to encourage the development activities to focus on elaborating sophisticated improvement devices and means of communicating them. Developing improvement devices that are adapted to the needs of potential change users and change management strategies that are beneficial to their routinization was rather called for.

Discussion and Implications

This study set out to understand the general improvement inability of LTCOs by focusing on how LTCOs engage improvement processes. To do so, its objectives were to characterize their improvement engagement activities and explain their determinants. An improvement process engaged by an LTCO was studied through an action research to highlight discrepancies between "espoused-theories" and "theories-in-use" regarding improvement engagement. The results identified and described four types of improvement engagement activities: 1) authoritarian and disconnected impulsion; 2) intuitive and technical concretization; 3) partial and symbolic diagnosis; and 4) content and communication focused development. These activities appeared to take root in a tacit improvement governance system that co-existed alongside an espoused

counterpart. This tacit improvement governance system promoted rapid, standardized, comprehensive, instigated and structural improvement. This system is construed as the product of the LTCO's interactions with its internal and external environments. In this view, the representation of positive external evaluation as a superior measure of improvement, and consequently of performance, led the LTCO to adopt a subservient position in regards to its external environment. Regulatory bodies' valuation for structural soundness and the mass media's eagerness to report negative events are thus conceived as determinants of an improvement governance system designed to produce apparent gains, more so than effective gains. The preponderant attention granted by the LTCO to its externally projected image would also lead to the apprehension of its internal environment as a source of potential defects needing to be controlled. Consequently, the LTCO seemed to engage improvement intentions with minimal concern for the limits and possibilities of its internal context or for their actual effect on internal functioning or evaluation. This external focus would come at the price of the stagnation of actual quality and, consequently, of the growing cynicism and disengagement of internal stakeholders. The non-actualized products of improvement engagement processes would thus be viewed as symbols of disregard on behalf of the LTCO for the actual living and working conditions of their residents and caregivers.

The nature of the four types of tacitly stimulated improvement engagement activities described by this study is not surprising. Multiple studies describe LTCOs through their autocratic culture (Benbow, 2008; Kelly & McSweeney, 2009), the deficient relationship of their managers and caregivers (Kinjerski & Skrypnek, 2008; Ragsdale & McDougall, 2008), the lack of communication between their stakeholders (Levenson, 2009; Schruijer, 2006) and their general disconnection from the needs of their residents (Masso & McCarthy, 2009; White-Chu, Graves,

Godfrey, Bonner, & Sloane, 2009). However, the results do not identify contextual attributes (e.g. lack of financing, lack of managerial training, high turnover, etc.) (Dannefer, Stein, Siders, & Patterson, 2008; Koren, 2010; Shanley, 2007a) as the primary source of these features or of the deficient change management strategies they produce. By contrasting espoused- and in-use views, this study highlighted the likelihood than a gap between what is possible and what is done in terms of quality improvement exists in LTCOs. Espoused managerial principles promoted the scientifically grounded benefits of "impulsing" improvement intentions identified as priorities by frontline employees (Clegg & Walsh, 2004), of concretizing improvement intentions by sense-making (Gioia & Chittipeddi, 1991), of conducting diagnosis activities to reveal local particularities and evaluate disposition to change (Kitson et al., 2008) and of developing change management strategies that are adapted to the results of a prior diagnosis (Friedberg, 1997). Consequently, the LTCO's lack of financing or of a highly qualified and stable workforce can be considered as subordinated to its inability to translate its cognitive, human and financial resources in terms of improvement obstacles. Difficulties using its resources' full potential would be deleterious to the quality of care and the quality of life of the LTCO's residents, but also seemed to exponentially fuel the organization's improvement challenge.

These means of improvement engagement would be entrenched in a tacit improvement governance system which identifies matters associated with the LTCO's external environment as "strategic issues" crucial to its survival (Dutton & Duncan, 1987). The consequent adoption of an outward-looking stance would lead the LTCO to devote a disproportionate amount of its improvement attention to its external environment to the detriment of its internal environment. From an institutionnalist perspective (Lawrence & Lorsch, 1967), change management strategies dedicated to the sole diffusion of sophisticated structural devices, considered at face value by

regulatory agencies and readily usable to deflect organizational responsibility of publicized deficiencies towards aberrant offenders, appear adapted. The evaluation means utilized by regulatory agencies can thus be portrayed as compelling the LTCO to be more *regulation-centred* than *patient-centred* as also suggested by Banerjee & Armstrong (2015). From a psychological perspective, the insight provided by studying improvement engagement rather depicts the LTCO as psychotically coping with its environments. According to Sievers (1999), organizational psychosis manifests itself by a culture that values immediate efficiency, a climate that favors control over individual initiative and a formal discourse that promotes the presumptive idea that things are evolving. In this view, espoused-theories regarding the LTCO's capability to engage improvement intentions would allow decision makers to defend themselves from apprehending a reality they consider too painful. Theories-in-use would be the product of a failure to learn that entities that generate frustration (i.e. internal environment) can also be sources of gratification (Lawrence, W. G., 1999). This explanation resonates with the concept of functional stupidity (Alvesson & Spicer, 2012) which advances that certain organizations willingly inhibit the utilization of knowledge and reflexivity to favour certainty.

The value of the theory developed in this paper must be considered in light of being produced through a single case action research, aimed less at producing generalizable knowledge than actionable knowledge. For LTCOs' stakeholders feeling compelled by the explanation put forward, contributing to the development of a more inward-looking organizational design seems a recommendable course of action. Designs which focus organizational attention on internal needs and abilities are recognized as beneficial (Weick, 1993) and especially adapted to the low uncertainty of the public sector (Liedtka, 2000). That being said, it is important to note that this study was conducted in collaboration with a publicly subsidized private organization. The private

imperative to remain a viable partner of the public sector may have exacerbated the LTCO's attention towards its external environment. Protecting their organizations from the hypertension to improve produced by their external environment (Liedtka, 2000) should nevertheless be considered as a central role of decision makers in all forms of LTCOs. The adaptation of a more balanced representation of the external environment would enable the canalization of the improvement energy it contains rather than answering every anxiety it produces. In doing so, slack resources could be retained for investing internally driven improvement priorities. Such an approach could be facilitated by the adoption of new means of evaluation by external agents. Progressive and objective evaluation criteria, concerned by the development of proper improvement governance systems and concrete practice improvements, could be conducive to such a reorientation.

In sum, revisiting the principles that are at the heart of the change governance systems in which take root improvement engagement activities in LTCOs, appears required to utilize available resources to their full potential and properly evaluate how much new resources are required to reach contemporary expectations. Without carrying out efforts to improve LTCOs' abilities to properly engage improvement intentions, the addition of new resources or attempts to transfer new knowledge into practice will produce apparent, improvement over effective improvement.

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Discussion supplémentaire

Cet article propose une explication systémique à l'indisposition des OHSLD à utiliser les meilleures pratiques de gestion du changement. Cette explication est issue d'une caractérisation des activités typiquement associées à l'engagement d'intentions d'amélioration – c'est-à-dire des activités qui précèdent l'implantation de nouvelles pratiques – dans les OHSLD et d'une analyse de leurs déterminants. La focalisation de l'étude sur l'amont des processus d'amélioration permet d'exposer les liens entre les valeurs qui gouvernent l'amélioration dans les OHSLD et leur capacité à mobiliser les meilleures pratiques de gestion du changement. Ces résultats peuvent être réfléchis à la lumière de trois thématiques, soit les fondements de l'inhabilité générale des OHSLD à s'améliorer de façon significative et durable, les sources et effets d'une posture « outward-looking » par les OHSLD et la subjectivité des représentations de la performance en OHSLD.

En ce qui a trait aux *fondements de l'inhabilité générale des OHSLD à s'améliorer*, cet article propose une explication de nature plus managériale que contextuelle. Alors que plusieurs études focalisent leur attention sur le manque de ressources propre aux contextes des OHSLD pour expliquer leur stagnation (p ex. Lopez, 2007), nos résultats, sans nier ce manque de ressources, mettent plutôt l'accent sur la gestion contre-productive de ces ressources pour l'expliquer. Cette responsabilisation managériale s'observe par la démonstration des divergences entre les caractéristiques épousées et les caractéristiques effectives des activités d'engagement d'amélioration. Des obstacles au transfert en action des ressources managériales de l'organisation (ex. : connaissances scientifiques en gestion du changement, connaissances expérientielles des effets des activités antérieures d'engagement d'amélioration, etc.) seraient à la source de cette utilisation inefficiente des ressources disponibles. Ce constat est soutenu par l'affirmation de Voyer (2016) voulant qu'il soit nécessairement possible de faire mieux avec les ressources

actuellement consacrées aux CHSLD, bien que plus de ressources sont requises pour qu'elles incarnent l'idéal tracé par les orientations et réglementations adoptées. La particularité de cette explication managériale repose sur sa corrélation à des déterminants systémiques, c'est-à-dire sur une mise en lumière des effets de la nature des interactions entre les différentes parties prenantes de l'OHSLD. La conséquence la plus significative de ces interactions serait l'adoption d'une posture plus « outward-looking », soit tournée vers son extérieur, par les OHSLD. Ce résultat est cohérent avec la conclusion de Ragsdale et McDougall constatant que: « *Traditional nursing home care has historically been provided to accommodate regulatory requirements without consideration of meeting the resident's individual needs* » (2008, p. 993). Notre étude décrit cette attention disproportionnée des OHSLD à l'égard de leur environnement externe, et des acteurs réglementaires qui le composent, comme la conséquence d'un passage d'une relation de négligence à une relation d'assujettissement des OHSLD aux entités gouvernementales et réglementaires. Le management stratégique des OHSLD semble ainsi faire abstraction de leur potentiel pouvoir d'influence ou de leur potentielle marge de manœuvre à l'égard des impulsions de changement émanant de leur environnement externe. Selon Friedberg (1997), la relation entre les organisations et leurs environnements gagnerait à être conçue comme un processus d'inter-structuration où l'organisation crée son environnement et en est influencée à la hauteur de son ouverture à celui-ci (Friedberg, 1997). Cette affirmation est issue d'une critique des conceptions de l'environnement en tant que toile de fond régi par des règles immuables (Perrow, 1986) et pose cette inter-structuration comme un objet d'intervention managériale. De cette perspective, il devient beaucoup moins pertinent de savoir ce qui se trouve à l'extérieur d'une organisation qu'en son intérieur (Weick, 1993) comme cet intérieur est le lieu où l'inter-structuration s'observe dans le moment du changement. Quinn (1980) dit à ce sujet que le changement stratégique émerge de

l'identification de situations ciblées de résolutions de problèmes locaux et donc moins de façon réactive à l'environnement externe.

La faible incertitude du contexte public serait opportune à l'adoption d'une représentation de la performance plus centrée sur des besoins locaux que sur des exigences environnementales (Liedtka, 2000). Un retournement stratégique vers leur intérieur permettait aux gestionnaires d'OHSLD de jouer un de leurs rôles essentiels dans le secteur public, soit d'agir de façon à minimiser les discontinuités et de garder le cap malgré les changements d'orientation environnementaux (Moore, 1995). La capacité de gestionnaires d'organisations publiques à rallier leurs membres à une vision claire de leurs futurs et à assurer une progression constante vers ceux-ci favorise l'émancipation de leurs organisations du dictat de leurs environnements (Liedtka, 2000). Inspirés par Weick, qui a écrit que « *managers construct, rearrange, single out, and demolish many objective feature of their surroundings* » (1979, p. 164), nous concevons donc qu'il est de la responsabilité des gestionnaires d'OHLSD de protéger leurs acteurs de la surtension au changement générée par leur environnement externe. Une posture « inward-looking » ne doit cependant pas mener à une fermeture complète à l'égard de son environnement et générer un bricolage d'arrangements locaux aveugles aux normes, réglementations ou produits des milieux académiques. A contrario, un isolement complet serait possiblement plus néfaste qu'une ouverture sans bornes, pensons notamment aux OHSLD dans lesquelles une trop grande familiarité a mené à des situations de maltraitance (Chouinard-Desrosiers & Camera, 2003).

Finalement, la *subjectivité de la performance organisationnelle* est une thématique centrale de cet article. À première vue, la performance en OHSLD semble être un concept univoque. Une OHSLD performante serait une organisation qui incarne l'idéal défini par le grand mouvement de changement de culture, c.-à-d. où les soins et les services aux résidents sont dirigés par ceux-ci.

Cet idéal s'incarne par une organisation qui offre une atmosphère résidentielle plutôt qu'institutionnelle, qui favorise l'établissement des relations étroites entre les résidents, les familles, le personnel et la communauté, qui « empower » son personnel, qui emploi des processus décisionnels collaboratifs et établit des processus d'amélioration de la qualité systématisés permettant l'évaluation des acquis (Harris, Poulsen, & Vlangas, 2006). Les résultats de notre article exposent toutefois que les OHSLD peuvent être estimées performantes sans égard à leur capacité effective à incarner ces critères de performance. Ceci est cohérent avec les résultats de plusieurs autres études qui décrivent les OHSLD comme des organisations extrêmement conscientes de leur performance formelle de peur de nuire à leur représentation publique déjà fragile (Steven A. Levenson, 2010; Presutti, 2006; White-Chu, et al., 2009). La valorisation de la performance ostensible d'un point de vue externe aux OHSLD rappelle que les organisations peuvent jouer avec les critères utilisés pour évaluer leur performance (Crozier & Friedberg, 1977). Lorsque confrontées à des niveaux de performance décevants, les organisations détiennent le pouvoir de modifier leurs critères de performance ou le fonctionnement à la source de la sous-performance (Weick, 1993). En ce sens, l'existence de principes tacites de gouvernance de l'amélioration ne serait que le produit d'un virage systémique vers une approche de modification de critères de performance au détriment d'une approche d'amélioration effective de fonctionnement. Ces principes tacites peuvent ainsi être considérés comme une façon appropriée de jouer le jeu de la « mock accountability », c'est-à-dire d'imputabilité factice, mise de l'avant par le troisième article de cette thèse. Cette conception plus stratégique qu'effective de la performance organisationnelle représente aussi une possibilité pour les OHSLD d'incarner un repli positif sur leur mission explicite.

En somme, nous considérons que les résultats de l'étude dont fait état cet article permettent une explication originale des difficultés d'amélioration reconnues des OHSLD. La mise à profit de connaissances issues de la gestion du changement et du développement organisationnel permet d'orienter la recherche d'explication à la stagnation des OHSLD vers ce qui est possible plutôt que vers ce qui ne l'est pas, faute de ressources suffisantes. Le concept d'engagement de processus d'amélioration élaboré dans le cadre de cet article permet de mieux apprécier l'influence de la phase antérieure à l'implantation de dispositif d'amélioration sur les résultats qui en découle. La déclinaison de cette phase en activités types permet de penser au-delà de l'initiation de changement et d'être clairvoyant à l'égard des investissements requis pour démarrer des processus d'implantation en des conditions gagnantes. Finalement, la contribution la plus importante de cet article est possiblement de démontrer que des systèmes de valeurs plus ou moins explicites influencent la capacité des agents de changement de faire usage de leurs compétences managériales. L'analyse des valeurs gouvernant l'amélioration dans les OHSLD expose du coup l'incohérence des représentations de la performance qui prévaut dans leurs contextes avec des investissements bénéfiques à générer des améliorations effectives des soins et services qu'elles dispensent. Bien que cette discussion encourage les gestionnaires à vivre avec les conséquences de la non-réponse à certaines impulsions environnementales, nous sommes conscients des conséquences pouvant découler de tels écarts. Nous considérons en fait que la marge de manœuvre que possède les gestionnaires des OHSLD, et plus largement d'organisations de santé ou de services publics, pourrait faire l'objet de futures études pour mieux apprécier la capacité réelle d'individus à détourner leur regard des impulsions externes à l'amélioration. Le prochain article de cette thèse propose en ce sens une analyse moins contextualisée des résultats de la recherche-action que nous avons réalisée. Plus spécifiquement, cet article a permis d'extraire une

compréhension des dynamiques qui maintiennent des organisations de santé dans des cercles vicieux de sous-performance des données issues de la collaboration avec une OHSLD. Une concentration sur l'influence des caractéristiques des activités d'engagement d'amélioration sur les processus de changement en découlant et leurs retombées permet d'y arriver.

Troisième article

Ce troisième article présente des résultats tirés de la recherche-action décrite dans l'article précédent. Cet article analyse la contribution des modalités d'engagement d'amélioration du CHSLD à son maintien dans un cercle vicieux de sous-performance. Des apprentissages plus génériques à propos des dynamiques qui empêchent des organisations de santé d'améliorer leur performance organisationnelle en sont extraits. Ce travail mena à la rédaction d'un article soumis pour publication au *Health Care Management Review* en octobre 2017 et intitulé : « Analyzing the Dynamics of Persistently Underperforming Healthcare Organizations Through the Prism of Change Engagement ».

Analyzing the Dynamics of Persistently Underperforming Healthcare Organizations Through the Prism of Improvement Engagement

Abstract

Background: The study of outperforming healthcare organizations has revealed a correlation between their performance and their ability to improve. However, the apparent inability of underperforming healthcare organizations to utilize change opportunities as levers of performance improvement remains under-examined.

Purpose: The aim of this study was to analyze the dynamics of underperforming healthcare organizations through the lens of improvement engagement, i.e. the activities realized prior to the implementation of new practices. By focusing on the precursory phase of change processes, we intended to uncover the fundamental determinants of the inability of underperforming organizations to potentiate their change opportunities.

Methodology/Approach: We elected to conduct our study in the long-term care sector as it is recognized to be persistently underperforming. An action research following an improvement engagement process in a long-term care organization located in Quebec, Canada, was completed.

Results: The asymmetrical interactions of the long-term care organization and its internal and external environments were identified at the source of a tacit improvement governance system, which would shape the common nature of its improvement engagement activities. The typically non-dynamic processes that arise from the long-term care organization's engagement activities would produce improvement debris, which appeared to stimulate its underperformance cycle.

Conclusion: The organization's underperformance cycle appeared to be rooted in the decoupling of its improvement intentions and abilities. The ensuing improvement engagement activities would

contribute more to widening the gap between the LTCO and its performance ideal than to closing it.

Practice Implications: Our results suggest that unsuccessful improvement intentions do not only impede performance gains, but also exacerbate the dynamism of the vicious cycle of underperformance. Healthcare managers could thus benefit from engaging their improvement intentions equivalently committed to generating gains than to preventing the production of improvement debris.

Keywords

Organizational development, change management, permanently failing organizations, long-term care, nursing home

Introduction

Organizations strive to perform and, some would say, need to perform to survive. From this rational standpoint, organizations can be categorized as underperforming or outperforming in relation to determined performance criteria. Organizational performance can be evaluated transversally, but organizations could only be deemed underperforming or outperforming in regards to their ability or inability to perform in the long-term (Weick, 1993). While durably outperforming organizations have been recurrently studied, persistently underperforming organizations have generated less attention (Rouleau, Gagnon, & Cloutier, 2008). Outperforming healthcare organizations have notably been scrutinized to identify the attributes associated to their maintained ability to exceed expectations (i.e., Baker & Axler, 2015; Baker et al., 2008; Forbes-Thompson, Leiker, & Bleich, 2007; Nelson et al., 2002). The studies devoted to outperforming

healthcare organizations have contributed clearer insight on the determinants of outperformance than on the investments required to enter the apparently virtuous cycle of performance (Baker et al., 2008). Outperforming healthcare organizations or systems are notably unanimously identified as possessing a heightened ability to change or, more precisely, improve as one of their core attributes (Baker et al., 2008; Forbes-Thompson et al., 2007; Nelson et al., 2002).

The most recognized contribution to understanding underperforming organizations is the seminal work of Meyer and Zucker (1989) on permanently failing organizations. Their work, as well as the few studies that have followed in their footsteps (Eitel, 2004; Rouleau et al., 2008; Seibel, 1996), reveal dynamics that concurrently impede performance and maintain survival. These studies correlate the diverging interests of stakeholders (Meyer & Zucker, 1989), lenient external support (Seibel, 1996) and indiscriminate hope (Rouleau et al., 2008), to persistent underperformance, but only indirectly address how these characteristics curb the organizations' improvement efforts. Eitel's (2004) case study is set apart from the others as it explains a public organization's continued underperformance by the progressive undermining of the organization's improvement abilities through cumulated improvement failures. Nonetheless, knowledge on the characteristics of the improvement means utilized by persistently underperforming organizations, and more specifically by healthcare organizations, and their influence on the maintenance of underperformance is scarce. Organizational change studies contribute some knowledge to this question, but are characterized by two biases that leave this field of knowledge incomplete. Firstly, organizational change studies tend to study innovations from an episodic rather than holistic and longitudinal perspective, which prevents understanding the mechanisms and processes from which they stem (Pettigrew, 1990). A better understanding of the processes by which organizations capture ideas and manipulate them into efficient change processes is called for (Greenhalgh et al.,

2004). Secondly, organizational change studies suffer from a pro-innovation bias which grants more value to studying successful cases than unsuccessful ones (Greenhalgh et al., 2004). Knowledge on the characteristics of change strategies that favourably support the attainment of change objectives is consequently abundant (Paton & McCalman, 2008), but much less is available on the contexts and dynamics that prevent organizations from engaging change endeavours adequately (Saka, 2003). In other words, what characteristics of the context and dynamics of persistently underperforming healthcare organizations prevent them from transforming their change opportunities into performance gains? How can they exit the vicious cycle of underperformance if they do not possess the skills necessary to develop the improvement abilities that would allow them to better perform?

One type of healthcare organization that can be identified as persistently underperforming is the long-term care organization (LTCO), otherwise known as a nursing home. Even though LTCOs represent a major and costly institution dedicated to offering quality care in homelike environments, they would fail at doing so according to numerous literature reviews and surveys (e.g. Doty, Koren, & Sturla, 2008; Masso & McCarthy, 2009). LTCOs would not ensure the well-being of their residents, nor of their employees (Yeatts, Cready, Ray, DeWitt, & Queen, 2004). They would rather contribute to the functional decline of their residents and to the burnout of their employees (Koren, 2010). The improvements called for and attempted from multiple perspectives in the last decades would have improved their average performance level (Levenson, 2009), but a vast majority of LTCOs would be very far from incarnating the vision they strive to achieve (Koren, 2010; Levenson, 2009; Yeatts et al., 2004).

This study thus takes on the objective of identifying the dynamics of persistently underperforming healthcare organizations through the specific lens of improvement engagement

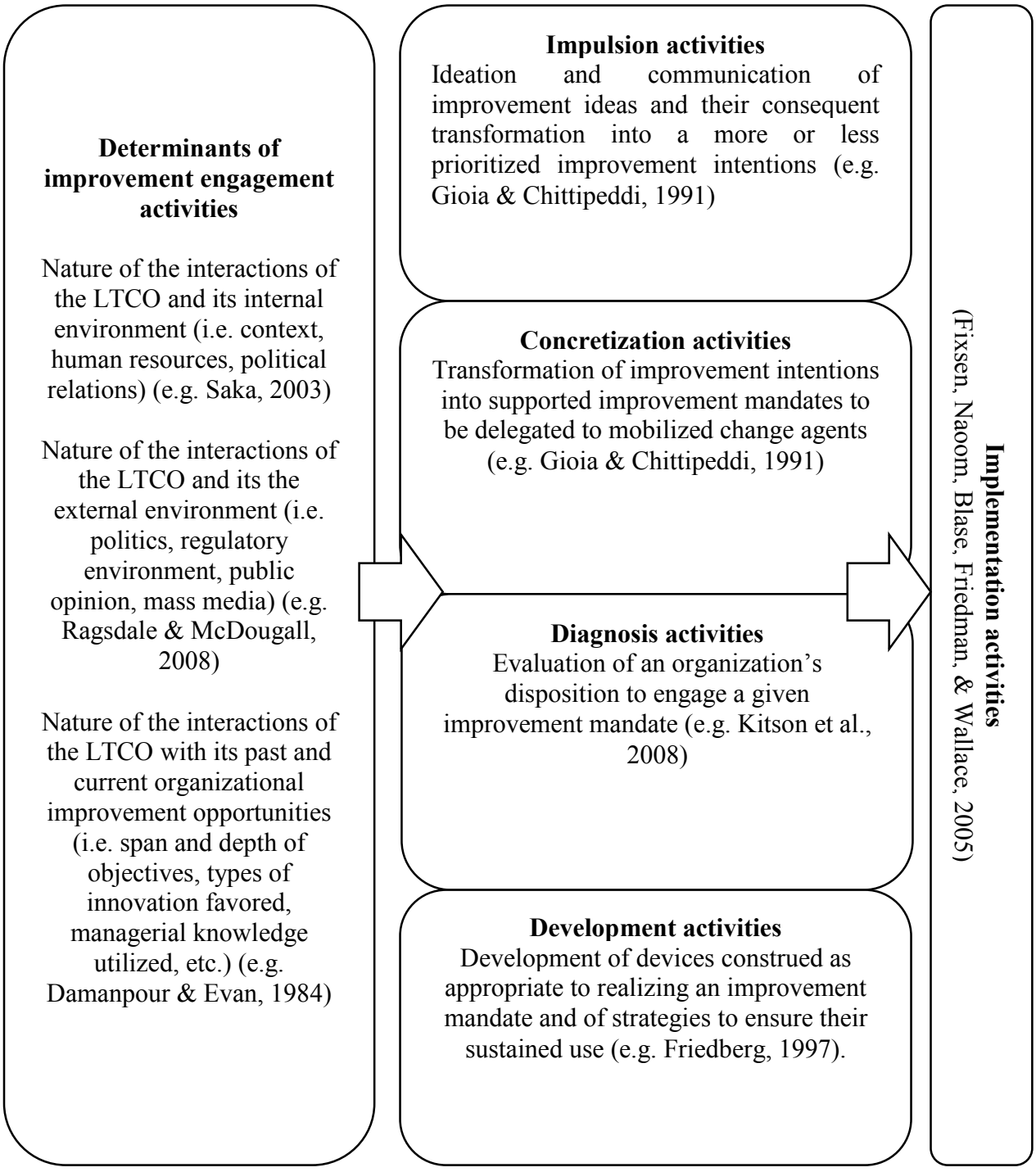
in LTCOs. Improvement engagement can be defined as the activities carried out prior to the implementation of new practices. Specifically, this study's objectives were to:

- Describe the *characteristics* of improvement engagement activities associated to persistently underperforming healthcare organizations;
- Describe the *determinants* of improvement engagement activities associated to persistently underperforming healthcare organizations;
- Analyze the *influence* of the characteristics of improvement engagement activities on the improvement abilities of persistently underperforming healthcare organizations.

Theory

This study aims to understand the dynamics that maintain healthcare organizations in apparent vicious cycles of underperformance by studying how they engage their improvement intentions. To do so, we adopted a symbolic interactionist perspective (Blumer, 1969) to study how LTCOs, as "acting units", grant meaning to their reality and act upon it. Our study was fundamentally interested in "how the private troubles of individuals, which occur within the immediate world of experience, are connected to public issues and to public responses to these troubles" (Denzin, 2014, pp. 5-6).

Figure 1. Conceptual Framework



A conceptual framework based on a literature review was elaborated to orientate this study. The review aimed to retrieve literature pertaining to the engagement of improvement processes,

i.e. to the precursory phase of organizational improvement processes. Activities commonly carried out prior to implementation, which can be defined as the "specified set of activities designed to put into practice an activity or program of known dimensions" (Fixsen, Naoom, Blase, Friedman, & Wallace, 2005, p. 5), were considered as such. The key words "improvement engagement" and "change engagement" did not allow the collection of any pertinent material. The key words "change initiation" coupled with a snowball method allowed identifying 30 pertinent documents.

We nevertheless opted to conserve the term "engagement" in the framework as it represents a *characterizable period* in contrast with the term "initiation" which represents an *objective moment*. We also preferred the term "improvement" to the term "change" as organizational change efforts rationally aim to produce improvement rather than change. As no literature specifically focused on improvement engagement in LTCOs was retrieved, a research using the key words "nursing home or long-term care or residential aged care" as contextual identifiers coupled with the key words "change management" (91), "organizational development" (25) and "decision-making" (19) allowed the identification of an additional 135 documents containing pertinent material.

The analysis of the 165 retained documents enabled the construction of the components of the framework, which are "determinants of the improvement engagement activities" and "improvement engagement activities" (Figure 1). The first component of the conceptual framework is comprised of three potential determinants of the nature and form of improvement engagement activities. Identifying these potential determinants required distinguishing them from determinants of general organizational performance. The gathered literature was thus scrutinized in order to identify organizational dimensions that influence the onset of improvement processes and that can be acted upon during this process. For example, structural design, organization size,

workforce stability, availability of financial resources and organizational culture were described as influential on the improvement engagement by reviewed literature, but were not retained, as they were not specifically associated with the onset of improvement processes or malleable during the engagement process. The second component is rather comprised of four types of activities: impulsion (e.g. identifying an improvement need), concretization (e.g. delegating an improvement mandate to manager), diagnosis (e.g. identifying potential obstacles) and development (e.g. developing a training program).

Method

An action research in collaboration with a semi-private LTCO that encompasses multiple facilities was conducted. Having adopted an interactive research approach (Svensson, Eklund, Randle, & Aronsson, 2007), the study aimed to produce actionable knowledge more than to generate concrete transformation. To do so, the study's first author acted as an action researcher and integrated the LTCO with the explicit objective of accompanying them in engaging an improvement process of their choice. The researcher's integration into the LTCO debuted with the direct observation of a corporate level meeting, which served to orientate the rest of its research path. Other than direct observation (Peretz, 1998), work sessions with a project team (Svensson et al., 2007), semi-structured individual interviews concerning themes associated with the conceptual framework and emerging themes (Rapley, 2004), documentary analysis (Cellard, 1997) and a feedback session (Friedberg, 1997) were used to collect data (Table 1). The action research lasted 18 months and led the researcher to collaborate with the three levels of management that were involved in improvement engagement processes. These levels are the corporate level (i.e. directors overseeing activities of all establishments), facility level (i.e. directors and managers overseeing

the activities of a group of facilities) and practice level (i.e. middle managers overseeing the activities of a subunit of a single facility). The action collaboration consisted of the assistance of one project team in engaging a process that aimed to improve the welcoming and integration of new residents. This improvement intention was chosen by the LTCO for reasons detailed in the results section. The researcher's role during the team's work sessions was to experience the engagement activities, observe emerging conflicts and difficulties, as well as to stimulate reflection amongst the team members in regards to said conflicts (Albinsson & Arnesson, 2010).

Table 1. *Data Collected at Each Management Level*

Corporate level	Direct observation: 1 corporate meeting (2 hours of field notes) Interviews: 5 recorded and transcribed interviews of 1.5 hours Feedback session: 1 recorded session of 2 hours Documentary analysis: content analysis of organizational plan, strategic plan, etc.
Facility level	Direct observation: 8 regional meetings (16 hours of field notes) Interviews: 11 recorded and transcribed interviews of 1.5 hours Work sessions: 9 project team sessions (18 hours of field notes) Documentary analysis: content analysis of yearly lists of improvement objectives
Practice level	Interviews: 8 recorded and transcribed interviews of 1.5 hours

The data analysis was guided by the concepts presented in the conceptual framework (Miles & Huberman, 1994). The framework oriented the production of conceptual codes and sub-codes, as well as relationship codes to define the correlation between improvement engagement activities and their potential determinants (Bradley, Curry, & Devers, 2007). Coding of the data and line-by-line checking was conducted by the action researcher and checked by the second author (Miles & Huberman, 1994). The discrepancies between "espoused-theories" (principles and values people believe their behaviour is based on) and "theories-in-use" (principles and values implied by peoples' behaviour) represented the primary approach to analyze the data (Argyris &

Schon, 1974; Denis & Lehoux, 2009). Theories-in-use were principally uncovered by the work sessions and direction observation, but also by fitting descriptions provided by interviews. The following results section is composed of four subsections, which include written descriptions and in-quote citations.

Results

Characteristics of the Improvement Engagement Activities

Our results characterized and validated the existence of the four types of improvement engagement activities presented by the conceptual framework. The "espoused" and "in-use" views of each of them are contrasted in the following paragraphs and in the timeline of the improvement engagement collaboration (figure 2).

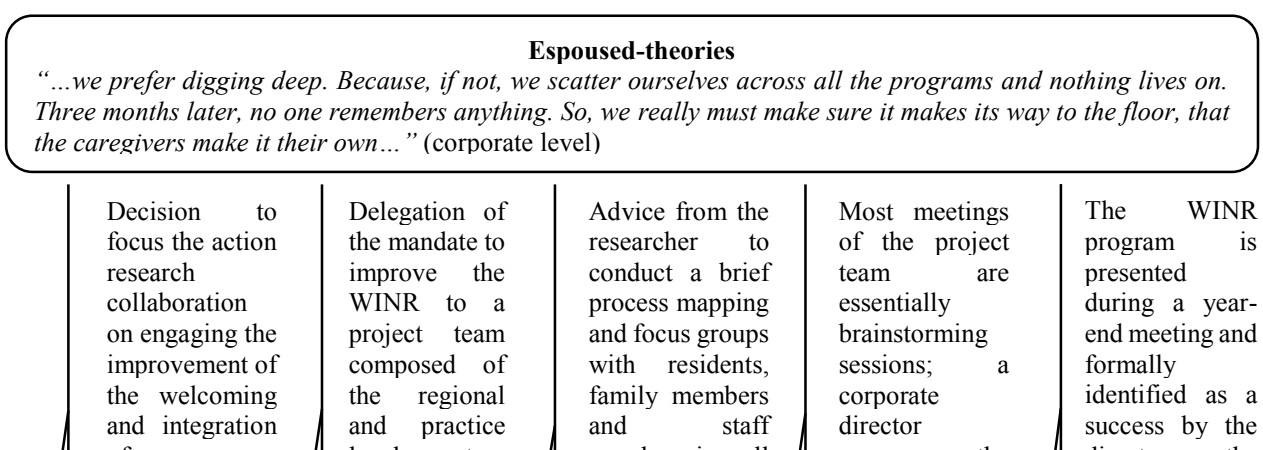
Impulsion activities were described by espoused-theories as closely tied to the reality of their organization. They were defined as a prerogative of the top-level actors of the LTCO, but also as rooted in the reality of its practice level: *"I bring our daily realities to the corporate level and it's with them that we agree upon priorities. Everything is linked together."* (regional level). Theories-in-use rather characterized them as controlled by the corporate level of the LTCO. A lack of consideration for the reality of the practice level would lead to the impulsion of improvement intentions considered as disconnected from the primary needs of the residents or the fundamental deficiencies of the LTCO: "*...we are working in the opposite direction. I look at my day and it's more and more orders from the top: 'Hey! I work for the residents, not for you!'"* (regional level). Thus, the typical nature of the in-use impulsion activities would be authoritarian and disconnected.

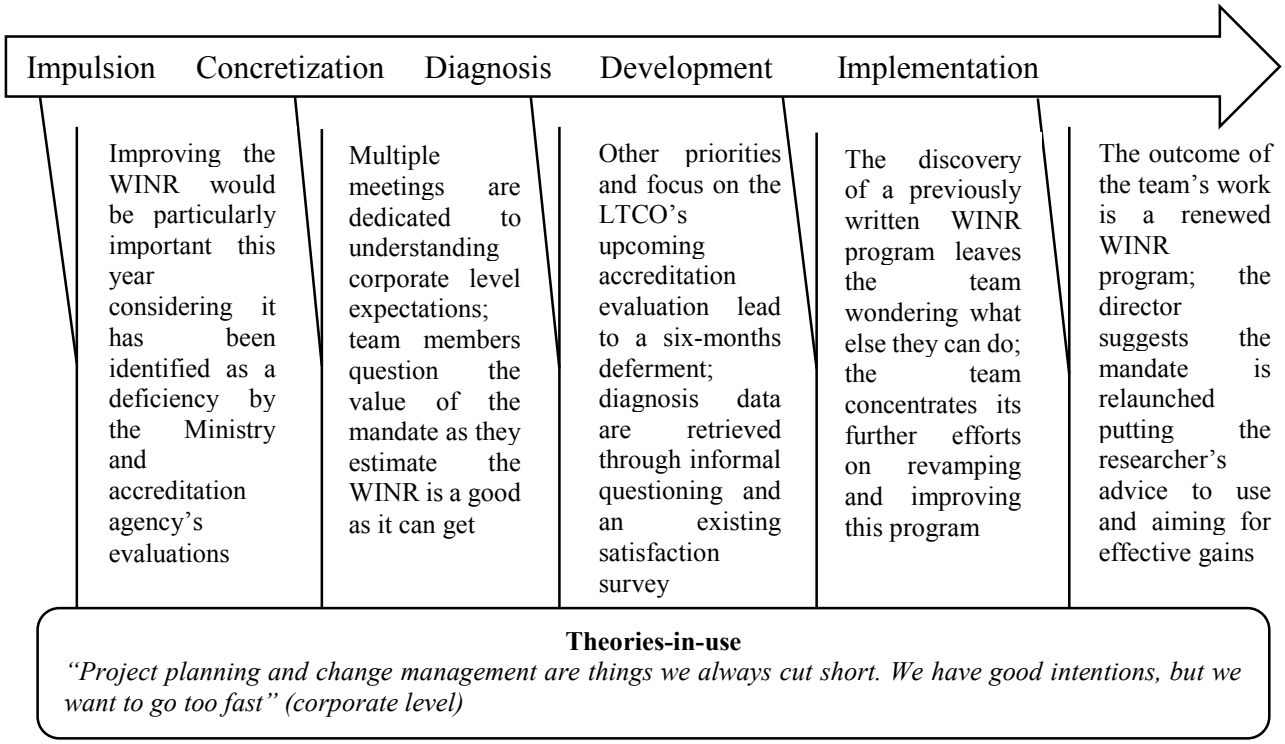
Concretization activities were defined by espoused-theories as oriented by the intuitive aim of creating the best pairing of improvement intention and change agents. Important efforts would

consequently be devoted to ensuring the improvement intentions are clear and the change agents are dedicated. An important sense of responsibility and accountability would be generated: *"If we write it in our plan, we have an agreement, we are signing a check…"* (regional level). Theories-in-use rather described them as insufficiently invested in terms of sense-making and accountability: "*It's not normal, I've been in business a long time and you must measure everything, you must be aware of everything that is happening. Here, we trust people because they are professionals?*" (regional level). Most change agents accordingly appeared to grant mitigated importance to their improvement mandates. Thus, the typical nature of the in-use concretization activities would be intuitive and technical.

Diagnosis activities were characterized by espoused-theories as consistently carried out: "*[The middle manager] must be convinced he can mobilize his troops, because he has little turnover, because his people expressed: 'It's not working anymore, we have to do something about it!' He must grasp that momentum!"* (regional level). Theories-in-use rather emphasised the defaults that stemmed from the lack of knowledge and time to perform diagnosis activities, but also from the general indisposition to question the unrealistic corporate demands. The top-down pressure to improve would lead diagnosis activities to be neglected or their results to be disregarded. "*Unfortunately, we don't do prior analyses, but it would be interesting to do so. That being said, it wouldn't change our orientations."* (corporate level). Thus, the typical nature of the in-use diagnosis activities would be partial and symbolic diagnosis.

Figure 2. *Timeline of the "Espoused" and "In-Use" Action Research Collaboration*




Impulsion
Concretization
Diagnosis
Development
Implementation
Improving the WINR would be particularly important this year considering it has been identified as a deficiency by the Ministry and accreditation agency's evaluations
Multiple meetings are dedicated to understanding corporate level expectations; team members question the value of the mandate as they estimate the WINR is a good as it can get
Other priorities and focus on the LTCO's upcoming accreditation evaluation lead to a six-months deferment; diagnosis data are retrieved through informal questioning and an existing satisfaction survey
The discovery of a previously written WINR program leaves the team wondering what else they can do; the team concentrates its further efforts on revamping and improving this program
The outcome of the team's work is a renewed WINR program; the director suggests the mandate is relaunched putting the researcher's advice to use and aiming for effective gains
Theories-in-use
"Project planning and change management are things we always cut short. We have good intentions, but we want to go too fast" (corporate level)

Development activities were described by espoused-theories as leading to the deployment of multidimensional change management strategies. These strategies would frequently encompass participative management devices: *"I talk with the nursing assistants, I ask questions, I try to understand, so they see that I considered their perceptions, their opinions. I do that at every change."* (practice level). Theories-in-use rather viewed them as conducted by change agents interested in prescribing and diffusing sophisticated new practices without regards to their operability. The development and deployment of change management strategies adapted to ensuring the implementation and sustainment of the devices seemed secondary: "*When we want to plan a change, we also have to plan how we will make it happen. If we only plan what we're aiming for without planning how we will get there, we are way off the track!*" (regional level). Thus, the typical nature of the in-use development activities would be content and communication focused.

In sum, the nature and form of these engagement activities essentially combined to produce a top-down process mainly oriented towards the production of a multiplicity of superficially ostensible innovative prescriptions. The next section aims to uncover the fundamental stimulants of these improvement engagement activities through the interactions of the LTCO and its environments.

Determinants of Improvement Engagement Activities

The relationship of the LTCO with its external environment was described as rooted in a historical lack of societal and political interest: "*Long-term care has been, and remains, the poor cousin of the healthcare system (...) but with all the horror stories that we've seen, with the increased media coverage, there is increased preoccupation."* (regional level). The nascent exposure of long-term care deficiencies would have led to a multiplication of regulatory

requirements (i.e. evaluation by the Ministry of health and social services, obligatory accreditation by an external agency, evaluation by professional orders) and exacerbated media scrutiny. This evolution would have stimulated LTCOs to abandon their typically inward-looking stance, identified as a source of inertia and unprofessionalism, to adopt a more outward-looking one. Espoused-theories considered this shift as a means of stimulating uniform improvement: "*Now, the accreditation agency forces us to write more rules and policies to ensure more uniformity. When it was not written, it was up to the managers to say: 'I want to focus on this rather than on that!*'" (corporate level). Theories-in-use conversely described the influence of the intensification of the relationship of the LTCO with its external stakeholders adversely: "*...we are well behind everyone. We are trying to integrate new expectations and trying to catch up. So, we are over-saturated of changes to implement, but we can't do all this at the same time*" (corporate level). The performance criteria the LTCO should strive for were described as disarrayed by the difficult integration of expectations to deliver high-quality healthcare and offer home-like quality of life, as well as by the progressive complexification of residents' needs. The dialectical interaction between the externally driven hypertension to improve and the shared recognition that internal resources are insufficient to adequately respond appeared at the source of a hypocritical relationship:

> *"How can things change if we never show our true face to the media, the government and all that? We always camouflage our reality. We make a nice little speech to our employees: 'The accreditation agency is coming. You must address the residents politely, you must do this, you must do that…' It's phony, but it's like that everywhere and everyone knows it, the Ministry included."* (regional level)

The accreditation system, which would prescribe more than 500 quality standards, monitor their respect through planned triennial visits and predominantly use document auditing to evaluate, would incarnate this flawed relationship: "*Between respecting the norms and the actual quality of the care the residents receive, there is a gap. In my view, that's why our almost perfect accreditation score is only smoke and mirrors. I don't believe it, it's not right!"*(regional level). Past investments in the LTCO's organizational structure, notably the creation of a position responsible for the coordination of external evaluation and of a tool intended to document communication efforts associated with external evaluation criteria, were designed to ensure quality interactions with the external environment. Iterations and negotiations with external stakeholders would be common practice to obtain the highest possible evaluation scores, but the relationship of the LTCO and its external environment would be pre-eminently apprehended as unidirectional: *"…because of the media and new ministerial expectations (…) you say: 'Some of the changes I couldn't do now, I will be forced to do them because if I don't, I may end up in the hot seat…"* (regional level).

Espoused-theories expressed the LTCO's intense interactions with its external environment did not prevent it from being closely-knit to its internal stakeholders: "*Our ultimate client is our resident, and all the people, the employees and the managers that work for our residents. So, we make giving them extraordinary support our duty…*" (corporate level). Theories-in-use rather evoked the general lack of empathy and understanding of the LTCO for the reality of its caregivers. Some considered the frontline caregivers intrinsically resistant and ultimately responsible for the LTCO's inability to put the externally prescribed improvements into action. Others highlighted the organization's disconnection with its internal environment. Excluding the development of a set of

quality indicators utilized to monitor clinical and financial data, investments in the communication structure linking the LTCO to its caregivers would have been essentially dedicated to "descend" information and improvement prescriptions through middle managers. Practice level realities and improvement priorities would frequently remain unaddressed: "*The everyday things we live, us, with the nursing assistants and all the employees, are not a priority for them. I'm not saying they don't listen at all, but it takes time.*" (practice level). A general lack of communication and confidence would mark the interactions between the LTCO, the caregivers, but also with the residents and their family members: *"Families need to be more involved or at least informed. (…) we would avoid complaints if we would inform them better. Communication is a very important and vast issue, and we have major, major deficiencies."* (practice level). A lack of transparency and honesty would also define the relationships of the LTCO's managers: "*During that committee, what some people are putting forward is nothing but smoke and mirrors. They say: 'Everything is fine', but we know it's not true.*" (practice level). Internal competition and factions would traverse the LTCO, but rarely be apprehended as problematic to avoid further confrontation: "*At the corporate level, something is happening, some cliques are rigid. Our general director is aware of that. During our committees we are comfortable, we laugh, we have fun, but there is like this cement between us.*" (corporate level).

In sum, the LTCO's interactions with its internal and external environments could be characterized as polarized, yet intertwined. The LTCO's interactions with its external environment appeared entrenched in a representation of long-term care as a problematic institution in need of patronage. The dependent relationship this representation entailed would have the led the LTCO to develop a disproportionally outward-looking stance to the detriment of its interactions with its internal environment. An externally driven hypertension to improve juxtaposed to feeble

confidence and investments in the internal stakeholders' abilities to carry out the required improvements would have generated the emergence of a set of principles and devices that effectively govern improvement in the LTCO. These principles are the necessity to improve comprehensively, rapidly, homogeneously, modestly and structurally and are notably incarnated by the LTCO's strategic planning, staff development planning, managerial reward system and auditing tools. As they support engagement activities than run counter current to local managerial knowledge, these principles and devices can be considered as making up a tacit improvement governance system.

Influence of the Characteristics of Improvement Engagement Activities

Espoused-theories estimated that the LTCO's tacit improvement governance system positively influenced the organization's improvement abilities. The LTCO's overflowing improvement agenda was considered beneficial to maintaining improvement pressure and cohesiveness, but also ethical, as attempting to improve everything would be owed to the residents. This view was validated, internally, by the repeated assessment of the LTCO's yearly list of improvement intentions as accomplished and, externally, by the repeated positive evaluation of the accreditation agency: "*An evaluator told me he felt a lot of coherence in our organization, that directors and employees were holding the same discourse, but in different words. That means the information is trickling down and it confirms that we are progressing…"* (regional level). In contrast, theories-in-use were very critical of the influence of this conjecture. From this perspective, the tacit improvement governance system led the LTCO to an important decoupling of its improvement intentions and abilities, which shaped the LTCO's improvement efforts in the following ways:

Dispersion of improvement abilities. A first consequence would be the engagement of an untenable rhythm and quantity of improvement intentions: *"We receive orders from the top and from the bottom, so we are always in the crossfire. (…) You want to concentrate on one thing, but you must put time on others. That's why so many people don't last long."* (practice level). This hypertension to improve would be the primary determinant of the LTCO's inability to engage and support their improvement intentions using the managerial knowledge they possess: *"When we are pushed around by all these programs and they expect everything will be done, it forces some managers to say: 'Yes, it's done. I gave it to my team.' But it's done very partially and superficially…"* (practice level).

Fragmentation of the improvement agenda. A second consequence would be the engagement of improvement intentions without the complementary and interacting input of pertinent services or contributors: "*Why do we start so many different projects at the same time? Except for the accreditation, we are never all invested in one project, we work in silos."* (regional level). The potential impacts or interactions of improvement intentions of a specific nature (i.e. clinical, managerial, technical, technological, human resources) on the various services of the LTCO would be mostly under-examined. Clinical improvement intentions would notably be frequently engaged without regards to the LTCO's ability to manage the enactment of new practices they entail. The lack of a proper management system and of a shared blueprint of how an improvement intention should be engaged to favour effective gains greatly diminished the influence of intentions of other nature. The ambiguity created by the lack of common improvement framework and vocabulary seemed to be utilized to favourably negotiate or communicate the accomplishment of improvement intentions. Secondly, "new" improvement intentions would be engaged without proper investigation into past efforts dedicated to similar issues and the

sequencing of improvement intentions would not be thought out: "*We should build our foundation by focusing on one of the projects we have that could instil hope. Once we've found our footing, by working progressively on a project to consolidate what we achieve, we could start another."* (regional level).

Demotivation of change agents. A third consequence would be that the middle managers, who essentially act as the LTCO's change agents, would frequently lead improvement mandates without recognizing the legitimacy of their undertakings or the value of the solutions they must promote: *"We implemented a whole bunch of things, but look at our falls prevention program, for example. We had to give it to our teams in a hurry (…) but I didn't receive training on it, I didn't understand it completely."* (practice level). From this demotivation would also stem the sentiment of engaging ungrounded and generic projects: "*We should bring the whole process of changing to a smaller scale, so everyone feels compelled in their daily lives (…) Now, everything that lands on the floor, ends up in a no-man's land, is only good for others.*" (regional level).

Discontinuation of improvement processes. A fourth consequence would be fuelled by the idea that the LTCO should aim to accomplish its improvement journey through sprawling, yet loosely coupled phases rather than through focused, yet accumulating processes. From this view, all dimensions of the LTCO should be tackled at the same time, but also equivalently invested to ensure they progress at the same rate. In other words, the LTCO would consider beneficial investing all structural aspects of its organization, before investing their communication, their enactment or their routinization. Engaged improvement intentions would thus be conceived as needing multiple years of effort, or as needing to be recurrently re-engaged, without necessarily ensuring some form of stabilization: *"I tell them: 'Don't try to reach your destination, you will never reach it.' We may identify or attain some objectives, but we may modify or enhance it next*

year. We will never, ever reach the end of the road." (corporate level). Multiple participants rather valued the idea of incrementally building the LTCO's performance by accumulating routinized improvements: "*Shouldn't we limit ourselves and mobilize everyone to start something, to put it in place and consolidate?"* (regional level).

In sum, the tacit improvement governance system in use in the LTCO appeared to engender mostly non-dynamic improvement processes. The dispersion, fragmentation, demotivation and discontinuation of the LTCO's improvement resources and processes (i.e. human, intellectual, financial, temporal) would lead to the underutilization of their transformational potential: "*We don't need more resources; we just need to start working better. We are not working properly at all; we are stuck in the mud."* (corporate level). Most improvement intentions would thus appear to be insufficiently fuelled to traverse the inertia separating them from their realization and mostly result in the production of improvement debris, as acknowledged by all levels of the LTCO:

- *"All our nice programs, all the tools and objectives that we have, they are gravitating around the basic health and security needs of our residents."* (practice level)
- *"It's like it all stayed in a vegetative state. Now, we are trying to take it back."* (practice level)
- *"There is an enormous backlog in terms of program implementation. The clinical services are moving forward even though we have this millstone around our neck and aren't in a condition to recuperate this mountain."* (practice level)
- *"It's done, but in another way."* (practice level)
- *"Some things have not been stabilized and they force us to come back because our audits show it's not working."* (regional level)

- *"When we say it's not going down, it's because we bit off more than we could chew, and now, it's like jammed up here."* (regional level)
- *"The difficulty we have is to make our changes take root, so they can survive changes and personnel turnover."* (regional level)
- *"It's not going all the way down, we can't do it because we don't have enough time…"* (regional level)
- *"They are there, but they are sleeping."* (regional level)
- *"All this is floating; all the projects are in silos."* (regional level)
- *"It looks like it's all clogged up."* (regional level)
- *"Let's put our programs and structure in place, we need to make land everything we started."* (corporate level)
- *"We should focus on keeping the good things we do, on optimizing them to improve. Like that, we wouldn't hurt our people as much…"* (corporate level).

As described, this debris takes the form of unused or misused improvement prescriptions, communicated by memos, guidelines, tools and training sessions, but also has immaterial correlates. This immaterial debris is composed of the sentiments associated with unrealized improvement objectives or with the replacement of worthwhile practices by new prescriptions. This improvement debris, and the tacit improvement governance principles at their source, appear to act as the engines of the vicious cycle of underperformance in which the LTCO revolves (see figure 3). The four consequences of the improvement debris would be the following:

Non-improvement fatigue. While espoused-theories argued that the work accomplished in past years allowed generating a sense of pride, notably in regard to the LTCO's accreditation with

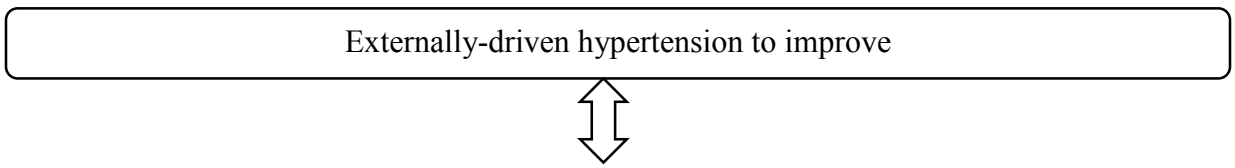
honours, theories-in-use oppositely stated it contributed to a generalized fatigue. The necessity for change agents to support the principles of the tacit improvement governance systems would stimulate a sentiment of dissonance: "*It's eating me from the inside out. I would like to tell the accreditation agency that we didn't do something for this or that reason instead of sketching up some procedure just for show.*" (corporate level). Similar sentiments would be experienced by change users: "*…our people are exhausted. They don't see the end of it and they say: 'Why did we do this? We don't even integrate it and then we ask us to do something else just for show?'"* (corporate level). The LTCO's lack of engagement towards producing significant and lasting improvement would prevent replenishing the change energy of their human resources and be a source of waste: "*We don't even integrate [improvements] in most cases. They may end up being integrated, but it takes two or three times the time that a better planned and structured change would take.*" (practice level).

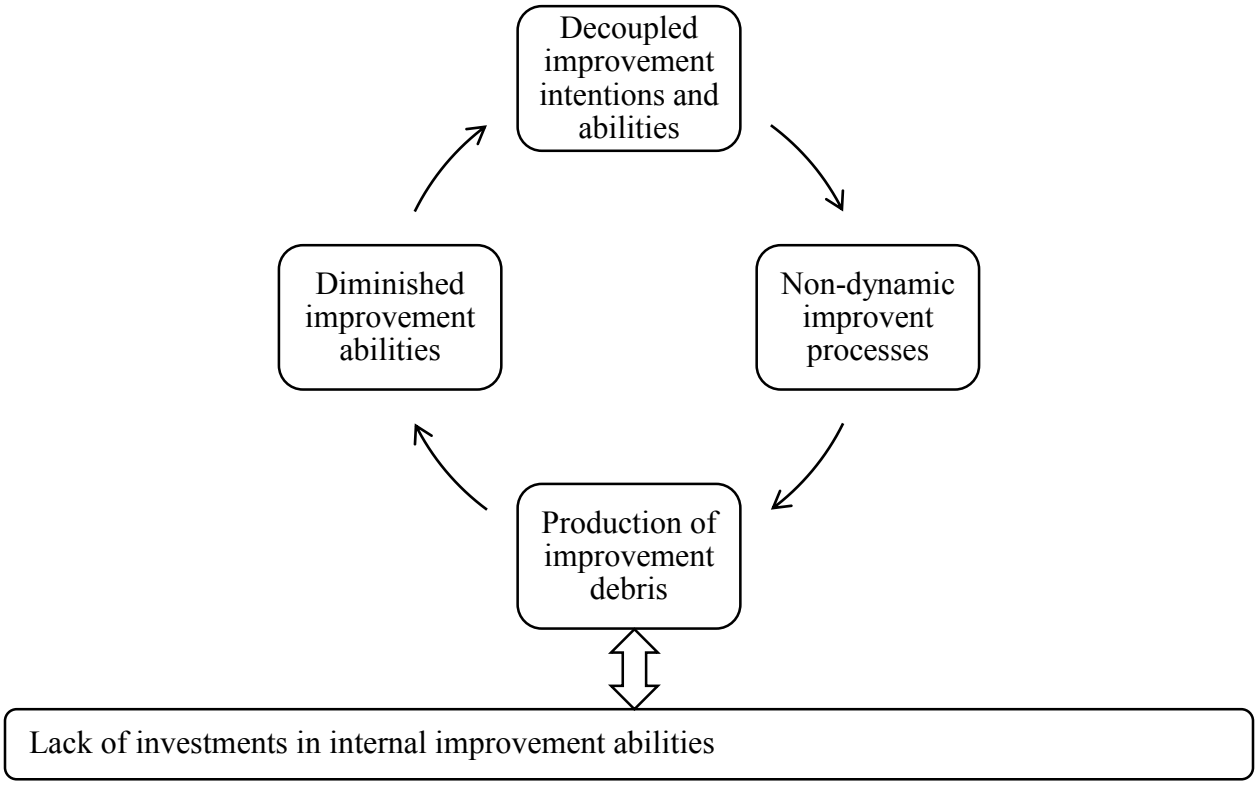
Diminished receptivity to change. While espoused-theories express the intensified structural investments of past years served to establish the LTCO's foundation, theories-in-use rather communicated a sense of confusion and disorder which complicates future improvement engagement: "*At this point, after one year in the organization, I'm mixed up with all the politics and procedures that are not always updated. It's confusing!"* (practice level). Furthermore, the credibility of the LTCO's change agents would have been tarnished by the frequent need to restart failing endeavours or the tendency to replace useful practices by new prescriptions: "*To some degree, my team must say: 'Who cares! It's not the end of the world, it's going to fall apart sooner than later.' It's only human for them to say so. That's why our projects are not well received."* (practice level). Management turnover would also be an important contributing factor to the cynicism of change users: "*When you try to implement a change, the employees say: 'He won't*

last long, let's just listen to what he has to say, he'll be leaving soon anyways.'" (regional level). The LTCO would thus represent a very hostile territory for improvement initiatives: "*When I ask people why they are for or against something, they say: 'I don't know, but I am against!' There is no more reasoning, it's become second nature to be against the direction.*" (regional level).

Diminished improvement urgency. While espoused-theories communicated that the ample evaluation criteria utilized by the accreditation agency and the seriousness granted to the process by the LTCO kept employees on their heels, theories-in-use criticized the effect of their lenient evaluation: "*When we heard we got an almost perfect score, we all started laughing! (…) Listen, we're not crazy. Obviously, the employees were happy, but (…) some may say: 'Look, don't ask us anything else, we're good enough!*'" (practice level). The sense of urgency to improve would also be diminished by an impression of lack of consideration for internally valued improvement intentions. Many participants expressed being resigned or having accepted fundamental flaws. The inefficiency of the communication structure, lack of orientation of newly hired managers, lack of recognition of employees, lack of supervision during the evening and night shifts and inability to ensure efficient personnel replacement are some examples. The problems that perpetually arise from the non-resolution of these issues also diminish the availability of resources planned to support formally engaged improvement intentions.

Figure 3. *Main Contributors to the Underperformance Vicious Cycle*





Personnel and vision instability. While espoused-theories considered that the realization of the different phases of the improvement agenda elaborated and engaged by the LTCO required different types of managers, theories-in-use stated that the non-improvement fatigue contributed to personnel instability: "*I'm not blaming anyone since it's so long and complicated to implement a program, but as soon as you push a little too hard, well, they all become sick.*" (regional level). High management turnover would also be influenced by non-improvement fatigue: *"There is a lot of turnover in our managers since they become tired, overwhelmed by the need to redo things they already did."* (regional level). In turn, the heavy turnover of managers would exacerbate the unstable ideal to which the LTCO strives for: "*Employees are right to be critical because our changes should be oriented by a vision and continuity. We can't be changing every three years.*" (regional level).

In sum, the engagement activities typically used by the LTCO appeared to maintain the organization in state of persistent underperformance as it transformed its improvement resources into improvement obstacles more than into performance gains or into heightened improvement abilities.

Discussion

This study set out to analyze the dynamics of underperforming healthcare organization through the lens of improvement engagement. To do so, an action research was conducted in the persistently underperforming sector of long-term care. Its results described the activities commonly used by the LTCO to engage its improvements intentions as running counter current to locally available managerial knowledge. These activities appeared to be oriented by a tacit improvement governance system designed to favour more externally apparent than internally significant performance gains. This tacit system would be rooted in the historical interactions of LTCOs and their internal and external environments. The mediatisation of the general inhospitality and major deficiencies of LTCOs would have stimulated the development of a patronizing form of support from their external stakeholders. This patronage would have incarnated itself through the multiplication of regulatory agencies and improvement prescriptions, and by the consequent adoption of a disproportionally outward-looking stance by LTCOs. This presumably typical asymmetry would have led the LTCO to decouple its improvement intentions and abilities. This decoupling would coerce the LTCO to disperse and fragment its improvement resources. Succeeding improvement processes would be insufficiently dynamized to traverse the LTCO's contextual inertia and generally produce improvement debris rather than entrenched improvements. This debris seemed to fuel a vicious cycle of underperformance. The fatigue and

instability generated by the LTCO's means of engaging improvement intentions would contribute more to widening the gap between the LTCO and its performance ideal than to closing it.

These results can be discussed in view of the two fundamental questions called upon by the concept of persistently underperforming organizations. The first question is: how do persistently underperforming healthcare organizations survive? And the second is: why can't persistently underperforming healthcare organizations improve their performance? Regarding the first question, it is important to recall that this study was conducted in a private, but publicly subsidized and regulated, healthcare organization. Its survival is thus ensured by the institutionalization of long-term care and the constant inflow of public funding, but also by the ability of the private organization to maintain its representation as a quality provider. The necessity for the private stakeholders to maintain an image of worthy partners of the public system, as the necessity for the public stakeholders to maintain an image of trustworthy authorities, may generate interest in "symbolic problem solving" (Seibel, 1996). While Seibel's argued that the public and private sectors' respective anchoring to accountability and competition principles diminished their interest for symbolic problem solving, our results propose the contrary. The LTCO and its external stakeholders appeared interested in concealing the insufficiency of resources to improve the quality of long-term care and to establish a form of mock accountability. LTCOs have been described as traversed by mock behaviours at practice and managerial levels (Lopez, 2007), revealing a possible fractal declination of the LTCOs interactions with its environments, but other types of healthcare organizations may also be inclined to symbolic problem solving. Contexts of disjointed improvement requirements and abilities, which could be stimulated by the swift replacement of a laissez-faire managerial approach by a command-and-control approach (Stensaker, Meyer, Falkenberg, & Haueng, 2002), or of equivocal performance criteria (Meyer &

Zucker, 1989; Weick, 1993) may be particularly subject to dedicating resources to essentially ostensible improvement. Further research on the recourse to mock accountability in other healthcare sectors could be useful.

Regarding the second question, previous studies on persistently underperforming organizations emphasized diverse contextual dynamics to explain their inability to improve, notably the coupling of lenient external support and internal deficiencies (Seibel, 1996), the coupling of diminishing organizational performance with increasing employee influence (Meyer & Zucker, 1989), or the coupling of indiscriminate hope with inefficient practices (Rouleau et al., 2008). Rouleau et al. (2008)'s defined these dynamics as paradoxical situations and identified them as the determinants of the practices that tend to push organizations into situations of permanent failure. This insight was supported by the rooting of the LTCO's tacit improvement governance system in the paradoxical representation of the externally driven hypertension to improve, coupled with meagre internal improvement abilities. The tacit improvement governance system can be considered as the most appropriate coping mechanism the LTCO could produce when confronted with this paradoxical context. Coping behaviours, incarnated by the multiplication of espoused-theories communicating recognized managerial knowledge (ex.: espousing the belief that the LTCO aims for in-depth changes apparently to deny contributing to the contrary), ideologically justifying the status quo (ex.: espousing the idea that improving everything at once is owed to the residents), or erroneously associating recognized managerial knowledge and deleterious engagement practices (ex.: espousing the idea that attempting to improve everything at once is a means of ensuring integrated improvement) can be considered responses to the cognitive dissonance generated by these apparent paradoxes. However, in contrast with Rouleau et al. (2008), this study did not apprehend these behaviours as unaligned with or as countering the

strategic actions of the LTCO, but rather as oriented by its strategic means of engaging improvement. While the LTCO's tacit improvement governance system may represent a contingent product of its environment (Lawrence & Lorsch, 1967), or an adapted means of survival (Hannan & Freeman, 1977), or a form of psychotic coping (Sievers, 1999), it can also be seen as a rational means of knowledge transfer obstruction or of "functional stupidity"(Alvesson & Spicer, 2012). Espoused-theories did reveal the LTCO's managers possessed sufficient knowledge to transform their improvement intentions into routinized performance gains more frequently, but that governing principles inhibited their application. Organizations displaying functional stupidity have been described as settings where: *"Independent thinking is discouraged by an emphasis on the rationality of formal structures and procedures and the imitation of others in order to make things look good and legitimate."*(Alvesson & Spicer, 2012, p. 1204).

Against this contextual view, this study's most idiosyncratic contribution is to highlight the influence of the LTCO's means of engaging their improvement intentions on their persistent underperformance. In fact, with the exception of Eitel (2004)'s case study, others only indirectly address how contextual dynamics curb the organization's improvement efforts. The results of our study and Eitel's (2004) case study of a professional bureaucracy's continued underperformance both develop a theory of underperformance as a vicious cycle propelled by the cumulated effects of multiple aborted, discontinuous or unsuccessful improvement efforts. This explanation is corroborated by Stensaker et al.'s (2002) study on the effects of excessive change which suggests that a "*circular relationship exists between coping mechanisms and implementation failure*". The concept of improvement debris, which acts similarly as space debris in complicating future space travels, is thus validated by both studies that identify past wounds associated to botched improvement efforts or to the discard of well-functioning routines as negatively affecting the

organization improvement abilities. Improvement abilities would be diminished concurrently by the intensification of inertia (i.e. raised apprehension of change users, non-improvement fatigue, general confusion, etc.) and diminished improvement resources (i.e. change agent disengagement, waste of resources, leadership discontinuity) (Eitel, 2004; Stensaker et al., 2002). This finding contests the idea that even unsuccessful improvement efforts may be valuable (i.e.: tacit learning, problematization) (Couturier & Etheridge, 2012) by suggesting that failed improvement efforts do not only prevent improvement, but also exacerbate the improvement challenge.

Practices Implications

In view of this study's results, we believe managers of healthcare organizations, and especially of persistently underperforming organizations, can rethink their improvement engagement activities in the following ways:

- Ensuring they invest the impulsion, concretization, diagnosis and development activities to set up the emergence of dynamic implementation processes.
- Devoting resources to highlighting and transforming the improvement governance system in-use in their organization, if it prevents the application of proper managerial knowledge, rather than to furthering managerial training.
- Addressing the existence of improvement debris, by physically removing them (i.e. binders, posters, etc.) and emotionally recognizing them (i.e. addressing their existence, explaining their production, etc.), to diminish their impact on subsequent efforts.
- Implementing improvement devices only when sufficient resources are available to ensure they are supported by dynamic improvement processes to prevent the production of improvement debris.

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Discussion supplémentaire

Cet article propose une explication à la sous-performance persistante d'organisations de santé. Le contexte des OHSLD y est présenté comme propice à une compréhension plus générique des mécanismes qui maintiennent des organisations de santé dans un cercle vicieux. L'explication élaborée prend racine dans les études portant sur le concept nommé « permanently failing organizations » par Meyer et Zucker (1989). Elle se construit principalement par la mobilisation de connaissances issues de la gestion du changement et du développement organisationnel. Cette discussion supplémentaire portera sur les thématiques suivantes, soit l'influence de l'imputabilité factice, la production de débris d'amélioration, la stupidité fonctionnelle et la potentielle structure fractale des organisations.

En ce qui a trait au concept *d'imputabilité factice*, nommée « mock accountability » dans l'article, plusieurs écrits propres aux OHSLD soutiennent son existence en décrivant des éléments y contribuant sans le nommer ainsi. Par imputabilité factice nous référons aux arrangements qui contribuent à produire une impression d'imputabilité des OHSLD à l'égard des organisations réglementaires, notamment de contrôle de la qualité. Les écrits stipulants que les cadres

réglementaires imposés aux OHSLD sont impossibles à respecter faute de ressources (e.g. Ragsdale & McDougall, 2008), décrivant leurs modalités d'évaluation irrégulières et imprécises (e.g. Levenson, 2009b), exposant le très peu de ressources consacrées à leurs évaluations ou le peu de conséquences associées à leur non-respect (e.g. Lenhoff, 2005) en sont des exemples. Un article publié dans le Journal of Law and Health affirme que : «*poor enforcement of existing laws remains the bane of the nursing home regulatory regime. This is an occurrence detrimental to patients, the intended beneficiaries of all nursing home regulations, as study after study by U.S. government agencies seems to validate* ». (Aka, Deason, & Hammond, 2001, p. 14). Il est aussi possible de représenter l'écart important entre les curriculums utilisés pour former les préposés aux bénéficiaires et les possibilités d'action propres aux OHSLD comme un autre contributeur à cette imputabilité factice (Aubry & Couturier, 2014). L'enseignement de pratiques impossibles à appliquer dans un contexte de contraintes temporelles importantes peut être conçu comme une autre stratégie pour détourner la responsabilité des lacunes des OHSLD des acteurs gouvernementaux vers des acteurs organisationnels ou individuels délinquants. Le respect des meilleures pratiques de soins enseignées aux préposés aux bénéficiaires ou des normes et réglementations imposées aux OHSLD augmenterait nécessairement la qualité des soins et services rendus à leurs résidents, mais leur nature utopique et déracinée serait une composante d'une dynamique néfaste. En effet, les résultats de notre étude exposent les effets délétères de l'apparente adaptation des OHSLD à la nature factice du système réglementaire en vigueur. Le développement et la mise en application de systèmes de gouvernance de l'amélioration priorisant la production d'améliorations significatives aux yeux des organismes réglementaires sont décrits comme les vecteurs des défauts d'amélioration des OHSLD. Leurs intentions de répondre aux exigences des entités composant leur environnement externe ne doivent toutefois pas être

représentées comme mal avisées en soi. L'attribution de la majorité des ressources de développement organisationnel des OHSLD à la production de gains ostensibles d'un point de vue extérieur, voilant la réalité intérieure, au détriment de l'engagement d'intentions d'améliorations estimées prioritaires à l'intérieur est problématique. Nous voyons dans cette explication de l'incapacité des OHSLD à s'extraire de leur cercle vicieux de sous-performance une analogie avec la théorie du management par les ressources, ou la « resource-based view » des organisations (Barney, 1991). Bien que celle-ci s'intéresse aux modalités permettant à des organisations de développer leurs avantages sur leurs compétiteurs, elle soutient l'idée que la performance organisationnelle ne se construit pas par l'importation de connaissances extérieures, mais plutôt par la potentialisation de ressources déjà possédées. Cette théorie soutient que la capacité des gestionnaires d'une organisation à comprendre et décrire le potentiel de ses ressources internes, notamment associées à leurs processus stratégiques informels ou à leurs systèmes de gestion de l'information, est une ressource fondamentale à exploiter ou à développer. En ce sens, nous estimons qu'il est du ressort des gestionnaires d'organisations de santé durablement sous-performantes d'identifier les habiletés et marges de manœuvres (March, 1988) propres à leurs organisations et d'y adapter leurs intentions d'amélioration.

Deuxièmement, les stratégies d'innovation mal accomplies produisent des *débris d'amélioration*. Par débris d'amélioration, nous référons à conséquences matérielles et immatérielles de la non-réalisation d'intention d'amélioration. Nous reconnaissons que l'acte d'engager une intention d'amélioration pourra engendrer des effets positifs même si les retombées attendues ne sont pas formellement observées (Couturier et Etheridge, 2012). Cependant, malgré cette lecture optimiste, force est de constater que des intentions de changements mal abouties génèrent un grand nombre de débris d'amélioration. Les effets des débris d'amélioration décrits

dans cet article apparaissent suffisamment contre-productifs pour justifier des investissements importants dans les activités diagnostiques de la phase d'engagement d'amélioration pour éviter de stimuler le déploiement de processus d'implantation voués à l'échec du départ. De ce point de vue, les activités d'engagement d'amélioration deviennent tout aussi pertinentes comme prémisse à l'implantation ou la non-implantation de dispositifs d'amélioration. Écrit autrement, il est possible de concevoir que la performance organisationnelle se construise tout autant par les intentions d'amélioration concrétisées que par des intentions d'améliorations freinées ou retardées. L'inévitable conduite de projets d'amélioration qui seront estimées être des échecs mérite toutefois d'être appréhendée comme des sources d'apprentissages.

Troisièmement, le concept de *stupidité fonctionnelle* élaboré par Alvesson et Spicer (2012) apparaît très explicatif de la réalité observée et agir en tant que toile de fond de la sous-performance persistante. La stupidité fonctionnelle peut être définie comme la tendance de certaines organisations à sous-utiliser leurs habiletés ou ressources intellectuelles pour maintenir ou renforcer un état organisationnel favorable à des intérêts incompatibles à une amélioration effective. La description des OSHLD comme des milieux qui contraignent les préposés aux bénéficiaires à « désapprendre » des connaissances et compétences acquises en formation considérant le manque de temps pour les appliquer (Aubry & Couturier, 2014) est cohérente à cette définition. Toutefois, deux distinctions entre cette sous-utilisation forcée des connaissances et compétences des préposés aux bénéficiaires permettent de mieux situer la manifestation de la stupidité fonctionnelle dans les OHSLD. Premièrement, la sous-utilisation forcée des connaissances et compétences des préposés aux bénéficiaires est traitée comme formellement inacceptable bien que tacitement reconnue comme inévitable (Lopez, 2007). Les incarnations du phénomène de stupidité fonctionnelle sont plutôt formellement soutenues et encouragées par les

organisations qui en font usage. De plus, bien qu'il exige la mise à l'écart de connaissances, le « désapprentissage » des préposés aux bénéficiaires n'aurait pas la même fonction que les incarnations de la stupidité fonctionnelle. Les pratiques clandestines des préposés auraient comme cible ultime l'amélioration de la réalité effective, soit la réalité du résident plutôt que la bonification de la réalité symbolique, soit la réalité perçue par les parties prenantes externes des OHSLD. La stupidité fonctionnelle mènerait donc à un contexte où : « *image building, often becomes more significant than production (Alvesson, 1990). This can weaken 'substance' and 'craft' as the key features of organizations (Sennett, 2006, 2008) and emphasize symbolic manipulation »* (Alvesson & Spicer, 2012, p. 1203). Ce concept semble ainsi très cohérent avec l'explication de la sous-performance persistante développée par notre article, c'est-à-dire concentrée sur le rôle d'une gouvernance de l'amélioration orientée vers les gains apparents plutôt qu'effectifs. Paradoxalement, la stupidité fonctionnelle s'incarnerait par une apparente inclinaison vers l'action et conséquemment par l'impulsion de changements motivée par de fausses urgences créées par des gestionnaires plus intéressés par l'avancement de leur carrière que par l'influence effective potentielle de changements engagés. Dans notre article, les théories épousées soutenant le devoir moral d'agir toutes les intentions d'améliorations impulsées par souci pour le mieux-être des résidents sans égard à la capacité réelle à les réaliser exemplifient cette manifestation. Finalement, comme une gouvernance de l'amélioration dirigée vers la performance apparente, la stupidité fonctionnelle est reconnue comme une source de bénéfices pour les organisations et les individus qui la composent. Pour les organisations, elle est une source de certitude, de fluidité et de performance, et pour les individus, une source de réduction d'anxiété ou d'avancement de carrière. De façon tout aussi cohérente à la réalité relatée par notre étude, la stupidité fonctionnelle est à la source de nombreux maux et risques, notamment une source de dissonance, d'aliénation,

de démotivation et de sous-engagement à l'égard de l'organisation. Ce serait finalement une cause de : « *reproduction of problematic conditions »* (Alvesson & Spicer, 2012, p. 1200) et donc un moteur de cercles vicieux. Pour toutes ces raisons, nous considérons juste d'affirmer que la stupidité fonctionnelle réfère à une dynamique organisationnelle connexe à la dynamique décrite par notre étude. Telle que révélé par les écarts entre les théories épousées et en usage dans l'OHSLD à l'étude, les conséquences négatives de la relation dialectique entre des intentions d'améliorations élevées et des habiletés d'améliorations faibles sont le produit d'une sous-utilisation de connaissances que de manque de connaissances.

La quatrième et dernière thématique de cette discussion supplémentaire est celle de la potentielle structure *fractale* des organisations. Sans être directement associée au phénomène de la sous-performance persistante, cette idée émerge d'une analogie entre la nature des relations entre les OHSLD et leur environnement externe, marquée par une nécessité de performance apparente, et les relations entretenues entre les différents paliers hiérarchiques internes des OHSLD. L'étude de Lopez explicite en effet l'existence d'une forme de routinisation des écarts entre la norme et la pratique autant au niveau des macrosystèmes (c.-à-d. entre les organisations réglementaires et les OHSLD, entre l'opinion publique et les OHSLD) que des microsystèmes des OHSLD (c.-à-d. entre les gestionnaires et le personnel soignant, entre le personnel soignant et les résidents). Ces similarités permettent une analogie avec la forme fractale, c'est-à-dire « *a rough or fragmented geometric shape that can be split into parts, each of which is (at least approximately) a reduced size copy of the whole »* (Mandelbrot, 1982). La partie reflète, suivant cette analogie, la forme du tout, l'échec local reflétant l'échec global, la faillite d'une innovation reflétant la faillite d'une organisation, les débris des divers échecs et demis-succès se reportant dans une organisation globale structurée par ces débris. La structuration fractale du local et du

global explique une part importante de l'inertie au changement caractérisant un grand nombre d'OHSLD. Cette conceptualisation fractale des phénomènes organisationnels permet peut-être d'anticiper que des efforts d'amélioration ciblant un niveau organisationnel puissent enclencher l'émergence des transformations équivalentes à d'autres. Évidemment, des investissements aux plus hauts niveaux des systèmes pourraient se révéler être des leviers de transformation puissants localement, car créant des conditions au succès. Toutefois, il serait intéressant d'étudier les effets de microchangements, motivés par des formes de courage managérial, par exemple soutenu par des cadres intermédiaires, sur la structuration plus large de leurs champs organisationnels. Cet intérêt recoupe aussi l'idée de mieux comprendre l'ampleur de la marge de manœuvre des organisations et des gestionnaires agissant dans des contextes d'imputabilité factice.

Recommandations

Cette section regroupe et bonifie les recommandations tirées des trois articles qui composent cette thèse. Ces recommandations sont organisées en deux grands thèmes interreliés, soit la gestion du changement et la gouvernance de l'amélioration. Les sections propres aux deux thèmes comportent des recommandations plus spécifiquement dirigées vers les OHSLD.

Gestion du changement

Nos résultats permettent des recommandations propres à l'étude et à la pratique de la *gestion du changement*. Nous utilisons ce vocable comme il réfère à des concepts dont les représentations sont relativement partagées, malgré que le terme « gestion » renvoie à l'appréhension de quelque chose d'existant. Bien que ce projet doctoral soit fondé sur l'axiome voulant que le changement soit l'unique voie vers l'amélioration, et donc que des opportunités de

changement *existent* dans les organisations, nos résultats exposent que la tâche des agents de changements est de faire émerger *l'inexistant*. Les stratégies de gestion du changement, telles que conceptualisées dans cette thèse, visent à faire naître des pratiques inexistantes dans un contexte donné par la mise en place de modalités de soutien propice à générer du dynamisme. Nos résultats décrivent cette fonction de dynamisation comme se réalisant majoritairement en potentialisant des ressources existantes dans les organisations, mais de façon à créer une énergie nouvelle et particulière. Pour cela, nous considérons que le vocable « gestion du changement » est plus approprié pour décrire les activités ou efforts découlant plus ou moins naturellement d'un changement non planifié dans l'environnement interne ou externe des organisations. Pensons par exemple à la gestion des effets de modifications à des conventions collectives, du départ d'employés ou de gestionnaires ou de la transformation des besoins typiques d'une clientèle. Nous recommandons ainsi l'adoption de la terminologie « soutien à l'amélioration » pour référer aux actions visant à favoriser la mise en œuvre de pratiques conçues comme préférable à des pratiques actuelles. Le remplacement de pratiques actuelles par des pratiques améliorées peut se réaliser de façon planifiée ou non, mais ce degré de planification n'est pas dichotomique. Peu d'intentions ou de projets d'amélioration pourraient être définis comme purement émergents ou planifiés, bien que le soutien à l'amélioration planifiée ou émergente est possible. Les systèmes dits d'amélioration continue et plus largement les cultures stimulant l'apprentissage organisationnel représentent des modalités de soutien à l'amélioration émergente. La création de telles cultures ou l'implantation de tels dispositifs ou systèmes, comme de pratiques plus circonscrites, requiert néanmoins la contribution de stratégies de soutien à l'amélioration plus ou moins formalisées. Les trois paragraphes suivants présentent des recommandations pertinentes, à notre avis, à l'élaboration et au déploiement de stratégies de soutien à l'amélioration d'envergure et de nature variée.

Premièrement, l'utilisation du vocable « plan de communication » pour référer aux efforts de soutien à l'amélioration mérite d'être remplacé dans les organisations qui en font un usage courant. En effet, nous considérons que l'utilisation de cette terminologie stimule l'élaboration de stratégies de soutien à l'amélioration de formes reconnues inefficaces, soit essentiellement composées de dispositifs communicationnels. Les acteurs de l'élaboration de stratégies de soutien à l'amélioration devraient plutôt planifier des interactions complémentaires entre des modalités de gestion visant à influencer le processus de changement de façon « make-it happen », « help-it happen » et « let-it happen ». L'élaboration de stratégies de soutien à l'amélioration devrait être guidée par l'intention d'engendrer des sentiments antinomiques aux sentiments associés à la résistance au changement, notamment l'urgence de changer, la solidarité entre les parties prenantes, l'intensité des efforts d'amélioration et l'accumulation de compétences. L'identification et la mise à contribution des « pools locaux » d'expertise et de connaissances seraient une heuristique utile pour générer ces sentiments et le dynamisme requis pour surmonter les forces d'inertie propres à un contexte donné.

Deuxièmement, notre intérêt pour l'amont des processus d'amélioration permet de souligner la valeur des efforts consacrés à préparer l'implantation de dispositif d'amélioration. Nous recommandons ainsi d'investir les quatre types d'activités identifiés comme préalables à l'implantation. Des activités d'impulsion plus collaboratives et fondées sur la réalité pratique, des activités de concrétisation structurées et visant à mobiliser les agents de changements, des activités diagnostiques étoffées et dont les résultats sont considérés ainsi que des activités d'élaboration moins préoccupée par les dispositifs d'amélioration que par les stratégies de soutien à l'amélioration seraient bénéfiques. Les efforts pré-implantation permettent de créer et nourrir progressivement le dynamisme du processus d'amélioration. Autrement écrits, nous

recommandons que les activités d'engagement soient investies de façon à éviter le déploiement de processus d'implantation voués à s'éteindre à mi-parcours.

Troisièmement, nous recommandons de reconnaître l'existence de débris d'amélioration et, plus largement, l'influence de l'historique d'amélioration d'une organisation sur ses intentions actuelles. Cette reconnaissance doit notamment s'incarner par des activités diagnostiques de qualité pendant la phase d'engagement. Un travail diagnostique sensible à la présence de débris d'amélioration permettra l'adaptation conséquente de stratégies de soutien. L'identification et la prise en considération des effets et contre-effets potentiels de projets d'amélioration engagés nous apparaissent recommandables. De plus, prévoir l'élimination de débris matériels (p ex. : affiches associées à des projets désuets, programmes ou procédures écrites non appliquées, outils inutilisés, etc.) et des échanges sur les sources de débris immatériels (p ex. : désillusion associée à des tentatives échouées, cynisme ou méfiance découlant d'écart entre le discours et la pratique de gestionnaires, sentiments d'incohérence découlant d'écart entre des pratiques prescrites et réalisées, etc.) pourrait diminuer les forces d'inertie à surmonter.

Gouvernance de l'amélioration

Nos résultats permettent aussi des recommandations sur le plan de la *gouvernance de l'amélioration*. Cette notion de gouvernance de l'amélioration peut être définie comme la matrice de qui stimule l'ensemble plus ou moins chaotique de décisions et d'actions visant à améliorer la performance d'une organisation. À ce sujet, nous soulignons l'importance de reconnaître l'existence de valeurs, de principes, de structures et d'outils qui composent ces matrices ou, écrit autrement, ces systèmes de gouvernance de l'amélioration. Subséquemment, nous recommandons aux gestionnaires de consacrer des efforts à identifier la nature des valeurs et principes qui sous-

tendent le système de gouvernance de l'amélioration agissant dans leur organisation et observer leurs effets sur l'habileté de leur organisation à s'améliorer. En ce sens, nous considérons que l'amélioration de la performance d'une organisation est toujours possible, mais qu'elle requiert des systèmes de gouvernance de l'amélioration résolument orientés vers la performance effective et adaptés aux habiletés d'amélioration de son organisation. Par exemple, en OHSLD, l'amélioration de la performance effective exigerait généralement des systèmes de gouvernance de l'amélioration valorisant l'amélioration pratique et progressive plutôt que structurelle et révolutionnaire. Ceci étant dit, nous sommes lucides quant à la nature fortement politique de la gouvernance de l'amélioration. Les jeux de pouvoir interne et externe aux organisations auront toujours une influence fondamentale sur la nature de cette gouvernance. Par exemple, une telle transformation du système de gouvernance de l'amélioration dans les OHSLD exige d'accepter une certaine mise en danger de leur image publique et une évolution hétérogène de leurs performances comme elles ne partent pas toutes sur un pied d'égalité. Cette transformation pourraient être légitimée et défendue par le principe qu'il vaut mieux s'améliorer de façon lente, hétérogène, mais réelle que de façon rapide, homogène, mais qu'apparente. L'idée que la performance organisationnelle se construit tout autant par des décisions d'implanter que de ne pas implanter des dispositifs d'amélioration peut aussi stimuler ce changement. Une « charge » d'amélioration adaptée à la capacité et aux habiletés d'amélioration d'une organisation serait permise par des activités d'amélioration adéquates et pourrait être l'une des clés à la sortie de cercles vicieux de sous-performance.

Ensuite, la gouvernance de l'amélioration en OHSLD serait plus productive en orientant la recherche de solutions dans leur environnement interne qu'externe. Il nous apparaît ainsi recommandable d'utiliser les ressources présentement consacrées à l'importation de connaissances

externes (p ex. : formations sur de nouvelles pratiques cliniques, formation sur de nouvelles pratiques managériales, implantation de nouvelles philosophies d'intervention) faiblement absorbées à la construction de systèmes plus « inward looking ». Ces systèmes pourraient comprendre une structure de communication ascendante propice à l'identification de priorités d'amélioration internes, des modalités diagnostic capables de faire émerger des obstacles à la réalisation d'améliorations, des espaces encourageant la réflexivité et des échanges transparents à propos des succès ou insuccès de projets d'amélioration, des guides à l'élaboration de stratégies de soutien à l'amélioration collaboratives, etc. Néanmoins, nous considérons que le plus puissant moteur de changement serait la transformation du système d'évaluation de la qualité en place. L'établissement d'un système d'accréditation fondée sur des critères adaptés à la performance singulière des organisations utilisant des évaluations imprévues et centrées sur des pratiques effectives et offrant un accompagnement à l'élaboration de modalités de gestion favorables à l'amélioration serait de mise. Une révision des effets de la réaction défensive du macro-système des OHSLD à la mise en lumière de leurs nombreuses lacunes nous apparaît être le meilleur moyen pour soutenir des améliorations dans leurs micro-systèmes et ainsi construire leurs habiletés à s'améliorer progressivement.

Conclusion

En conclusion, nous considérons que cette thèse par article permet une compréhension novatrice des difficultés d'amélioration des CHSLD et plus généralement des organisations sous-performantes. La pertinence et l'originalité de sa contribution découlent d'un simple constat, soit que toutes les organisations ont des opportunités de s'améliorer, mais que seules certaines d'entre elles réussissent à transformer ces opportunités en amélioration effective. Ce constat est à la source de la mise à profit de connaissances issues du champ de la gestion du changement à une

compréhension plus large des dynamiques d'organisations sous-performantes. Les principaux résultats de cette thèse, pensons notamment à l'identification de sentiments antinomiques à la résistance au changement, à l'influence de systèmes de gouvernance de l'amélioration sur l'utilisation de connaissances managériales, au concept de débris d'amélioration ou à la structure fractale des organisations, méritent toutefois d'être étudiés davantage. L'étude de ces concepts dans des OHSLD strictement publiques et dans d'autres types d'organisation, notamment de santé, permettrait d'augmenter leur validité ou de raffiner leurs définitions. Plus de recherche sur les leviers disponibles et utiles pour infléchir les systèmes de gouvernance de l'amélioration défavorable à la production d'améliorations significatives et pérennes sont apparaît également pertinente.

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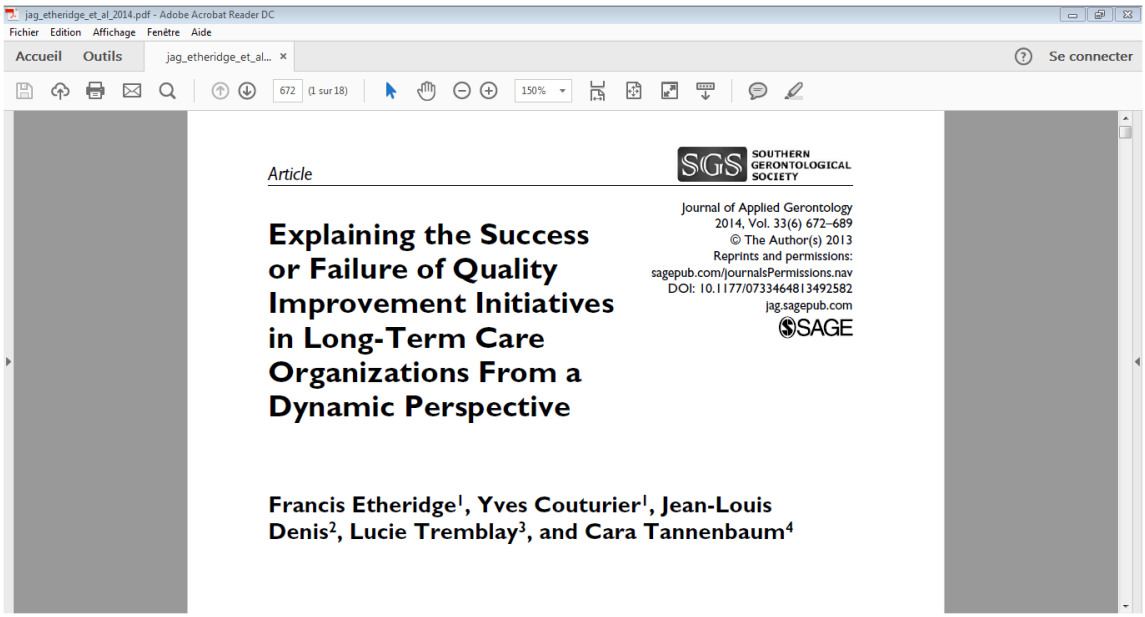
Annexe I

Preuve de publication du premier article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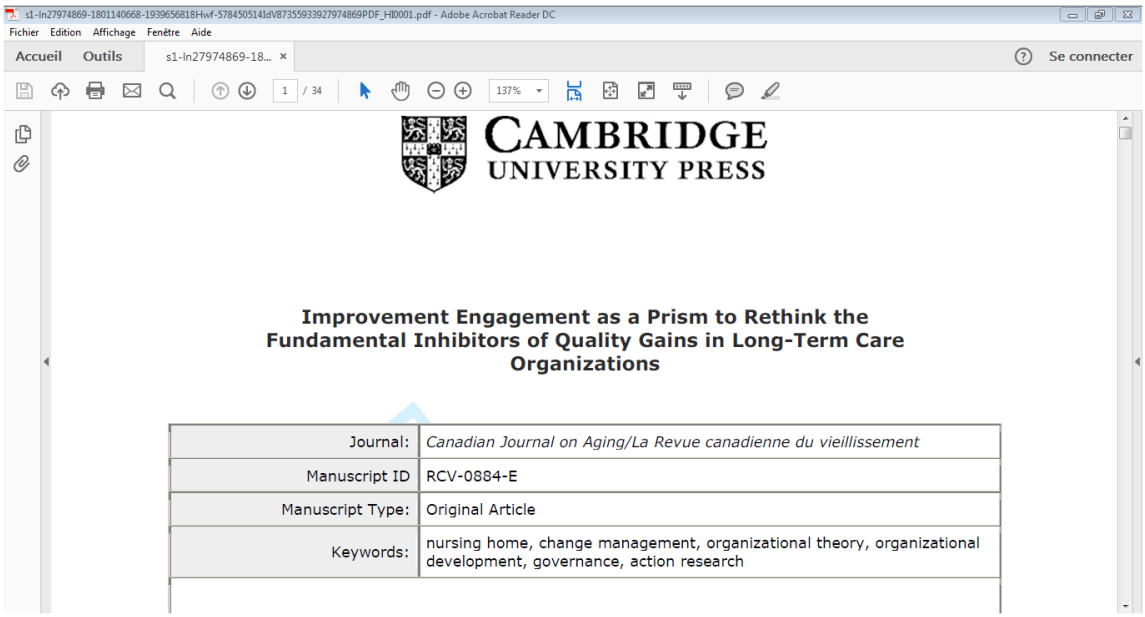
Explaining the Success or Failure of Quality Improvement Initiatives in Long-Term Care Organizations From a Dynamic Perspective

Francis Etheridge[1], Yves Couturier[1], Jean-Louis Denis[2], Lucie Tremblay[3], and Cara Tannenbaum[4]

Annexe II

Preuve de soumission du deuxième article



Annexe III

Preuve de soumission du troisième article