



RESEARCH

Creating Cultures of Care: Exploring the Social Organization of Care Delivery in Long-Term Care Homes

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Context: As a result of changing demographics, the number of older adults living in long-term care homes (LTCHs) is expected to rise dramatically. Thus, there is a pressing need for better understanding of how the social organization of care may facilitate or hinder the quality of work-life and care in LTCHs.

Objectives: This study explored how the social organization of work influences the quality of work-life and care delivery in LTCHs.

Method: Institutional ethnography followed by theory building provided the conceptual underpinnings of the methodological approaches. Participants included 42 care team members who were employed by one of three participating LTCHs. Data were derived from 104 hours of participant observation and 42 interviews.

Findings: The resident care aides (RCAs) were found to rely on supportive work-teams to accomplish their work successfully and safely. Reciprocity emerged as a key feature of supportive work-teams. Management practices that demonstrated respect (e.g., inclusion in residents' admission processes), recognition, and responsiveness to the RCAs' concerns facilitated reciprocity among the RCAs. Such reciprocity strengthened their resilience in their day-to-day work as they coped with common work-place adversities (e.g., scarce resources and grief when residents died), and was essential in shaping the quality of their work-life and provision of care.

Discussion: The *empowerment pyramid for person-centred care* model proposes that the presence of empowered, responsive leaders exerts a significant influence on the cultivation of organizational trust and reciprocating care teams. Positive work-place relationships enable greater resilience amongst members of the care team and enhances the RCAs' quality of work-life, which in turn influences the quality of care they provide.

Limitations: Whether there were differences in the experiences, opinions, and behaviour of the people who agreed to participate and those who declined to take part could not be ascertained. Further research is required to determine and understand all of the factors that support or inhibit the development of empowered leaders in LTCHs.

Implications: Cultures of caring, reciprocity and trust are created when leaders in the sector have the support and capacity to lead responsively and in ways that acknowledge and respect the contributions of all members of the team caring for some of the most vulnerable people.

Keywords: quality of care; nursing homes; leadership; empowerment; quality of work-life

Introduction

Most of the Western world is experiencing the effects of population aging, defined as the extent to which a population's age structure is distributed in the older cohorts (McPherson, 2004). Given these changing demographics, the number of older adults living in long-term care homes (LTCHs, also referred to as nursing homes, long-term care facilities, and residential care facilities) can be expected to rise dramatically. This is especially likely because the population over 85 years is one of the fastest-growing age

groups, and this group is most likely to require long-term residential care (Statistics Canada, 2017).

Despite the highly regulated nature of the long-term care sector, there continues to be pervasive concern regarding the quality of care in LTCHs (Castle & Ferguson, 2010; Corazzini, et al., 2015). The persistent negative perception of life in LTCHs is likely intensified by press coverage of quality problems (Dubinski & McKee, 2017) and research that highlights dissonance between recognized best practice and the quality of care and life often experienced in these care settings (Doty et al., 2008; Fossey et al., 2014; Spilsbury et al., 2011).

In light of these realities, much emphasis has been placed on increasing our understanding of the factors that influence the quality of care and life in LTCHs. A review of

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the literature indicates that quality of work-life, as indicated by staff turnover and job satisfaction, exerts a significant influence on the quality of care in these settings (Berridge, Tyler & Miller, 2018; Howe, 2013; Squires et al., 2015). Specifically, low job satisfaction and high turnover among resident care aides (RCAs, also referred to as Certified Nurses Assistants—CNAs) has been linked to poor quality of care (Chou, Boldy & Lee, 2002), poor quality of life (Pekkarinen et al., 2004), and poor end-of-life quality indicators and resident behaviour deficiencies (Castle & Anderson, 2011; Lerner et al., 2014). Research also indicates that care staff members who are dissatisfied with their work-life often show signs of burnout in the form of an unreliable work ethic (e.g., taking unscheduled days off) (Castle, Degenholtz & Rosen, 2006). Finally, evidence suggests that some dissatisfied care staff show greater aggression towards residents (Parsons et al., 2003) and other workers (Spector, 1997).

Given these associations between quality of work-life and quality of care, it is important to determine the factors that influence care aide job satisfaction in long-term care settings. Review of the literature indicates that care staff empowerment and autonomy, co-worker relationships, adaptive nursing leadership, communication, teamwork, management support, workload, and job meaningfulness and opportunities have all been found to be strongly tied to care aide retention and job satisfaction in the long-term care sector (Barry, Brannon & Mor, 2005; Berridge, Tyler & Miller, 2018; Brannon et al., 2007; Caspar & O'Rourke, 2008; Castle, Degenholtz & Rosen, 2006; Corazzini et al., 2015; Howe, 2013; Squires et al., 2015; Wiener et al., 2009).

Existing literature clearly demonstrates that there are strong associations between quality of work-life and quality of care. Missing from the literature, however, is research that attempts to help us understand how and why these associations exist. To address this gap, we examine how and why institutional processes and social relations shape RCAs' work-life experiences and their ability to provide high quality care in LTCHs. We show not only the challenges but also the success stories, taking an appreciative approach to highlight 'the best of what is, in order to imagine what could be' (Bushe, 2013: 1). The purpose of our research was to explicate the processes and relations in LTCHs that influence the provision of exceptional quality of care in long-term residential care settings by comparing and contrasting the factors that impede and support the institutional goal of providing high quality, person-centred care. Person-centred care has been described as care that respects the care recipient's preferences and encourages an overall sense of well-being (Fazio et al., 2018). It is considered by many to be best practice in the long-term care sector (Fazio et al., 2018). The ultimate goal was to create a model of 'what works' by delineating the key factors contributing to practices that influenced quality of work-life and quality of caregiving in LTCHs.

Methods

We used institutional ethnography (IE) as a method of enquiry to explore the social organization of care in three LTCHs located in Western Canada. IE was developed by

Canadian sociologist, Dorothy Smith (2005), who believed that human experience needed to be examined in a novel way—by examining and talking about everyday experiences rather than by examining theories. Smith asserted that discussing everyday experiences becomes a means of generating knowledge through discovering the 'embodied knowing' of the expert, who is the person living the experience (Smith, 2005). Accordingly, we recognized RCAs as experts from whom we needed to learn, and we anchored our research in their experiences.

Consistent with recommended IE methods, the data collection process began with the broad intent of accurately describing the everyday experiences of RCAs, and gradually focused in more narrowly until no new variations or contradictions emerged in the observed everyday practices (Townsend, 1996). Data were gathered in the form of observations and interactions over a period of seven months through two primary investigative methods—naturalistic observations and in-depth interviews. Following the completion of data collection, we applied theory building (Eisenhardt & Graebner, 2007) to develop the model. Theory building from case studies is a research strategy that involves using one or more cases to create theoretical propositions, constructs and/or midrange theory from case-based empirical evidence (Eisenhardt, 1989).

Setting and Sample

The study was conducted from 2013 to 2014 in three LTCHs located in Western Canada. These LTCHs were selected based on several features: (a) they were home to between 120 and 150 residents; thus, they were similar in size to many LTCHs within the region where the study was conducted; (b) they were home to residents who were assessed as having complex care needs and thus required the presence of skilled nurses 24 hours a day, 7 days a week; (c) they were similar to the majority of LTCHs within the region in their staffing mix (e.g., a registered nurse [RN] oversaw a licensed practical nurse [LPN] who was a team leader who oversaw the RCAs); (d) similar to the vast majority of LTCHs in the region, the care staff were members of a union; (e) they had claimed, via their mission statement and public literature, to have implemented a person-centred model of care, and (f) they were located within reasonable proximity so that they were readily accessible for observations to take place during all shifts and for extended periods.

A key differentiating feature among the three LTCHs was their ownership status. A substantial body of research has assessed the relationship between ownership status and quality of care in LTCHs. A systematic review and meta-analysis by Comondore et al. (2009) concluded that, on average, not-for-profit LTCHs provide higher quality of care compared with for-profit homes. However, their findings also suggested that while a positive association is evident, it likely varies across situations and is potentially mediated by management philosophies and related work organization systems. It is because of these equivocal findings that the study LTCHs were purposefully selected to represent three different cases, which varied by ownership status. Facility #1 was a private-for-profit facility,

Facility #2 was a private not-for profit facility, and Facility #3 was owned and operated by the government funded regional health authority. See **Table 1** for an overview of the contextual factors of the three participating LTCHs. University-based research ethics approval was obtained for each study site.

Our primary sampling strategy was purposive. We included RCAs (i.e., unregulated care staff members who provide direct care to residents) working in a permanent part- or full-time position at the study sites. We introduced the study to RCAs at regularly scheduled staff meetings at each site, and invited their participation. Those who were interested contacted the researchers individually to obtain more information. During the course of the study, we observed others whose work had a direct influence on the everyday work of RCAs. These individuals were also invited to participate, and included regulated care-staff members (e.g., registered nurses, licensed practical nurses), members of the interdisciplinary care team (e.g., social workers), and members of the management teams (e.g., administrators, nursing supervisor/managers). All of these individuals, who were approached directly, agreed to participate. After describing the study requirements, we obtained informed, voluntary, and written consent from all study participants.¹ See **Table 2** for details of the study participants stratified by LTCH.

Data Collection

Guided by an observation framework grounded in IE, the first author (Caspar, who had over 15 years of experience working in long-term, residential care settings), proceeded to ‘shadow’ RCAs as they performed their daily work. Each observation began at the start of the RCA’s workday and concluded at the meeting held at the end of the shift. The RCAs who worked full-time were shadowed during day shifts (0700–1500 hours), evening shifts (1500–2300 hours), and night shifts (2300–0700 hours). The RCAs who worked part-time were shadowed during shifts that lasted between four and six hours on day and evening shifts. We attempted to mitigate, as much as possible, the possibility of the Hawthorne Effect (Wickström & Bendix, 2000) (i.e., reactivity whereby the behaviour of the RCAs being observed may differ from their usual behaviour) by being present for a sufficient period of time in each LTCH, such that the RCAs became accustomed to the researcher’s presence. A total of 104 hours of participant observation were completed, during which detailed field notes were written that included questions that arose as a result of the events or activities observed (Emerson, Fretz & Shaw, 2011). These notes and observations guided the subsequent interviews.

Each study participant participated in an individual, in-depth interview with the first author. The interviews were approximately one hour in duration, conducted in a

Table 1: Contextual Factors of the Study LTCHs.

Contextual Factor	LTCH #1	LTCH #2	LTCH #3
Ownership Status	Private For Profit (Contracted)	Private Not-for-Profit (Contracted)	Public Not-for-profit (All owned and operated)
Accredited with Accreditation Canada	Yes	Yes	Yes
Number of Residents	<135	<125	<150
Staffing RN: Resident*	Day/Eve/Night: 1:131	Day/Eve/Night: 1:122	Day/Eve/Night: 1:75
Staffing LPN: Resident*	Day/Eve: 1:45 Night: 1:66	Day/Eve: 1:46 Night: 1: 62	Day/Eve: 1:36 Night: 1:50
Staffing RCA: Resident*	Day: 1:8 Eve: 1:11 Night: 1:27	Day: 1:7 Eve: 1:9 Night: 1:23	Day: 1:6 Eve: 1:9 Night: 1:12

* These ratios are approximate because some units or neighbourhoods may have had different ratios within the facility.

Table 2: Number of participants stratified by site and job title.

Long-Term Care Home Number	LTCH #1	LTCH #2	LTCH #3	Total
RCAs: Resident Care Aide	8	6	4	18
Leaders: Administrators	1	1	1	3
Team Leaders: Nursing Supervisor/Manager	1	1	1	3
Team Leaders: Registered Nurse	2	2	1	5
Team Leaders: Licensed Practical Nurse	2	2	1	5
Team Members: Social Worker	2	1	1	4
Team Members: RAI-MDS Coordinator	2	1	1	4
Total	18	14	10	42

private location in the site, and recorded with the participant's permission. According to Smith (2005), adhering strictly to an interview script limits the institutional ethnographer to what she or he has already anticipated and hence forestalls the process of discovery. Thus, consistent with the IE approach and intent to discover the everyday experience of participants, these interviews were more conversational in nature and were not structured (i.e., interview guides were purposefully not used) (DeVault & McCoy, 2002; Smith, 2005). The interviews all began with general questions such as, 'With as much detail as you can, describe a regular work-day.' 'What makes a good day?' and 'What makes a bad day?' All other questions evolved out of the course of the conversations and interviews as they would normally arise (Smith, 2005). As each interview progressed, the first author sought clarity and accuracy by reframing questions as needed, and clarifying the responses when necessary (DeVault & McCoy, 2002). All interviews were transcribed verbatim. The focus of these interviews was to (a) identify the discourses and institutional work processes that shaped the RCAs' everyday work and (b) describe how these processes influenced the RCAs' ability to provide high quality care to residents (DeVault & McCoy, 2002).

Data Analysis

Data analysis in IE is not a prescribed approach. According to Smith (2005), the purpose of the analysis is to explicate how work is socially organized, rather than seeking patterns or themes. We aimed to obtain an accurate understanding of the relationships between the everyday practices of care giving in LTCH settings and how the organizational culture and institutional priorities and mandates affect RCAs' work-life and provision of care.

We analyzed our data in two phases. Phase one was an exploratory analysis, during which we used Microsoft Word to manage and group the data from the observations and interviews into categories. This analysis was a multi-step, iterative process, which began with the interviews. Data were not grouped according to pre-defined categories; rather, salient categories of meaning and relationships among the categories were derived from the data through a process of inductive reasoning similar to that which is described as the constant comparative method (Glaser & Strauss, 1967). Reading and re-reading the interview transcripts and then the field notes from the observations resulted in the development of categories of key organizational factors that contributed to practices that influenced quality of work-life and quality of caregiving in LTCHs.

Simultaneous data collection and interpretation facilitated the exploration and expansion of these categories from earlier interviews and the tailoring of subsequent data collection. Data collection continued in this way until we believed we had obtained an accurate understanding of the everyday practices that either supported or impeded quality of care and work-life in LTCHs. We attended to rigor during this phase in several ways: prolonged engagement in the field, attention to reflexivity in all field notes, member-checking of emergent findings with participants,

and maintenance of an audit trail by documenting key decisions, activities and insights (Creswell & Poth, 2018; Onwuegbuzie & Leech, 2007; Tracy, 2010).

In the second analytical phase, we applied theory building from case studies (Eisenhardt & Graebner, 2007) to develop the model. Since case studies emphasize the rich, real-world context in which the phenomena occur, it has been asserted that, "building theory from cases is likely to produce theory that is accurate, interesting, and testable" (p 26, Eisenhardt & Graebner, 2007). The theory-building process in case studies occurs via 'recursive cycling' among the case data, emerging theory, and later, extant literature (Eisenhardt & Graebner, 2007: 25). Thus, during this phase, preliminary categories of the organizational factors underwent content and definition changes as incidents from the three cases were compared and categorized, and as understandings of the properties of the categories and the relationships among them were developed and refined over the course of the analytical process. This process enabled us to analyze the data derived from observations and the participants' perspectives and experiences such that they could be integrated into a model that explained the key factors contributing to practices that influenced the quality of work-life and quality of caregiving in the LTCHs. The research team met regularly during this analytical phase and the model underwent multiple revisions and iterations before it was finalized.

Results

The three LTCHs included in this study functioned under the same regulatory standards, had access to similar levels of funding, and were home to residents with similar levels of care requirements. Despite these similarities, considerable differences were found in their work-climates. In LTCH #1, a work climate was cultivated that enabled an outstanding culture of care in which extraordinary examples of person-centred care were observed. In contrast, the organizational climates and cultures in LTCH #2 and LTCH #3 seemed to negatively affect the quality of work-life and the quality of care. In these care settings, we observed some care practices that were, at times, uncomfortable to bear witness to. Careful observation and analysis have prepared us to discuss what we see as the differences between these sites in terms of organizational factors that resulted in the divergent work climates and ultimately either supported or impeded RCAs in their efforts to provide high quality, person-centred care.

To illuminate the best of what is and what could be in LTCHs, we applied a pragmatic approach, that was outcome focused and primarily concerned with what works (Garrett, 2007). Based on our findings regarding 'what works' to improve care practices in LTCHs, we elucidated a model – the *Empowerment Pyramid for Person-Centred Care*. The model, when presented to the study participants from all levels of the organizational hierarchy, was reported to accurately depict some of the key factors influencing the provision of high-quality care in LTCHs. These factors include: empowered leaders who demonstrate respect, recognition and responsiveness, the presence of organizational trust, and reciprocity amongst care team

members, which in turn supported resilience of care team members and quality of work-life. The factors and the proposed associations or links between them are depicted in **Figure 1**.

The proposed associations between the factors depicted in the model can be summarised as follows – empowered management, nursing supervisors, and team leaders: (a) responded to the needs and concerns of RCAs, (b) appreciated the RCAs and recognized them for a job well done, and (c) demonstrated respect of the RCAs’ knowledge and skills (e.g., by expanding their roles on the care teams with participation in such matters as admissions assessments and work-load committees). These empowered leaders cultivated organizational trust, which in turn cultivated the presence of supportive, reciprocating care teams. This essential teamwork enabled the RCAs to remain more resilient as they faced common workplace adversities. In short, the responsiveness of the leaders within the organization to the needs and concerns of the RCAs was observed to be reflective of the RCAs’ level of responsiveness to the needs and concerns of the residents and their family members. Accordingly, the RCAs’ quality of work-life was directly associated with the quality of care provided.

Although this model was specifically developed to represent the ‘the best of what is’, it is important to note that our observations of the organizational factors that *impeded* RCAs in their efforts to provide high-quality care were influential in our development of the model. Osho (2010: 88) explained that ‘a certain darkness is needed to see the stars’. That is, observing the negative consequences of what occurred in the absence of these organizational factors, and contrasting those outcomes to what occurred when they were present provided additional and

important data from which to refine and validate the final model. Thus, in the presentation of our findings, we have labeled the best of what is as the ‘stars’ and then contrast those findings with a description of the outcomes we observed in the absence of these organizational factors, which we have labeled ‘in the darkness’. In what follows, we provide a brief summary of the organizational factors depicted in the model and then present our findings with respect to the contrast between the ‘stars’ and the ‘darkness’ that enabled us to see more clearly.

Table 3 presents the categorized organizational factors with sample quotations from participants.

Empowered Leaders

The presence of empowered leaders was found to be essential to the creation of cultures of care within which high-quality care was provided. Empowered leaders consistently demonstrated key leadership behaviour, including responsiveness, respect, and recognition. The leaders’ ability and propensity to engage in this behaviour seemed to be dependent upon the leaders’ self-perceived levels of empowerment and ability to respond to the needs and concerns of the RCAs. It is for this reason that we characterized these leaders as ‘empowered leaders’. Empowered leaders and the leadership behaviour they demonstrated counteracted the negative outcomes of the deeply entrenched social organization of care most frequently found in LTCHs.

Stars – Empowered leaders as the foundation of cultures of care

The empowered leadership behaviour of responsiveness, recognition and respect was demonstrated by the

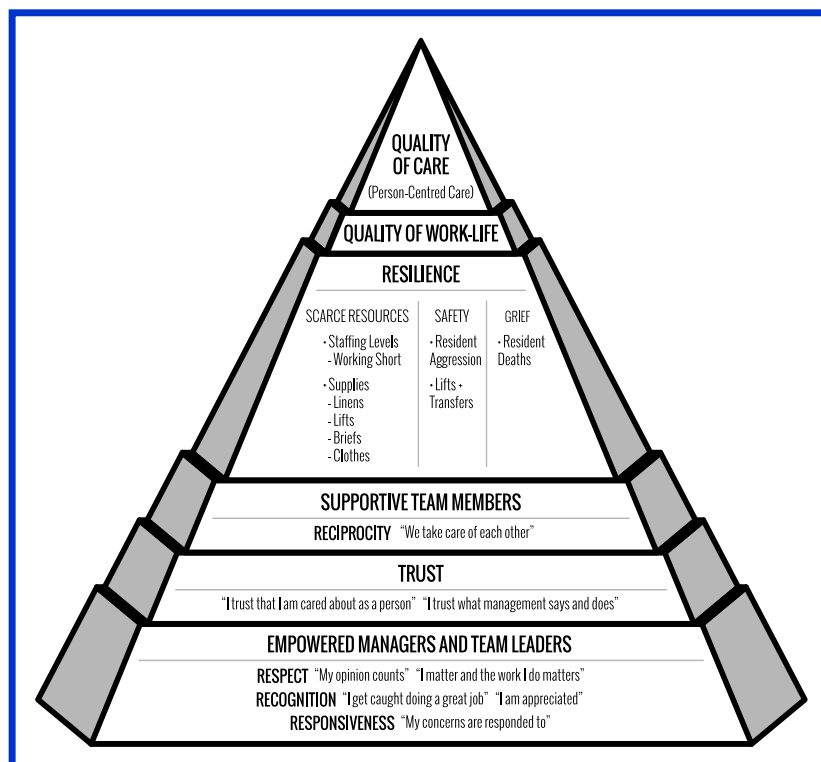


Figure 1: Empowerment Pyramid for Person-Centred Care.

Table 3: Organizational factors with sample quotations.

Organizational factors	Definition	Sample: Stars—Factors present in LTCH	Sample: In the Darkness—Factors absent in LTCH
Empowered Leaders	Leaders who had either assumed or were granted the power, right, or authority to perform various acts or duties based on their assessments of priorities, goals, and needs.	Manager: It's important to make people feel — feel cared for. And if they have to have time [off], you have to, you know? I'm sort of winning because you're not supposed to do this as a corporate player, but sometimes you have to be willing to stand up on behalf of your staff and just say, 'Well I'm sorry, but I gave her that day [off]'. [and they say,] 'Well yeah, but you shouldn't have.' Well yeah but I gave it to her because she needed to have it and we'll put that as a — shall we put that as a vacation day or a sick day? Ok, we'll put that as a sick day. And then you get heat because your sick time is way up and you can't misuse it but you have to have that judgement to know that, in the long-run, being that supportive to that person in a time of distress is going — it makes a huge difference because — it's the same with any kind of leadership thing —if you have a relationship with a trusted leader you will go so much further for that leader than you will for somebody that is just a corporate mouthpiece.	Administrator: The managers have very little autonomy within [the Health Authority]. We [the group of LTCH managers] get together as a management group and define our goals, objectives, our quality measures, all the accountabilities that we want done. But many of those are handed to us. So, yeah we have the perception of authority and autonomy and maybe we have a little bit of discretion in how we implement these [initiatives] in our facility. But, you're pretty much told what needs to happen.
Empowered Leadership Behaviour: Responsiveness	Leaders who were quick to respond or react appropriately or sympathetically to the needs and concerns of the RCAs	Manager: It's being out on the floor. It's having mini-conversations — so, if I'm walking down the hallway and I see a group of three staff, and they're obviously engaged in some kind of dialogue around what needs to be done, or their work, I will stop and engage. I'll stop and I'll talk with them about, 'OK, what's going on? What do you need from me?' And frequently, that's how it's actually put...is 'What do you need from me? What do you need from me to get your job done?'	Manager: Pretty much the only autonomy I really have is prioritizing everything that needs to be done. Other than that, I have no power. None whatsoever....
Leadership Behaviour: Recognition	Leaders who consistently gave special notice, attention, appreciation or praise to RCAs for their work.	RCA: She [team leader] approached me, she said, 'You know, I'm really proud of the way that you took care of this resident.' And I was like, 'Thanks!...' You know, it kind of gave me that little, well, it felt really nice...	RCAs: The leaders' ability and propensity to engage in this behaviour seemed to be dependent upon the leaders' self-perceived levels of empowerment and ability to respond to the needs and concerns of the RCAs.
Leadership Behaviour: Respect	Leaders who consistently demonstrated that they held the RCAs' knowledge, skills, and position on the care team with high regard, value, and esteem.	Manager: Well, it's essentially several RCA volunteers—they receive a concern from a care aide or group of care aides—they talk to their peers—they identify what the issues are, where the problem areas are. Then they represent their peers in a meeting with myself and [the Director of Care]. We discuss it and then we troubleshoot some solutions. That's essentially it.	RCAs: In five years working on that unit I saw her [the manager] once, and it was to come down to tell us [she had received a complaint about us] being too noisy on a night shift and then she went back and sat down [in her office], and that's it.

(Contd.)

Organizational factors **Definition** **Sample: Stars—Factors present in LICH** **Sample: In the Darkness—Factors absent in LTCH**

The presence of empowered leaders, who actively engaged in behaviours demonstrating responsiveness, respect, and recognition to the RCAs, was foundational to the creation of high organizational trust. High levels of trust were further cultivated when empowered leaders engaged in honest, forthright, and open communication.

Organizational Trust
 The global evaluation of an organization's trustworthiness. Organizational trust is defined as an employee's feeling of confidence that the organization will perform actions that are beneficial, or at least not detrimental, to him or her.

Manager: I think that's why I excel in my position, because people trust me, they will follow me, they believe me, and I'm all about that...

RCA: If everyone would be honest, like truly honest, it would make a huge difference. If management would communicate better and be more open!

RCA: I, really, I think it would be better communication with management. You know...honest communication. There's a lot of...um... I don't like dishonesty. That really bothers me. Especially when I know you're lying. ...and no one feels they [management] are honest with us.

Trust in what management says and does was found to be essential to the development of supportive teams of staff members who actively took care of each other as well as the residents.

Supportive Team Members: Reciprocity
 The propensity of RCAs to exchange help and support with one another for mutual benefit of both themselves and the residents for whom they provide care.

RCA: It's the most important thing to me. It could be the toughest day. There could be [a] Norwalk [virus outbreak], vomit, feces, could be anything. And who cares? You just get it done...because if you're working with people that you have a good time with, it can still be a wonderful day.

Researcher: So, what do you do if you need assistance?

RCA: You can go looking for somebody, but it's often a waste of time...everyone's busy, they're in other resident's rooms giving care so they can't come anyway.

Reciprocating teammates were essential to the RCAs' resilience as they faced workplace adversities such as scarce resources, safety risks, and grief, each of which is commonly found in LTCHs.

Resilience in the Face of Scarce Resources
 The propensity of RCAs to collaborate, work together, and support one another when they experience the state of being in scarce or short supply of needed resources.

RCA: We're always really short on linens. So, part of that first half an hour of my shift is kind of going between the floors and we ration out the linen. We're like, 'Oh, we don't have enough blue cloths.' ...And sometimes we have to really count them and make sure [everyone will have enough]...because we're always a little bit short.

RCA: The residents suffer so much when we work short...I was in tears a month ago, and I'm pretty good at handling my stress levels. And it wasn't any one person. It was the fact that I didn't have another person there. And I just went to the nurse, I was like, 'I'm gonna pull my hair out. I'm starting to cry.' I'm like, 'I can't go back in that room and tell that old woman I don't have time to do what I have to do.' ... You get a little overwhelmed sometimes, especially when you don't want to cut corners and you wanna...it's hard, really hard. Because they're not machines, they're people. ...They really suffer when we work short. It's brutal. Because you don't have as much patience, you don't have as much time. You're running and rushing and frustrated, and it's not good. We're all used to it, I guess. We have a whole procedure on how to work short. Literally, it's like a plan. But it ain't pretty.

(Contd.)

Organizational factors	Definition	Sample: Stars—Factors present in LTCH	Sample: In the Darkness—Factors absent in LTCH
Resilience in the face of Safety Concerns	The propensity of RCAs to collaborate, work together, and support one another when they experience workplace safety concerns related to caregiving.	<p>Manager: If somebody has a behavioural concern, then we start a behaviour flow sheet for seven days. The nursing assistants [RCAs] fill that in for a week and we look and see how many incidents of whatever is occurring. And then, from there, we'll identify if that resident is a care risk.</p> <p>RCA: And if that [my approach in working with a resident who is resisting care] doesn't work, I'm going to ask my partner [another RCA] what works for them. They tell me. I definitely take notes, in my head, and then I'll pass it on to the other aides.</p> <p>RCA: [Some RCAs] are very sensitive to somebody dying, and it really affects them. But you have so many people around you that have so much empathy. And, yeah. You have support that way.</p> <p>RCA: Yeah, it's more informal support. You know, if you're crying because a resident passed away, somebody's going to come up and give you a big hug and talk you through it, for sure. That's happened to me before. I'm really sensitive.</p>	<p>RCA: It [a bad day] looks like a mess. It looks like you've been bruised, you've been hit, you've been.... It just looks awful.</p> <p>RCA: If two of the girls don't like each other, one great tip that could save us all time and injury doesn't get shared.</p> <p>RCA: Patients will steal your heart, patients will make you cry. I've seen a male RCA cry when a patient died. ... they become your family, they really do. And sure that's bad, in aspects, but it's great. When you come to work and you're working with a [resident who feels like] family.</p> <p>Researcher: How do you think it's bad?</p> <p>RCA: I think because it's not really encouraged to have these relationships, almost. So, if you do get emotional when they die, people are like, 'You knew. You knew it was going to happen. So, why are you upset?'</p>
Positive work-place relationships seemed to enable greater resilience amongst members of the care team. Resilience played an important part in shaping the RCAs' appraisals of, and reactions to, their work experiences and thus, the quality of their work-life.		<p>Team Leader: And I think all of us feel that, you know, we're like a family here. Um... it's heavy. I've got 47 residents and that's more than any other facility that I know of. And, I've chosen to work here rather than other places that are closer and possibly newer and shinier. I come a long way to go to work here because I love working here. I love this establishment. I love the people I work with. I have the best director and administrator that I've ever worked with. And, we're talking from the East Coast all the way to here. We have a lot of staff who have been here for 20 and 30 years. That tells you a story right there. I...I want to retire from here. And...if I needed a facility to put a loved one in, this would be my top choice.</p>	<p>RCA: There's a lot of people here that don't like what they do. There's a lot of people here that should not be doing this job.</p> <p>RCA: People are really angry here right now.</p> <p>Researcher: They are very angry here right now. Do you know why?</p> <p>RCA: Management not telling you stuff, management not listening, is what I'm gathering..</p> <p>Researcher: Anything else?</p> <p>RCA: And not feeling supported. Yeah. Pushed down. People are being suppressed and not... In the last couple years I've seen some really upbeat healthcare workers get really bitter. Really angry. At management.</p>

(Contd.)

Organizational factors **Definition**

The more care staff members positively appraised the quality of their work-life, the more likely they were to engage in care practices that were demonstrably responsive to their residents' needs.

Quality of Care The degree to which health care services for individuals increase the likelihood of desired health outcomes and are consistent with current professional knowledge.

Sample: Stars—Factors present in LTCH

Manager: But, as far as a workplace, and quality of care [facility name] staff are awesome. It's an older building. A lot of the bells and whistles and the technology aren't here because of the type of building it is—no overhead lifts, no storage, small hallways. You know, it's challenging every day. But the staff just pull together. And it's because of the good relationship from a management level to staff—the dialogue is ongoing... and the staff are awesome. Incredible. Incredible amount of pride in what they do.

Sample: In the Darkness—Factors absent in LTCH

RCA: I had, for an example, I was serving the trays for breakfast and lunch, and I went in in the morning to give a tray to a lady, and I was already behind. And I smelled something in the room, and I figure, oh she had a bowel movement. And her care aide had just been in, so I just thought, okay, put the tray down in front of this lady, set it all up for her and just walk away. She finishes her breakfast. I come back at lunch and I can still smell something bad and I'm like okay, it's really not this morning's bowel movement is it? So I pull back the blankets and literally from her armpits to her ankles, there was BM everywhere. She was still in her brief; she was still in her night gown. Nothing. She hadn't been touched basically. And I went and found her – I went to do it myself until I realised I couldn't have handled it – like I could've, but I would have been in there for an hour cleaning this up, so I go down and think okay well her care aide is coming down the hall, can you give me a hand because she's got a bit of a mess. Her care aide comes in and it was very aggressive. She didn't want to be there; apparently the resident had been a bit rude to her in the morning. And she walked away from her because she had been rude. I understand walk away, give yourself a break, but come back after a couple of minutes, especially if she's had a BM. So she didn't go back, so she's in there and we were giving care and she was just rough with her and rolling her, and very aggressive and rude and it was disgusting. I was disgusted, I just wanted to – I went home crying I was so disgusted. I was mortified that somebody could be treated like a piece of meat. Basically was what she was treated like and I felt awful.

administrator and the leaders at every level of the management hierarchy in LTCH #1. When asked how and why this occurred, the administrator reported that his predecessor had exemplified active, responsive, and caring leadership, which he learned from her. This administrator began working in the long-term residential care sector as an activity assistant and, over the course of more than two decades, had worked his way to becoming an administrator. When asked directly about empowerment and autonomy, the administrator of LTCH #1 indicated that his perceived level of empowerment primarily arose because the corporate office was 'on the other side of the country'; he believed that he had more autonomy than other facilities' administrators. This, combined with the mentorship he received and his personal understanding and experience of having worked at different levels of the hierarchy found within LTCHs, were likely instrumental in his ability to create the culture of care found in LTCH #1.

Responsiveness, recognition and respect provided to RCAs by leaders

The empowered leaders in LTCH #1 were responsive to the needs and concerns of the RCAs. For example, a manager demonstrated responsiveness by appearing on 'the floor' to openly discuss a rumour about impending layoffs. This manager did not lead from an office, but was instead regularly found on the floor connecting with, learning about, and responding to the needs of both residents and care staff members:

Leader [01]: It's being out on the floor. It's having mini-conversations – so, if I'm walking down the hallway and I see a group of three staff, and they're obviously engaged in some kind of dialogue around what needs to be done, or their work, I will stop and engage. I'll stop and I'll talk with them about, 'OK, what's going on? What do you need from me?' And frequently, that's how it's actually put...is 'What do you need from me? What do you need from me to get your job done?'

The presence of empowered, responsive leaders was found to be inextricably linked with open communication that allowed for in-person information exchange between the RCAs and their team leaders, nursing supervisors, and management. This finding makes intuitive sense, given that the ability of managers and leaders to respond to the needs and concerns of RCAs is first dependent upon whether they know the nature of the RCAs' concerns and needs:

Leader [02]: And we try and encourage them [the care staff members] to be open. 'If you have a problem, come and see me. Come and tell me your problem, let's see if we can deal with it.'

Leader [01]: I think it's working with the staff to trouble-shoot issues [that's most important]. Staff know that if they bring something to us, we will

follow through. So, there's a high level of trust.... It's about being out on the floor. I think that's kind of it – it's walking the talk.

Empowered leaders also actively appreciated the RCAs by recognizing them for work well done. For example,

RCA [03]: She [manager] approached me, she said, 'You know, I'm really proud of the way that you took care of this resident.' And I was like, 'Thanks!...' You know, it kind of gave me that little, well, it felt really nice...

In LTCH #1, the expression of appreciation for the care staff members was abundant:

Leader [02]: A lot of them have been here for a long time. A lot of people [the RCAs] came in just after they left school, and they've stayed here. ...and I just think it's because we really appreciate them. I think they're the best bunch of people I have ever worked with, and I've been an RN for over 40 years. I just think they're amazing.

Finally, empowered leaders demonstrated respect for the RCAs' important contributions to the care team. Leaders demonstrated respect in LTCH #1 by taking actions such as including RCAs in residents' care decision-making (e.g., active participation in admissions assessments) and extending invitations to participate in organizational initiatives (e.g., participation on work-load and work-safety committees). Repeatedly, these managers were witnessed demonstrating respect for, and confidence in, the RCAs' skills, knowledge, and experience. This respect resulted in managers enabling RCAs to assume greater levels of autonomy than the traditional hierarchy typically allowed or fostered. As a result, these leaders actively minimized the effects of the hierarchy found in their LTCH:

Leader [02]: By trying to be open and respectful of everybody. Every single person should get the same amount of respect as you yourself expect.

In the darkness – Disempowered leaders

The managers in LTCH #2 and #3 reported very low levels of empowerment and autonomy. These disempowered managers felt compelled to focus their time, energy and resources on responding to priorities and regulations that were handed to them from upper management. They believed that their priority had to be on 'managing the system,' rather than on providing leadership and mentorship to the care staff. Inevitably, this reduced their capacity to be responsive to the needs of their care staff members (and at times their residents):

Leader [15]: Pretty much the only autonomy I really have is prioritizing everything that needs to be done. Other than that, I have no power. None whatsoever...

The managers of LTCH #2 and #3 indicated that it was frustrating and disempowering to not be able to put time, energy, and resources into initiatives that they wanted to implement based on their unique understanding of the needs of the staff, residents, and family members within their specific LTCH. For example:

Leader [14]: We talked about this at the [managers' meeting], the corporate requirement to meet the corporate objective and not allow sites to identify and select our own initiatives. It has to be corporate [initiatives] and it's so disempowering for the managers.

The greater the perceived sense of disempowerment, the less likely the nursing managers and supervisors were to develop close, trusting relationships with the staff. Logically, and indeed empirically, these managers were less aware of the needs and concerns of the RCAs, further undermining their ability to be responsive. This disempowering and frustrating cycle of disconnection was evident in the words of one manager who assumed personal responsibility for her inability to spend time creating and fostering a healthy team in her LTCH, despite feeling helpless to change it within the prevailing organizational systems:

Leader [15]: The thing is, is that you – you wear it. Like, absolutely wear it. This is me not talking to staff. This is me not developing trusting relationships. And, you own that. Even though I understand the system and so on, I'm actually very human. And, I think...well but, that [not being able to create positive relationships with her staff] is not what I mean to do. ...but, but it's also what is happening.

Two managers spoke directly about how the prevailing organizational system made them feel incapable of cultivating a sense of team spirit for themselves and the care staff members. For example:

Leader [15]: I think that the expectation of upper management is that we are the voice for upper management and that that's the side of the fence [we are required to be on]. There is a line drawn there. This side of the fence [is for management]. The other side of that fence is the other [care staff members]. So that's an expectation.

Leader [16]: It's a very tricky line to walk – you're expected to be a team player, but the definition of the team is the upper management. You're expected to be a member of the corporation, which goes totally against the way I see myself. I never wanted to be a corporate player, but that's what happened.

Of interest, even though the managers were clear that their 'team' was the corporate officers, none felt supported by

corporate personnel. Instead, they revealed how alone they felt in their positions and that there were very few, if any, people that they could turn to for support. For example:

Leader [16]: This is a very 'alone' job. Very alone. There is no even really safe place for me to turn to. If I do take a frustration up the ladder, is that a reflection on me? Is that a reflection on my capacity to perform in the position? So, you asked about autonomy. It's forced autonomy. If I want to do my job, then I do it, and I don't fuss. And, I take the directions and I get them forward. And I get measured on the statistics...on my injury rate, on keeping within a budget, on our sick time/overtime, those are the bars.

These 'bars' or quantitative metrics were used to determine whether the managers were in regulatory compliance and meeting corporate expectations.

Lack of respect, recognition and responsiveness provided to RCAs by leaders

On numerous occasions, the RCAs were referred to as 'the eyes and ears' of care in the LTCHs. However, in LTCH #2 and #3 we began to suspect that this was more rhetorical than genuine. Consistent with the literature in this area (Tellis-Nayak & Tellis-Nayak, 1989), we found that the care work in these LTCHs was socially organized to ensure that RCAs remained at the lowest level of a well-established and seldom-questioned hierarchy. The RCAs in LTCH #2 and #3 reported that they felt that they were at the 'bottom of the barrel'. Institutional processes in these two sites reinforced the message to the RCAs that their role within the care team was limited to that of keeping the residents' bodies clean and bowels moving. It is therefore not surprising that RCAs in these sites communicated feelings of being underappreciated, disrespected, and dismissed:

RCA [01]: We don't have the responsibility of the RNs and the LPNs and the pills and all that stuff, but I think our job is equally as important. And, lots of people don't know that because they just think that we're professional ass wipers. And really, that's not near what it is [that we do].

In LTCH #2 and #3, few leaders consistently provided recognition or appreciation of their subordinates. With very few exceptions, the RCAs in these LTCHs reported that they rarely felt appreciated by management for the work they did. For example:

Researcher: Do you feel like you're appreciated [by management]?

RCA [13]: Naw, not really. No. And you know what? No one does in here.

RCAs indicated that it mattered a great deal to them whether they felt appreciated by their managers and

peers. For example, in response to a question regarding feeling appreciated by management, one RCA replied:

RCA [03]: No. You're just another little pawn in the grand scheme of things.

Researcher: So, would things be different if you felt...?

RCA [03]: ...needed and wanted and respected and appreciated? Yeah, because the residents can't show appreciation. Well, most of them can't, you know? ... So, when your manager and staff show that you are appreciated, it makes you feel like, 'I can go to work and I'm actually doing something.' Not, 'Oh god I have to go to that place again...and again and again.'

In response to the question, 'If you could change one thing about this job, what would it be?' many answered that they wished management would appreciate them more.

RCA [09]: That, I think, is the worst part of the job. I don't feel valued [by management]...but when...you see the difference you can make with a resident... that is where the value comes in.

Organizational Trust

The ability to provide quality care seemed to be dependent largely upon the quality of the relationships, and the level of trust between the staff members and managers. High levels of trust between the RCAs and other members of the care team were cultivated when empowered leaders ensured that open gates of communication were present, which actively supported the development of positive inter-professional and inter-personal relationships.

Stars – Fostering trusting relationships

The management of LTCH #1 was viewed by most care staff members as respectful, supportive, and responsive. Participants from this LTCH described high levels of trust in management, and high quality inter-personal relationships. The phrase, 'we're like family here' was repeatedly stated by the study participants of this LTCH.

Team Leader [07]: And I think all of us feel that, you know, we're like a family here. Um...it's heavy. I've got 47 residents and that's more than any other facility that I know of. And, I've chosen to work here rather than other places that are closer and possibly newer and shinier. I come a long way to go to work here because I love working here. I love this establishment. I love the people I work with. I have the best administrator that I've ever worked with. And, we're talking from the East Coast all the way to here. We have a lot of staff who have been here for 20 and 30 years. That tells you a story right

there. I want to retire from here. And...if I needed a facility to put a loved one in, this would be my top choice.

When we asked how the manager of LTCH #1 had successfully created such a positive culture of care, he stated that it was because of the trust that had been established:

Leader [01]: I think that's why I excel in my position, because people trust me, they will follow me, they believe me, and I'm all about that...

High levels of trust between the RCAs and other members of the care team were cultivated when empowered leaders were viewed as trustworthy. Many of the RCAs also spoke about the importance of establishing good, trusting relationships within their teams. For example:

RCA [08]: When you're a care aide you really have to trust the person that you're working with and build a solid relationship. If there's conflict between you [and your team], then no one is safe, not you and not the resident. So, I think it's one of the most critical things to do, is build a good relationship with the people that you're working with.

In the darkness – Lack of trust

As described previously, the disempowered leaders in LTCH #2 and #3 felt less able to respond to the needs of the RCAs. This inability to respond to their needs and concerns diminished the trust that the RCAs felt towards their managers:

Leader [09]: I also see that she's [manager of the LTCH] trying to make a difference, and she's trying to help. But, you know what? The staff aren't trusting. The problem is that she's [the manager] caught... This [corporate initiative] is brought down; they're, saying, 'This is the plan.' I think the trust has been broken from the staff and I try to tell the staff that we're doing everything we can. But, they're not believing me anymore.

Specifically, the RCAs did not trust that they were cared about by their managers or their team leaders. This erosion of trust was exemplified in the poor quality of the inter-personal relationships found between the care staff members and their managers. Participants from LTCH #2 and #3 spoke often about the negative outcomes that occurred as a result of managerial practices that further reinforced their lack of trust in their managers and in the organization. An RCA from one of these LTCHs provided this example:

RCA [12]: People [the RCAs] are really angry here right now.

Researcher: They are very angry here right now. Do you know why?

RCA [12]: Management not telling you stuff, management not listening... In the last couple years, I've seen some really upbeat healthcare workers [RCAs] get really bitter. Really angry. At management.

Distrust in management and the resulting poor interpersonal relationships were observed to be linked to low morale in these LTCHs. The RCAs who were angry at and distrusted management demonstrated behaviour typically associated with burnout (e.g., highly critical of management, openly frustrated, and negative about their jobs) and provided what some RCAs referred to as 'slack' care (i.e., cutting corners to make their jobs easier at the expense of residents).

Supportive Team Members, Reciprocity, and Resilience

Trust that management cared about them as people was found to be essential to the development of supportive teams of staff members who actively took care of each other as well as the residents. Reciprocating teammates were essential to the RCAs' resilience as they faced workplace adversities commonly found in LTCHs (e.g., being short of supplies, working short staffed, navigating the risks of being injured as a result of residents demonstrating responsive behaviour or resisting care, managing the grief they experienced when residents died).

Stars – Team members that make a 'good day'

Without exception, the RCAs in all three facilities spoke about the importance of the quality of their relationships with their teammates to their work lives. When asked what made the difference between a 'good day' and a 'bad day', the unanimous response was that it had very little to do with the work itself and everything to do with the presence of teammates with whom they had reciprocal relationships of support. They stated that with supportive teammates they could successfully manage the most challenging workplace adversities they encountered:

RCA [07]: Well, it's great to work with partners that have the same philosophy that you do...that go out of their way to be helpful, cooperative. That's everything.

The care work that RCAs engage in on a daily basis is physically and emotionally demanding. Throughout the course of a regular shift, they provide the most intimate of care to individuals with highly complex needs. Much of the work that they do is considered unpleasant and is devalued in our society (e.g., assisting residents in going to the toilet). In addition, they routinely have to cope with scarce resources, including inadequate staffing and often limited access to appropriate supplies to accomplish their tasks. They also face risks to their own health and safety such as heavy lifting, providing care to those who may resist care, and the experience of grief caused by the death of a resident. Evidence of these challenges was apparent in our

findings, as was there evidence that reciprocity strengthened the RCAs' resilience in their day-to-day work as they coped with these challenges.

RCA [06]: Honestly, it depends on who you work with. I mean, I could have the most chaotic day ever, everybody's got diarrhea, we have a Norwalk [virus] outbreak...people are throwing up, and it could still be a good day if you have a good team on. You know, they'll come help you and you'll help them and we figure out a way to make it work.

Supportive teammates were especially important when the RCAs were 'working short'. Working short is the term used when a scheduled RCA is absent from work and has not been replaced with a casual employee or a permanent RCA working overtime. When this occurs, the RCAs are assigned additional residents for whom they are responsible to provide care. Across all sites, the RCAs worked short during 30% of the observation periods, and this invariably impacted the quality of care (e.g., baths were more likely to get missed, residents were more likely to be left in bed, mealtimes were more rushed). However, when RCAs in LTCH #1 worked short, they would come together, as a team, to decide how best to share in the care of their residents (i.e., determine who needed help with which residents and when and then work together as a team throughout the shift). They would, in effect, 'figure out a way to make it work', both for themselves and for their residents. As a result, the residents in this facility were observed to experience the least amount of negative impact on their care when the RCAs were working short.

In the darkness – Team members that make a 'bad day'

The lack of supportive team members and genuine reciprocity found in LTCH #2 and #3 (where teamwork, albeit present, was sporadic at best) had a significant impact on the quality of their work-life and care. The RCAs in these LTCHs frequently mentioned how poor working relationships among RCAs led to a breakdown in the transfer of important resident care information. This breakdown in communication had the capacity to impact both their safety and the safety of the residents. For example:

RCA [12]: If two of the girls don't like each other, one great tip that could save us all time and injury doesn't get shared.

In all three LTCHs, the primary method by which the RCAs shared and received information related to risk (and indeed to *all aspects* of the residents' care) was through talking with one another. Because they shared information verbally, what they shared, how they shared it, and even *if* they shared it were largely dependent on the quality of their working relationships. The quality of these relationships also determined whether or not they had a teammate to assist them when they needed help (e.g., when caring for a resident who may be resistant to care). It is for this reason that poor working relationships and

the lack of reciprocal teamwork was what the RCAs most often referred to when they spoke about what ‘makes a bad day’ at work:

RCA [19]: That makes a terrible day, a day that you have to spend lots of time by yourself. And you’re trying to, but you can’t get help when you need it...

Discussion

The *empowerment pyramid for person-centred care* model proposes that the presence of empowered, responsive leaders exerts a significant influence on the cultivation of organizational trust and reciprocating care teams. Positive work-place relationships, as were observed in LTCH#1, seem to enable greater resilience amongst members of the care team. The more resilient RCAs feel in the face of work-place adversities, the more likely they are to engage in care practices that are demonstrably responsive to their residents’ needs.

This was made particularly clear in LTCH #2 and #2, where the managers felt disempowered and less able to cultivate positive relationships with the RCAs. As a result, these managers were perceived by the RCAs as less responsive, less respectful and also less appreciative of the work they did. These negative perceptions influenced the levels of trust between management and care staff members in these LTCHs. This lack of trust was detrimental to the development of positive, reciprocal teamwork, which was found to be linked to the quality of care and quality of work-life for RCAs in these LTCHs. This finding is especially important because RCAs across all three sites indicated that their ability to provide quality care was often directly related to the quality of teamwork that they experienced during their shifts. Ultimately, our findings have suggested that the presence of empowered leaders exerts a significant influence on RCAs’ quality of work-life, which is in turn directly associated with the quality of care they provide. These conclusions are consistent with Vogelsmeier and Scott-Cawiezell (2011), who reported that nursing leadership who facilitated open communication and teamwork achieved improvement in quality of care while nursing leadership who impeded open communication and team work did not.

According to the literature, when asked what they need and want most, RCAs consistently state that they want to be respected and recognized for providing high-quality care and to be included in care planning (Andersen & Spiers, 2016; Deutschman, 2001; McGilton, 2002). We believe that the importance of leaders consistently responding to these needs cannot be overstated. Our conclusions are consistent with studies that have demonstrated that RCAs with supportive supervisors who respected and relied upon their knowledge of residents’ care needs experienced more job satisfaction and were more likely to express an elevated sense of responsibility toward residents (Bishop et al., 2008; Rader & Semradek, 2003). In addition, Tellis-Nayak (2007) found that supportive managers who create person-centred workplaces enable caregivers to actively engage in the provision of person-centred care, thereby improving residents’ quality

of life. Our findings add to this literature by further elucidating some of the factors that influence these outcomes.

Implications

This study adds to the body of knowledge postulating that improving the quality of care for residents in LTCHs is directly related to improving the quality of the work life of RCAs. Consistent with the published literature, our findings indicate that this latter consideration is an area in need of significant attention. Through in-depth interviews and observations across three LTCHs, we found that the presence of empowered leaders may be beneficial in improving both the RCAs’ quality of work-life and the quality of the care they provide. However, given its primary focus on the perceptions and experiences of RCAs in one geographic region, this study stopped short of being able to determine and understand all of the factors that support or inhibit the development of empowered leaders in LTHCs more generally. This is an area in need of further investigation.

As researchers with extensive experience in the residential care sector, we are well aware of the many challenges to the sector, including a persistent scarcity of resources (Stone, 2001), high turnover, a morally distressed workforce (Spenceley et al., 2017) and an all-too-frequent attitude of nihilism about life in residential care in a society obsessed with youth and vigour, and with cure over care. Although our study findings do not address these enormous systemic challenges, we suggest that the findings from this study do call attention to the power of a profoundly simple idea – that when we feel cared for, we are able to care better. Cultures of caring, reciprocity and trust are created when leaders in the sector have the support and capacity to lead responsively, and in ways that acknowledge and respect the contributions of all members of the team caring for some of our most vulnerable citizens. For leaders in these settings, we suggest that there are several questions to ponder: How do we arrive at decisions about care – collaboratively or unilaterally? Are our traditional care hierarchies serving us, or our residents, well? Are we truly respecting and acknowledging RCAs as the ‘eyes and ears’ of care? How can we create workplaces that are more connected and collegial? Is there a better way? We think that there is. The answer may be as simple as finding ways to ensure that leaders in this sector are empowered to respond to the needs and concerns of *both* the residents *and* the people who directly care for them.

Note

- ¹ We recognized that it was important to ensure that, to the extent they were able, residents with dementia understood that they were participating in research and were given the opportunity to agree or refuse to be observed. We accomplished this by obtaining signed consent from the resident (or designate) and also by seeking verbal assent—affirmative agreement to participate or, alternatively, respecting the resident’s expressed dissent or objection. For more information about this process see Caspar, S. (2017). Using institutional ethnography as a method of enquiry to

explore the social organization of care work in residential care facilities. *SAGE Research Methods Cases*. doi:10.4135/9781526423177.

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Competing Interests

The authors have no competing interests to declare.

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