KNOWING AND BEING KNOWN: THE QUALITIES THAT MAKE A LONG-TERM CARE FACILITY A HOME

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Dedication

This paper is dedicated to all those who have lived and worked in long-term care and for the many of us that will in the future. May the LTC ‘facility’ truly feel like a ‘home.’

Abstract

There has been consistent pressure to transform long-term care (LTC) facilities into more homelike settings. The concept of home within institutionalized care-based living environments is not well understood. For this study, a supplementary analysis was conducted to address two questions: (1) What factors contribute to a sense of home for people living and working in rural LTC homes, and (2) What organizational structures enable or impede a rural LTC home's ability to actualize the factors that help them feel homelike? Findings indicate that the physical environment should prioritize accessibility and personalization; the social environment should prioritize relationships and opportunities for connection; and psychological considerations should prioritize supporting choice, autonomy, and flexibility. Additionally, a sense of home in LTC is dependent upon leadership that empowers staff and enables a flexible and relational approach to care, which results in residents being truly 'known' by their care providers.

Contributions of Authors

I would like to acknowledge Dr. Julia Brassolotto, Dr. Sienna Caspar, and Dr. Shannon Spenceley who were the primary researchers for the study titled, *Intersections in Rural Long-Term Care: A Comparative Case Study in Alberta* (Brassolotto et al., 2019). It was the data collected for this study that I conducted a supplementary analysis on. Thus, my study would not have been possible without the prior work completed by these researchers. I would also like to acknowledge the study participants whose direct words were incorporated throughout this paper.

Preface

This thesis is an original work by Aimee Douziech. No part of this thesis has been previously published. This thesis was written using a manuscript-based format.

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I am further grateful to both my grandmothers. Your personal life story and experience living in long-term care has significantly influenced my journey. In many ways it is through both of you that has led me to where I am now.

Lastly, I thank my family members and friends who have supported me on this journey. I feel incredibly fortunate to have such a wonderful support system. Finally, I am thankful for my rural roots and upbringing. Completing this thesis has made me astutely aware of how thankful I am to have rural experiences at the core of my being.

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List of Acronyms and Definitions

Acronyms:

LTC	Long-Term Care
AHS	Alberta Health Services
RN	Registered Nurse
LPN	Licensed Practical Nurse
HCA	Health Care Aide

Definitions:

Long-Term Care: Long-term care refers to a residential care home where individuals who require 24 hour nursing care reside (Government of Alberta, 2018).

Rural: For this study, rural is defined in accordance with Statistics Canada as a population under 10,000 people and at least a 60 minute commuting distance from major urban centres (Statistics Canada, 2001).

Residents: In this study, this term is used in reference to individuals residing in long-term care.

KNOWING AND BEING KNOWN: THE QUALITIES THAT MAKE A LONG-TERM CARE FACILITY A HOME

Introduction

The term 'home' can be over-simplified and defined as "the place where one lives permanently, especially as a member of a family or household" (Mirriam-Webster Incorporated, 2019), but when you ask people to define home, they indicate that it means so much more (Habitat for Humanity International, 2019). Home is deeply interwoven into the human experience; it is an important and integral component to a person's life. The diversity of what home means is highly complex, it is fluid, and it changes through the life course (Dyck et at., 2005; Fay et al., 2012). Thus, home is multidimensional, layered, contextual, and relational. It touches on all aspects of a person—psychologically, physically, culturally, socially, spiritually, mentally, and emotionally. It is the unique combination of these varying elements, as well as others, that together construct the meaning of home for each person, and, as a result, significantly impact a person's identity (Dyck et at., 2005; Fay et al., 2012). The importance and relevance of one's sense of home continues through a person's life, including when a person moves into long-term care (LTC).

There has been public pressure for more than a quarter century to transform LTC facilities into more homelike settings (i.e., the culture change movement) (Armstrong et al., 2019), yet there is no comprehensive understanding in the literature of where and how a sense of home fits within these LTC settings. Within Canada, where there are numerous rural communities, we know even less about what contributes to making LTC facilities homelike. This is valuable to explore given the distinctness of the rural context.

Additionally, there is rising demand for LTC services due to an aging population and an increase in complex healthcare needs (Government of Alberta, 2018; National Institute on Aging, 2019; Statistics Canada, 2020; World Health Organization, 2019). Thus, we need to better understand how to support a meaningful sense of home for those who live and work in these rural LTC settings.

In the following section, I provide background information on the aging population, LTC, and rural health; the culture change movement in LTC; and sense of home in LTC. I then provide an overview of my research questions that tie into the background literature. Following this, I outline the methods I used for this study and ethical considerations. Finally, I share my results, discussion, and conclusions.

Background Literature

Aging Population, Long-Term Care, and Rural Health

The population is aging within Alberta, within Canada, and worldwide (Government of Alberta, 2018; Statistics Canada, 2020; World Health Organization, 2019). According to the World Health Organization (2019), the current 125 million people worldwide over the age of 60 will grow to 434 million by the year 2050. This is also seen on a smaller, yet similar, scale within Alberta. In 2017, those over the age of 65 was 529,942 and by the year 2027 this number is expected to increase to 816,192 (Government of Alberta, 2018).

Concurrent with the aging population, there is also a rise in the demand for LTC services. LTC homes are designed for anyone who requires 24-hour nursing care due to complex healthcare needs; therefore, age alone does not imply that a person will require

the services of LTC (National Institute on Aging, 2019). However, as a person ages, they are at a higher risk of developing complex, chronic health conditions (Braedly & Martel, 2015; Government of Alberta, 2018; National Institute on Aging, 2019; World Health Organization, 2019). It is not purely because we have an aging population that more LTC services will be needed, but the aging process does result in health conditions that contribute to the requirement of LTC support. An example of this is that, as more Canadians are living longer, more people are being diagnosed with dementia, which often results in being admitted to a LTC home due to the complexity in caring for someone with this disease (National Institute on Aging, 2019; Prince et al., 2015; Prince et al., 2016; Wong et al., 2016). In addition, the complexity of healthcare needs of individuals living in LTC is rising as more people who are admitted into LTC have multiple chronic conditions (Chamberlain et al., 2019; Miller et al., 2010, National Institute on Aging, 2019). The amount of LTC services required will continue to increase with the aging population and the simultaneous rise in complex care needs.

Furthermore, much of the research exploring LTC has taken place in urban settings. As a result, LTC services have primarily been understood from the urban perspective. Although some researchers (Brassolotto et al., 2020; Herron & Skinner, 2018) have noted that rural places have unique contextual considerations (e.g., a lack of tertiary services, distance and isolation from larger service centers, and limited transportation options), there is minimal knowledge about rural LTC and where LTC fits within the rural context, or how rurality can impact specific aspects of LTC service (Brassolotto et al., 2019). For example, in Alberta, healthcare has become increasingly centralized in urban centers over the last quarter century (Brassolotto et al., 2018), yet

there is limited knowledge about how this centralization impacts rural LTC. Some researchers (Brassolotto et al., 2018; Hanlon et al. 2007; Skinner & Joseph, 2007) have indicated that centralization can have direct implications for rural LTC (e.g., lack of training or resources that are context specific to the needs of rural LTC residents and staff). It is concerning that there is minimal understanding of rural LTC, while at the same time decisions are being made that can have direct impact on rural LTC services and rural Alberta communities. As of 2011, 17% of Alberta's population resided in rural communities (Statistics Canada, 2012). This means that in 2011 more than 600,000 Albertans lived in rural Alberta. It is further concerning that there is not more current and up to date statistical information available regarding the rural Alberta population.

Culture Change Movement in Long-Term Care

In the 1970's, public pressure to move away from the institutional environment of LTC facilities and towards more homelike environments began (Braedly & Martel, 2015). This shift became known as the culture change movement, led by the Pioneer Network—a coalition of people dedicated to changing the culture of aging and LTC (Dupuis et al., 2016; Miller et al., 2010; White-Chu et al., 2009). The culture change movement is a continuous and emerging process focused on moving away from an institutionalized medical model of care towards a more humanistic, individualized, and relational/community model of care (Dupuis et al., 2016; Miller et al., 2010). This can also be described as care that, at its core, values choice and self-determination, personhood, relationships, collaborative decision-making, purposeful living, respect and dignity, and supportive opportunity for growth (Dupuis et al., 2016). Although there is

movement and desire for LTC facilities to be more homelike, this transition has not been fully actualized in the many LTC facilities (Robinson et al., 2010).

Furthermore, the culture change movement has not yet been successfully integrated into LTC because there is a lack of research examining the processes and outcomes of the culture change movement (Dupuis et al., 2016; Miller et al., 2010; Shier et al., 2014; White-Chu et al., 2009). There is a disconnect, in which the research on culture change has not kept up with the developments in the implementation of changes to care of practices. For example, culture change initiatives that have been implemented, including models of care such as the Butterfly Approach, Wellspring Collective, or Green House, lack sufficient research, particularly regarding their long-term effectiveness (i.e., their ability to transform LTC facilities to be more homelike over an extended period of time) (Armstrong et al., 2019). Additionally, these practice models can have significant costs associated with them (e.g., the Butterfly model costs upwards of $100,000 CAD per home for the initial 12-month training) (Armstrong et al., 2019). Despite these costs and the lack of adequate research regarding these practice models, they continue being implemented in the attempt to make LTC facilities more homelike. In sum, there are culture change initiatives taking place and being implemented in LTC, without research to support what is necessary for these initiatives to be successful (Dupuis et al., 2016; Miller et al., 2010; Shier et al., 2014; White-Chu et al., 2009).

Meanwhile, some scholars (see for example, Baker, 2007; Dupuis et al., 2016; Hill et al., 2011) have noted that culture change is essentially about contextual relationships and community. Therefore, to create a homelike environment in LTC, residents and staff need to come together to create community. According to these

researchers, for culture change to occur, the process towards a more homelike environment needs to be context specific. Therefore, it is questionable whether one model of care (e.g., Butterfly Approach, Wellspring Collective, Green House) can be universally successful in providing a personalized homelike environment. These practice models have also been critiqued for their minimal regard for cultural differences, which is important to note considering the increasing cultural diversity in Canadian LTC homes (Banerjee et al., 2020). Furthermore, it has been suggested that these practice models can result in a rigid standardized approach (i.e., rigid rules and practices) (Armstrong & Lowndes, 2018). If culture change is about contextual relationships and community, then one lone model of care (i.e., one specific way of providing health care services) cannot account for each contextual situation and place.

Changing the culture of care in LTC is a complex process (Dupuis et al., 2016). There are layers of organizational policies and practices, different models of care, various relationships or lack of relationships, and constructs of the physical environment already in place (Dupuis et al., 2016). Furthermore, the people who work in LTC settings have traditionally taken a medical model approach to care (Crow, 2004), which does not align with the culture change movement. This means the care is focused on physiological care and biological data (e.g., hygiene, nutritional content/food intake, bathing, medication administration) over more social or relational care (e.g., engaging in meaningful conversations, a non-rushed atmosphere, emphasis on resident freedom, meaningful social activities, relationship-building amongst staff and residents) (Armstrong & Lowndes, 2018). The literature suggests that homelike-ness is challenging in its conceptualization and implementation (Robinson et al., 2010). This suggests that,

although there is substantial support for the culture change movement to transform LTC facilities into more homelike settings, there are significant challenges in realizing this transformation. The one common feature in the literature is that transforming LTC facilities to be more homelike is important, but there is no comprehensive understanding regarding how this is done. Meanwhile, the culture change movement continues; this highlights the need for further research pertaining to the culture change movement (i.e., actualizing the transformation of LTC facilities to being more homelike).

Sense of Home in Long-Term Care

Previous literature on the topic of home has recognized that certain factors are particularly salient in their ability to impact a person's sense of home. These include social factors (meaningful relationships and interactions, connectedness, activities, community), psychological factors (personal identity, one's habits and values, autonomy and control, coping), and the built/physical environment (indoor and outdoor physical space, architecture, privacy, safety, and predictability) (Johnson and Bibbo, 2014; Molony et al., 2010; Rijnaard et al., 2016; Verbeek et al., 2009; White-Chu et al., 2009). However, the importance of these factors to each person can differ and fluctuate throughout a person's life (Dyck et al., 2005). Thus, social factors, psychological factors, and the physical/built environment need to be flexible and altered to meet the changing needs of the individual person. Of note, recent literature emphasizes the importance of relationships while acknowledging that the physical environment and psychological factors also play a role in making LTC facilities more homelike (Rijnaard et al., 2016; Robinson et al., 2010). Unfortunately, the research examining these important concepts do not incorporate or address the rural context. Thus, our understanding of the extent to

which these factors (or other factors/considerations) impact the sense of home in LTC is not yet robust.

The overall living environment within LTC facilities is unlike previous environments a person has likely lived in and can result in their perception of home becoming altered. Relevant components necessary in creating a sense of home in LTC (including rural LTC) are not thoroughly understood (Fay & Owen, 2012; Hauge & Heggen, 2008). What we do know, is that, in addition to living more communally, residents living in LTC are often faced with being separated from partners, close relationships, neighbourhoods, leisure partners, daily roles and routines, and personal decorative items and memorabilia. This affects the meaning, experience, and sense of home for LTC residents (Brownie et al., 2014; Dyck et al., 2005), and can negatively impact their identity and overall wellbeing (Bland, 2005; Fay & Owen, 2012). Thus, there are unique considerations that need to be taken into account when considering what contributes to a sense of home in LTC.

Although the culture change movement put pressure on creating more homelike living environments in LTC facilities, there is a lack of thorough understanding as to how receiving care in an institutional environment impacts a person's sense of home (Dyck et al., 2005). This is relevant to residents in LTC since they are living in LTC precisely due to complex healthcare needs that require 24-hour nursing care. How this consistent amount of care impacts their sense of home is not well understood (Dyck e al., 2005). There is a tension and lack of clarity in how to actualize LTC facilities as "homespaces" while also being institutionalized places of care (Dyck et al., 2005). This has been

described as a tension between medical care and social care (Armstrong & Lowndes, 2018).

With all of its diverse meanings, people have a need to feel at home. When one has a sense of home, they have an increased sense of self, security, safety, and overall wellbeing (Board & McCormack, 2018). This remains true for residents in LTC, yet the unique environment of LTC results in additional complexity in creating a sense of home (Dyck et al., 2005; Fay & Owen, 2012; Robinson et al., 2010). Therefore, the LTC environment does not always feel homelike or support a personalized homelike environment (Braedley & Martel, 2015; Dyck e al., 2005; Fay & Owen, 2011; Knight et al., 2010). This further reinforces why homelike-ness in LTC is challenging in its conceptualization and implementation (Robinson et al., 2010).

Research Questions

In alignment with the culture change movement, LTC facilities have been attempting to shift their focus of care from being institutional, to being more homelike. While previous research has explored the combination of home and institutionalized care-based living environments (such as LTC), the research is not conclusive. The lack of in-depth understanding regarding a sense of home in LTC transfers into a lack of guidance in helping LTC facilities to effectively become more homelike. Furthermore, there is a gap in the LTC literature related to the rural context. Our understanding of rural healthcare, including LTC services, is limited (Brassolotto et al., 2020; Herron & Skinner, 2018). Yet the number of Canadians (including rural Canadians) requiring the support of LTC is increasing. The purpose of this study was to help address this gap in

knowledge by further exploring the concept of home in rural LTC facilities. Specifically, this study addressed the following questions:

1. What factors contribute to a sense of home for people living and working in rural LTC facilities?
2. What organizational structures enable or impede a rural LTC home's ability to actualize the factors that help them to feel homelike?

Methods

I used an exploratory descriptive qualitative design for this study. This method is well suited for research that aims to describe the 'who, what, where, and why' of events or experiences—particularly those that are not well understood from the viewpoint of those who have experienced them (Bradshaw et al., 2017; Sandelowski, 2000). Furthermore, according to Sandelowski (2000), this research design is the best choice to elicit rich descriptions of data depicted in a meaningful, comprehensive, straightforward, and easily understood language, which stays true to the participants' words. Participant experiences, perspectives, insights, and stories are at the core of this study.

Data Collection

Data for this study was derived from a previous multi-site comparative case study titled, *Intersections in Rural Long-Term Care: A Comparative Case Study in Alberta* (Brassolotto et al., 2019). The aim of the study that the data was originally gathered for was to deepen the understanding of the strengths and challenges in providing LTC in rural Alberta. Specifically, the study explored the intersections of formal and informal

labour, public and private lives, home and health care, expectations and lived experiences, and multiple intersections of identities (Brassolotto, et al., 2019).

Three Alberta Health Services (AHS) LTC facilities were purposively selected based on size (population under 10,000), geography (at least a 60 minute commute from major urban centres), varied local industries (i.e., agriculture, mining, oil and gas), having an auxiliary hospital model (in which there is both acute and LTC in the same health complex), and health zones within the provincial health authority of AHS (South, Central, or Northern Alberta) (Brassolotto et al., 2019). The LTC home being homelike was not a criterion for the purposive selection; however, this topic came about naturally during the data collection. All data was gathered between Spring 2017 and Summer 2018 (Brassolotto et al., 2019). The data gathered was conducted through week-long rapid ethnographies that involved the collection of data from multiple sources over a relatively short period of time (Brassolotto et al., 2019). Two types of data collection took place: 1) in-depth interviews (n=90) and 2) field observations (~200 hours), all of which took place between the hours of 7:00 am and 11:00 pm.

Qualitative interviews were conducted with individuals who provided care in the LTC home, LTC home residents, and family members who were willing to participate (Brassolotto et al., 2019). The interviews were in-depth, individual, semi-structured, in person, and approximately 30-60 minutes in duration. Interviewed participants were informed about the study and their rights as participants and were then asked to sign consent forms prior to their participation in the interviews (Brassolotto et al., 2019). Formal interviews were digitally recorded and professionally transcribed verbatim.

In-depth field observations were completed at each of the sites by numerous members of the research team (investigators and research assistants) (Brassolotto et al., 2019). Observations were confined to public areas of the home (hallways, dining areas, social and event spaces), and were conducted as unobtrusively as possible. Observations took place regarding the use of physical and social spaces, the rules and routines of the site, the daily events and activities, the decor and signage, public documents such as schedules or policies, and interactions between people (Brassolotto et al., 2019). Research team members recorded their field notes related to each of their observations, interviews, and reflexive processes.

Data Analysis

This rich data set enabled me to conduct a supplementary analysis of data, in which I was able to explore the sense of home in LTC. The primary aim of my analysis was to identify what factors contribute to a sense of home for people living and working in rural LTC facilities. Here, I was looking at any physical or environmental factors (the built environment), social factors, or psychological factors that were necessary in supporting rural LTC facilities in feeling homelike. While identifying these factors, it also became apparent that there were certain organizational structures in place that enable or impede a rural LTC home's ability to actualize the factors that help them to feel homelike. This, in turn, became an additional focus of my analysis.

To conduct my analysis, I used Braun & Clarke's (2006) approach to thematic analysis. Thematic analysis is a flexible and extensively used analytical method for qualitative analysis that is specific to identifying, analyzing, and organizing themes and patterns (Braun & Clarke, 2013). This method of analysis allowed me to search for

themes and patterns from which to build theory. Since the proposed study started from a significantly large amount of data, there were two phases to data analysis.

- Phase one: All data was first uploaded into NVivo. I then conducted an initial review of the data and removed any that did not have relevance to the proposed study topic.

- Phase two: This included line by line analysis of the data that included familiarization and data coding, identifying patterns, and analyzing and interpreting patterns across the data. During the coding process I used an audit trail to record my analytical decision-making process (Saldana, 2016).

Phase two: Familiarization and data coding. To begin, I immersed myself into the data and conducted the first in-depth read through of the relevant interviews and field notes that remained in NVivo following phase one of the data analysis. This initial analysis enabled me to articulate my initial impression of the participants' experiences (Braun & Clarke, 2006). I entered initial ideas into a Microsoft Word document. As I analyzed the data in more depth, I began to identify pertinent initial codes. I then conducted line by line analysis and looked for repeated words, segments of sentences, referred concepts, and any other elements within the data that were relevant. Codes that appeared similar and represented comparable experiences, thoughts, feelings, concepts, or relational dynamics were placed together.

Patterns in the data. Next, I put the coded data into categories (Saldana, 2016). Using NVivo, I first generated a codebook with six pre-set codes based upon the 6 key aspects of culture change: 1) care and all resident-related activities are directed by residents; 2) a living environment designed to be a home rather than an institution; 3)

close relationships between residents, family members, staff and community; 4) work organized to support and empower all staff to respond to residents' needs and desires; 5) management enables collaborative and decentralized decision making; 6) systematic processes that are comprehensive and measurement-based and are used for continuous quality improvement. I did, however, remain open to creating new categories when the data required it, which did occur. By doing this, I was able to identify pertinent aspects of the data. I systematically analyzed and compared the data within each interview and across interviews from all three sites to further develop the categories (Braun & Clark, 2013; Creswell & Poth, 2018). As patterns emerged, I revisited and revised the categories as necessary. The codebook, my journal notes, my audit trail, and discussions with my supervisor assisted me in identifying and evaluating themes from the data set.

Analyzing and interpreting patterns across the data. Each theme that emerged was formed from the coding, categorization, and through analytical reflection (Saldana, 2016). I continuously analyzed the data and introductory themes were refined and representative of the data and research questions. My analysis and interpretation of the data was iterative and reflexive to ensure my interpretations were transparent and that the themes were true representations of the participants' experience. My analysis of the data was regularly discussed with my thesis supervisor until the themes were clearly defined and named. To ensure that the voices and experiences of the participants were at the forefront of the study findings, I incorporated direct quotes from the participant interviews into this paper (Braun & Clarke, 2006). I also created a visual model to demonstrate the relationship between themes (Braun & Clarke, 2006). The following three questions helped me through this process: (1) what are these themes encompassed

by, (2) what enables these themes, and (3) what is necessary for these themes to be realized? Similar to the themes, I continuously refined and discussed the visual model of the themes with my thesis supervisor to ensure that it is a true representation of the data.

Rigour and Trustworthiness

For this study to have integrity, it was necessary that I maintained rigour and trustworthiness. To assist me in ensuring this, I followed the criteria set out by Guba (1981), which includes the following principles: credibility, transferability, confirmability, and dependability.

Table 1

Incorporated Strategies to Ensure Rigour and Trustworthiness

Rigour and Trustworthiness	Incorporated Strategies
Credibility. For a study to be credible, it needs to accurately and authentically represent the generated data and research findings (Guba, 1981). One way of helping to ensure this, is by implementing multiple data collection methods and having consistency in the themes across the different data sources.	• The data was initially collected through several methods, including interviews and field notes. • Since the interview guide was semi-structured and utilized open-ended questions, this adds another element of credibility because it allowed participants to express their experiences and viewpoints more freely (Liamputtong, 2013). • I regularly consulted with my thesis supervisor during the analysis process to ensure the findings were truly representative of the data.
Transferability. Transferability refers to whether the findings are applicable in other similar contexts.	• The data was collected from three different sites from three different health zones. • I provided rich descriptions, by way of sharing participant words to substantiate themes in quotations, which allows readers to evaluate if the research findings are appropriate to other settings (Liamputtong, 2013).
Confirmability. In qualitative research, confirmability refers to the researcher(s) reducing any bias that they may have entered	• I engaged in consistent reflective journaling from the start of my inquiry all the way through the final thesis (Bradshaw et al., 2017). I wrote out reflexive journal notes following any read

into the analysis of the data (Sandelowski, 1996).	through of the data, any discussion with my supervisor or after meeting with committee members, and at times when insights or thoughts came about naturally. These notes included my own reactions to the data, my feelings and thoughts through the process, potential biases that presented themselves, and any assumptions I had. Potential biases and assumptions were discussed with my thesis supervisor for additional insight and guidance. • I provided rich descriptions, by way of sharing participant words to substantiate themes in quotations, which ensured that the findings were drawn directly from the data, and therefore reducing researcher bias.
Dependability. Dependability refers to the extent to which there is enough information provided regarding the researchers' decision making, such that, if others were to replicate the study, similar conclusions would be found (Gillis & Jackson, 2002).	• Since this study is based on a supplementary analysis of data, I am not personally able to provide insight regarding the decision-making process on how the data was generated. However, I did maintain an audit trail with a clear outline of key decisions I made throughout the analytical process. This allowed me to further recognize any biases and to ensure that my decisions were intentional and well thought out. • I discussed my decisions with my supervisor to help ensure that I was presenting an accurate interpretation of the data.

Ethical Considerations

Ethical approval for the primary study was granted from the University of Alberta's Health Research Ethics Board and operational approvals were received from Alberta Health Services (AHS) (Brassolotto et al., 2019). I maintained adherence to these ethical guidelines throughout the analytical process of this study. Privacy and confidentiality were imperative components to ensuring the study followed ethical guidelines. Several strategies were implemented to ensure I maintained confidentiality

(i.e., to protect the privacy of personal information that was originally disclosed in a confidential relationship) (Beauchamp & Childress, 2009). All data was anonymized; thus, I had no access to participant names or identifying information. I maintained confidentiality in this study by using the encrypted software NVivo 12 for storing and organizing data. This software is compliant with General Data Protection Regulations on the protection of data and privacy, and the data is encrypted to prevent unauthorized access by any third-party service provider or staff member (NVivo, 2019). All files pertaining to the study were kept on a password protected desktop computer housed in a locked office within the Health Sciences department at the University of Lethbridge. Reflexive journal notes and any other paper documents related to the study were scanned and stored electronically on the same password protected computer as all other study files. No physical copies of documents exist.

Findings

While the three sites included in the study were purposively selected due to similar features (i.e., rural setting and population, auxiliary hospital model, within AHS), there were vast differences in their ability to incorporate a sense of home. Site 1 provided an extraordinary example of a LTC setting that successfully created a strong sense of home for those that lived there. Although direct resident testimony was not included through formal interviews at Site 1, the strong sense of home was echoed through informal conversations with residents and documented in field notes rather than interviews. The physical environment was personalized and accessible, social relationships were strong and meaningful, staff and residents were empowered by

supportive and responsive leadership, and contextual considerations were incorporated (e.g., integrating the rural environment). The LTC home was relational, community driven, and personalized for the residents and staff. In contrast, Site 2 lacked success in their attempts to provide a homelike environment. There was little evidence of supportive or responsive leadership. Staff indicated they felt micro-managed and lacked any sense of empowerment. Instead, ridged policies, procedures, and rules were followed and implemented. This resulted in a lack of resident choice and autonomy. The physical environment lacked personalization and accessibility, and contextual considerations were not evident. Finally, there was limited demonstration of positive social relationships or connections amongst residents, staff, and the community. At Site 3, a sense of home was attempted (e.g., staff made attempts at personalizing the physical environment and at building connections with residents), but there were many barriers that hindered their success. In particular, two main barriers stood out in the data as restricting the potential for a homelike environment to be actualized: 1) there was a lack of support and responsiveness from leadership, and 2) the transient population within this particular rural setting meant that staff and residents were not as known amongst each other or within their larger community. In turn, there were pockets of social connection, aspects of the physical environment that were personalized and accessible, and moments of incorporated resident choice and autonomy; however, this was not consistent.

In sum, it became apparent that Site 1 provided a uniquely homelike environment, while Sites 2 and 3 struggled in their attempts to meet this important organizational goal. Despite this, it is important to note that the data from all three sites informed the themes of the study. Specifically, an exploration of what factors were present and missing in each

of the sites was an important part of my analysis and theme development. However, since my aim was to discover what *contributes* to a sense of home in LTC settings, the presentation of my findings places a specific emphasis on data from Site 1.

A total of six themes emerged from the analysis of data. The first three themes addressed the research question, "What factors contribute to a sense of home for people living and working in rural LTC homes?" Three additional themes addressed the research question, "What organizational structures enable or impede a rural LTC home's ability to actualize the factors that help them feel homelike?"

What Factors Contribute to a Sense of Home for People Living and Working in Rural Long-Term Care Homes?

Three themes emerged in response to the research question, "What factors contribute to a sense of home for people living and working in rural LTC facilities?" The three themes are:

1. Physical environment *that focusses on accessibility and personalization*.
2. Social environment *that prioritizes relationships and opportunities for connection*.
3. Psychological considerations *that focus on supporting choice, autonomy, and flexibility*.

These three themes build upon what previous literature has identified as the main factors that contribute to a homelike environment: the physical/built environment, social factors (relationships, connection), and psychological factors (belonging, identity) (Johnson and Bibbo, 2014; Molony et al., 2010; Rijnaard et al., 2016; Verbeek et al., 2009; White-Chu

et al., 2009). Analysis of the data enabled me to identify, in further detail, what it is about these factors that makes them significant when considering a LTC environment (see **Figure 1**). In what follows, I describe each of these themes and detail the specific and salient qualities about these factors that make them uniquely influential in their ability to contribute to a homelike environment.

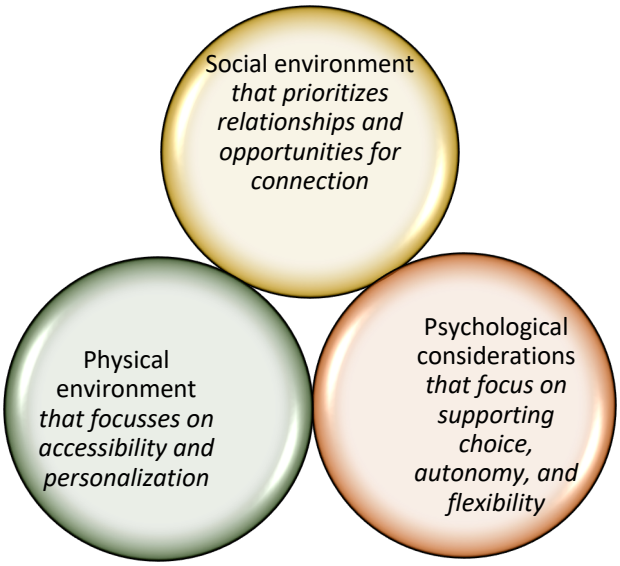

Figure 1: Factors that contribute to a sense of home for people living and working in rural LTC

Physical Environment That Focusses on Accessibility and Personalization

As noted previously, the literature demonstrates that the physical environment is an important factor in creating a sense of home in LTC (Brawley, 2006; Eijkelenboom et al., 2017; Reimer et al., 2004). My findings concur; however, the data demonstrated that how the physical space is used can be more important than the physical structure/architecture of the building. Specifically, the data highlighted the importance of accessibility and personalization within the physical space. An example of this was the

outdoor garden courtyard at Site 1, which was repeatedly brought up by study participants. The field notes of one researcher describes how the garden courtyard was both accessible and personalized for the LTC residents, staff, and the overarching community:

> "…the garden. It's very pretty. It is big and colourful and well decorated with lots of quirky garden decorations like a windmill that has been donated, some rocks that have been painted, birdhouses, a pale blue bicycle that is propped against a tree, etc. There are pots and raised beds at wheelchair level and lots of wooden stakes that indicate whose plants are where or what types of plants there are…. There's also a sandbox with toys for intergenerational visits and metal bars that line the gardened areas to provide assistance for those who need support when walking". - Field note, Site 1

The garden courtyard was accessible through an unlocked door so residents could come and go independently as they pleased. The courtyard also had metal bars that provided support for those who required mobility assistance. The garden beds and plants were also placed at wheelchair level for further accessibility. The garden was personalized using garden stakes that indicated whose plants were whose (i.e., which resident planted and cared for the particular plant(s)). The garden courtyard also provided an accessible space for meaningful socialization and leisure opportunities. For example, residents, staff, and volunteers would tend to the garden plants, staff would visit or take their meal breaks together, and residents would visit with family and friends. Furthermore, there was intentional effort to ensure the garden courtyard honoured the LTC facility's rural context. For example, this garden overlooked a farmyard landscape typical of the region

instead of facing buildings or a parking lot, which was the case at the other two sites. The design of the courtyard took into consideration the people that lived, worked, and visited the LTC home. As one participant shared:

> "…families visit, and they always sit out in the gazebo. Summertime, there's a sandbox for the kids. Cats climbing the tree, up and down the tree… it's amazing." - RN, Site 1

The garden courtyard at Site 1 exemplifies the positive impact a physical space can have in contributing to a sense of home when it is intentionally personalized and accessible. In contrast, at Site 2 there was a policy that residents could not access the courtyard without a staff member or volunteer. Thus, it was not surprising that participants at Site 2 noted how the courtyard was never used. This highlights how even though both of these sites had a garden courtyard, it was only when the courtyard was personalized and accessible that this physical space had relevance and was able to contribute to a sense of home (which was evident at Site 1).

Accessibility, in this study, refers to the practice of ensuring that there were accessible spaces and accessible resources throughout the home. An example of enabling accessible spaces was having open or unlocked doors within the building and to the outside environment. This practice, that was evident at Site 1, enabled residents to independently access physical spaces and environments within their home. In turn, this provided a variety of physical spaces that could be used for social and leisure activities for residents, staff, and community members/visitors (e.g., a corner nook for reading and the garden courtyard that enabled and encouraged visiting with family and friends). The presence of accessible resources was also exemplified by having interactive activities

available for independent engagement, such as word finds or trivia available on the walls or whiteboards, puzzles set up on tables, and reading material such as books on shelves. These items were independently accessible to residents, staff, and community members/visitors. There was also intentional effort to ensure that items posted on the walls or on shelves were at eye-level for residents in wheelchairs, ensuring they were within reach.

Personalization, in this study, refers to the modification of the physical space to suit personal preferences and overall identity. At Site 1, this was exemplified through the prominent display of community and resident photos throughout the home. One researcher commented on this observation in her field notes:

"Feels home-y, as though there are family photos proudly on display." - Field note, Site 1

Through the use of these photos, the physical space was used to represent the identity of the people who live and work in the setting, as individuals and as a collective.

Another example was through the incorporation of wall art that was representative of the rural landscape, setting, and life of the residents and staff. At Site 1, the art was intentional in that it represented rural themes such as historical photos, pictures of early farmers and their tractors, and grain elevators. This personalization of space ensured that the rural context (including the people who lived and worked in the LTC home) was acknowledged and incorporated into the home. In contrast, throughout the main living space at Site 2, the artwork was generic and rather impersonal. As such, the physical

space did not represent the overall identity of the people who lived or worked at the setting.

Furthermore, for the personalization and accessibility of the physical space to have relevance, both need to be present. For example, if certain areas of the home are personalized to the residents and staff, but they do not have access to these spaces, then it is less meaningful. This was the case at Site 2, where resident artwork was only displayed in the locked recreation room. This decreased its ability to contribute to a sense of home since the space was inaccessible to residents except during their limited recreation time. Similarly, if there is accessibility, but a lack of personalization, then again, it has less impact on contributing to a sense of home (e.g., if the reading books are accessible, but not personalized to the reading interests of the residents, then this accessible reading material has less meaning). Therefore, it is critical that the physical environment focus on accessibility *and* personalization.

Social Environment That Prioritizes Relationships and Opportunities for Connection

The literature refers to the social environment as being a critical factor in creating a sense of home in LTC facilities (Nolan, et al., 2002; Robinson et al., 2010). My findings support this, and participants emphasized the importance of prioritizing relationships and opportunities for connection in building a sense of home in LTC; this included relationships and connections amongst staff and residents, and with members of their larger community.

Study participants from Site 1 often referred to there being a sense of family—not in the traditional definition of family, but an expanded concept of family, where residents and staff value their bond and connection with each other that goes beyond their

designated roles. For example, when staff were asked about their care philosophy, they repeatedly mentioned family:

> "I don't think we've ever put a name on it other than you might hear a lot of them say it feels like family here and we treat each other like family and we want to treat our residents like family." - Manager, Site 1

> "Treat everyone like family." - RN, Site 1

When staff were asked about the strengths of the rural LTC home, again, they repeatedly mentioned family:

> "It's just – it's a family – it's a real family vibe." - Recreation Assistant, Site 1

> "Well, I can only speak to this place, but just the sense of home and family. The sense of family that's created here because that's what I really like and that's what I noticed about it right away was the strong sense of family…. People care about each other, people care —like staff care about each other. Staff care about the people who live here and are mindful that it's their home…. People go above and beyond." - RN, Site 1

When staff and residents treat each other in a way that is family-like, there is a relational connection and bond that transfers into more instinctive day-to-day interactions that are recognizable to a homelike environment. For example, one researcher's notes from Site 1 described a staff member gently setting a resident up with their hockey themed blanket while they watched the hockey game. In contrast, at Site 2 it was observed that residents were put back in their dirty clothes after their bath. This is a stark difference from the detail and attention provided at Site 1, where putting residents back into their dirty

clothes does not align with their approach in treating each other similar to that of family. At Site 1, family-like ties were also incorporated through the sharing of meals and daily activities amongst residents and staff. For example, there were instances of staff taking their meal break together in the communal garden courtyard, staff and residents sharing a meal together during BBQs, housekeeping staff taking the time to read with residents, and the security guard taking the time to do jigsaw puzzles with residents in the evening. It is these kinds of daily interactions that promote a sense of family and home for staff and residents. There is an honouring of their connection that is transparent through small, but meaningful, moments of the day, such as the one described in this field note:

> "From the activity area I can hear serving staff chattering and laughing with residents. One of the HCAs is telling a resident she is just brewing a fresh pot of coffee and will bring him a cup as soon as its ready…there is a member of the cook staff asking a resident to let her know if she likes how she's done the food this morning—I get the feeling of an extended family meal, rather than a facility mealtime. When I comment on that to one of the HCAs she notes "we're a small community, we all know each other for years…it's kind of nice". I notice as the other HCA helps people with putting on their water and food-proof 'bibs', she does so gently, relationally… and a couple of times I see her give a little hug to a resident as she puts on the bib. One resident comments to me that she loves the personal connections here with staff." - Field note, Site 1

This observation highlights the relational bond amongst staff and residents. It indicates that they care deeply and authentically about each other.

My findings also illuminate how staff members and residents in rural LTC settings have the ability to incorporate this expanded concept of family in an organic way. Many of the staff and residents from Site 1 knew each other prior to living or working in the LTC home (e.g., the nurse and resident who used to be neighbours), or they had family and friends that created minimal social separation (e.g., the health care aide who provides care to her friends' grandmother). The relationships are not necessarily unique to, or newly developed within, the LTC home; rather, they have often been developed for many years in various settings within and/or outside of the LTC home. When this is embraced, there is familiarity and closeness between residents and staff that enables meaningful bonding to exist. For example, in a field note from Site 1 a researcher noted that, *"the residents here have friendships with many of the staff…."* Participants repeatedly referenced how the relationships amongst staff and residents are both formal (due to the caregiver and care recipient roles) and informal (due to the creation of friendships). This can also be described as having dual roles. In turn, staff would go beyond their formal caregiver role/job title (e.g., the recreation staff member staying past her shift to help care for the garden, or the manager volunteering her time to run a music group with family and friends at the LTC home). My findings suggest that this was, in part, due to embracing the feeling that they are a part of the same larger community. Staff at Site 1 repeatedly expressed how the LTC home is not only somewhere they work, but somewhere they come to connect with those they care about. For example,

> "Even if I didn't work here I'd always come visit and stuff. I come here when I'm not working…. My son and I come for Halloween and Christmas and we come to different events just to hang out and see [residents]" - Housekeeping, Site 1

> "Even if there's like a barbecue or something going on and I had the day off, of course I'm going to come in and eat with the residents, you know, have a meal…." - HCA, Site 1

Residents were also invited to the personal homes of staff members, which further indicated that the relationships between staff and residents were reciprocal.

> "The residents come to my house every summer for hot fudge brownie delights." - Unit clerk/recreation assistant, Site 1

This crossover of formal and informal roles and relationships was embraced by residents, family members, and care staff. There is intentional prioritization of the relationships that is second nature due to the familiarity, closeness, and bonding between staff and residents. Though formal roles exist, informal roles are embraced and recognized as a strength that can positively contribute to the more formal caregiver and care recipient roles. In contrast, this was not observed at the other sites. Instead, there was effort to minimize this crossover of formal and informal roles. For example, the manager at Site 2 was noted to drive to another town to grocery shop to avoid having to see people from the community when not at work. As a result, Sites 2 and 3 did not reap the benefits that were apparent due to this crossover of roles that was embraced at Site 1.

There is also significant importance regarding one's connection to their larger community. My analysis of the data illuminated the importance of enabling community connections to ensure residents continue to feel a part of their larger community (i.e., beyond the LTC home). This was showcased in the data by staff members enabling and encouraging members of the larger community to come into the LTC home, and by

supporting the residents of the LTC home to go out into their larger community. Due to various constraints that the residents may be living with (e.g., health conditions that can restrict their independent ability to maintain connection to their community), to keep resident ties to their community strong, intentional effort by staff is necessary. Participants at Site 1 repeatedly acknowledged the significant role that the recreation therapy department had in effectively supporting and enabling residents to connect with their community. For example:

> "Well, I think our rec[reation] department is huge. The fact that these people go out all the time, they do so much. I think they make them happy, you know, trying to keep them still part of that community that they used to be in. They're still gardening, they're out there gardening, they're off and out to a bull auction or something. It's just like yeah, so I think we bring the community in…." - RN, Site 1

Furthermore, the recreation department incorporated personalized and context specific outings to various community locations and social environments. One participant described how the rural context and farming career of residents provided the basis for many recreation outings:

> "They [residents with support from recreation staff] go on country drives, you know, because these are all farmers that have watched the crops grow. So, they went and watched them seed it. They go and watch the crops — they will go for ice-cream out in the country for two or three hours… They love it. They go and see the baby lambs, and the baby cows, and the harvesting." - RN, Site 1

Another, similar example was when the recreation staff would facilitate residents in going to the local golf club where many of them still had friends:

> "…we go to the golf course and they're with all their old buddies and I've had people from the community say, 'this is so good, you brought them back.' So not only are we doing our residents a favour — the people in the community." - Unit Clerk/Recreation Assistant, Site 1

This quote further demonstrates how supporting residents to go out into their larger community also had a meaningful impact on community members in being able to connect with the residents. The residents in the LTC home live in a different setting than they likely did before, but they are still members of the community. Recreation therapy staff members at Site 1 helped to reinforce this by ensuring residents still had contact with people and places that are familiar, loved, and homelike, even outside the walls of the LTC home. This highlights that 'home' is much more than a single building; for some, home may be more about their hometown. In addition to supporting residents to go out into their community, the recreation staff were recognized for how they invested time and energy into aspects of the LTC home that intentionally encourage community involvement. Some examples include community-based BBQs at the LTC home, connecting residents with school-aged kids through intergenerational recreation programming, bringing local live music into the home, and creating a garden space that is conducive for social visits with family or friends from outside of the LTC home.

My findings further suggest that resident and staff relationships also encourage the forging of new additional relationships and community connections. For example, staff at Site 1 involved their families in the LTC home. One staff member would bring her son in when she worked evenings. Although this was due to a lack of childcare, instead of calling in or cancelling her shift, her son would come in with her and spend time visiting with the residents. Staff were supported to involve their own families in the life of the LTC home. This forging of new relationships was also demonstrated when the LTC staff would encourage and support the involvement of residents' family members. For example, in the following quote, we hear a family member share how staff supported her to remain involved and connected to her husband (a resident of the LTC home) with meals and even spending the night at the LTC home with him:

> "We used to be here for the first couple of weeks, we would be here about the time they opened in the morning and often didn't leave until about eight at night until we saw that he was settled. …he would be so agitated when he didn't see me. So, they put a cot in beside him and I slept beside him for three weeks in here, that was my holiday…. The cooks saw me always, you know, just there, but the kids would bring over stuff and I would just heat it up in the microwave. And she [the cook] came in one day at breakfast and she said, I see you sitting here every day, and she says, and I brought you breakfast and I'm going to bring you lunch and supper too. She did it for the rest of my stay." - Family member, Site 1

Another example was when a resident's grandson would come to play cribbage with his grandfather, yet he would also bring donuts in for all the LTC home residents and visit with others. Families of residents were encouraged to visit, connect, and develop or

maintain relationships with the various staff and residents at the LTC home. This was echoed by the recreation assistant:

> "Like we have a lot of family involvement and it's so good, and it isn't just good for the person, it's good for the rest of the residents because they all know each other from their communities." - Recreation Assistant, Site 1

These examples further highlight how a social environment that prioritizes relationships not only contributes to a sense of home for staff and residents but can also provide a homelike environment for visitors and family members of both residents and staff. In this way, the LTC 'facility' becomes a place of 'home' within the community. In contrast, at the other sites, there was minimal family involvement or development of relationships.

Psychological Considerations That Support Choice, Autonomy, and Flexibility

The literature refers to psychological considerations being an important factor in creating a sense of home in LTC (Briller & Calkins, 2000). The data further supports this and highlights choice, autonomy, and flexibility as being especially significant. Specifically, I found that the incorporation of choice, autonomy, and flexibility can influence how the home functions, thus impacting the sense of home for people living and working in the LTC home.

My findings suggest that at Site 1, resident autonomy and choice were ingrained into how care was provided. For example, in the following quotes we hear how the care that was provided worked around the residents' routines rather than staffs' routines:

> "It's their home, they have the choices that they can make whether or not they want certain things done…." - RN, Site 1

> "Person-centred care is at the heart of everything we do. When patients are admitted, we like to learn their routine, what they like…. Do you want to get up at 7 o'clock? Do you want to get up at 8 o'clock, just before breakfast? Do you like your baths morning or evening?.… What activities to you like? Our recreation team are fantastic at sitting down with residents and seeing what things they like…. We have one lady who likes to fold pillowcases on Friday evening and that sort of makes her feel at home…. We have one gentleman who gets delight out of watering the plants… so he sort of tends to the plants and stuff…." - RN, Site 1

> "We do individual birthdays, we don't do a group, yeah. So, we try and honour that person on that day." - Recreation Assistant, Site 1

Resident autonomy and choice were clearly imbedded as a priority in making care decisions when the resident first moved into the LTC home and throughout their time living there. My findings suggest that this was largely due to the flexibility of the staff who worked at the home. Staff were flexible to make changes and personalize the care based upon what residents expressed as important. In contrast, staff at Sites 2 and 3 were more restricted to following the rules, policies, and procedures in place, and personalizing the care was less evident. Instead, the care was routinized with very little opportunity for variety or flexibility. This was particularly true for Site 2, where strict rules, regulations and policies resulted in an overemphasis on the tasks of care-work and less regard for the quality or meaningfulness of the care being provided.

At Site 1, choice, autonomy, and flexibility was also demonstrated through an active resident council. At these resident council meetings, residents were supported in

expressing their concerns and in requesting changes they would like to see. For example, at one resident council meeting residents expressed their desire for certain changes with their meals:

> Residents spoke about wanting Roast beef, so they started cooking real roast downstairs in the kitchen." - Recreation Assistant, Site 1

This quote highlights a stark contrast from Site 2, where there were policies in place to ensure strict adherence to only offering meals within a prescribed menu. At another Site 1 resident council meeting, residents voiced their desire to keep a cat at the LTC home:

> "This is their home. You know, you look at that crazy cat, I mean, that cat came three years ago. … They [staff] tried to get rid of it, and the resident council, I think six of the 15 [residents], were so upset that this cat was going to be gone. So, well, this is their home, they've got a cat." - RN, Site 1

These resident council meetings at Site 1 provided residents the opportunity to express themselves, to make choices, and to demonstrate their autonomy. What is significant about these resident council meetings, is that these voiced concerns from residents were responded to. As mentioned previously, my findings suggest that this was largely due to the flexibility of the staff who worked at the LTC home. Staff were flexible to support what was important to residents (such as keeping the cat and having roast beef dinners). At the same time, since there was flexibility to make changes, residents were empowered to continue to express themselves, to make choices, and to demonstrate their autonomy. In contrast, the resident council at the other sites appeared to be more of a formality. In particular, at Site 2 the resident council binder was sparce, lacked mention of any changes

in response to any resident concerns, and there had not been a meeting in over a year. This is a stark contrast from the very active resident council at Site 1. My review of the data suggests that the ineffective use of resident council meetings, particularly at Site 2, is the result of the lack of empowered staff to make necessary changes (i.e., being able to respond to requests or concerns from residents and family members).

In summary, three themes addressed the research question, "What factors contribute to a sense of home for people living and working in rural LTC facilities?" My findings highlight the importance of a physical environment that *focusses on accessibility and personalization*; a social environment that *prioritizes relationships and opportunities for connection*; and psychological considerations that *focus on supporting choice, autonomy, and flexibility*. Each of these factors had a vital role in contributing to a sense of home and were prevalent throughout the data from Site 1. To further understand these factors that contribute to a sense of home in LTC, it is also important to understand the organizational structures that enable these factors.

What Organizational Structures Enable or Impede a Rural Long-Term Care Home's Ability to Actualize the Factors that Help Them to Feel Homelike?

My analysis of the data resulted in three themes that addressed the question, "What organizational structures enable or impede a rural LTC home's ability to actualize the factors that help them to feel homelike?" (See **Figure 2**). The first theme, *sense of home is dependent upon leadership that empowers staff and enables a flexible and relational approach to care,* emerged as a foundational organizational structure. Additionally, my analysis of the data demonstrated that the presence of leadership that

empowers staff further enhanced a sense of home because it enabled the physical environment, the social environment, and psychological considerations to interact with and influence one another in a positive and meaningful way. This interaction resulted in a virtuous cycle that further enhanced positive outcomes for staff and residents and was instrumental in achieving the ultimate outcome of increasing the homelike-ness of the LTC home. The interplay that occurs between the physical environment, the social environment, and psychological considerations is discussed in more detail within the second theme, which is titled, *meaningful interplay between the physical environment, the social environment, and psychological considerations*.

The final theme is *knowing the person*. Through my analysis of the data, it was apparent that knowing the history, preferences, interests, and personality of the person in care is central to enabling a rural LTC home to feel homelike. When residents and staff of the LTC home are known, the factors that contribute to a sense of home can be more seamlessly incorporated into to the LTC home. Knowing the history, preferences, interests, and personality of residents was found to help propel this continuous interplay between the physical environment, the social environment, and psychological considerations. At the same time, these homelike factors are also able to further support staff in knowing the person they are caring for. Thus, knowing the person can self-propel this virtuous cycle and positively contribute and enable a sense of home in LTC. Knowing the person was further made possible because staff were empowered to know each other and the residents of the LTC home. These themes highlight what *enables* a rural LTC home's ability to actualize the factors that help them feel homelike and were apparent at Site 1. Alternatively, the data from Sites 2 and 3 indicate that the absence of

these organizational structures *impedes* a rural LTC home's ability to actualize the factors that help them feel homelike.

In what follows, I describe each of these themes in greater detail and explain how they interact with and influence one another.

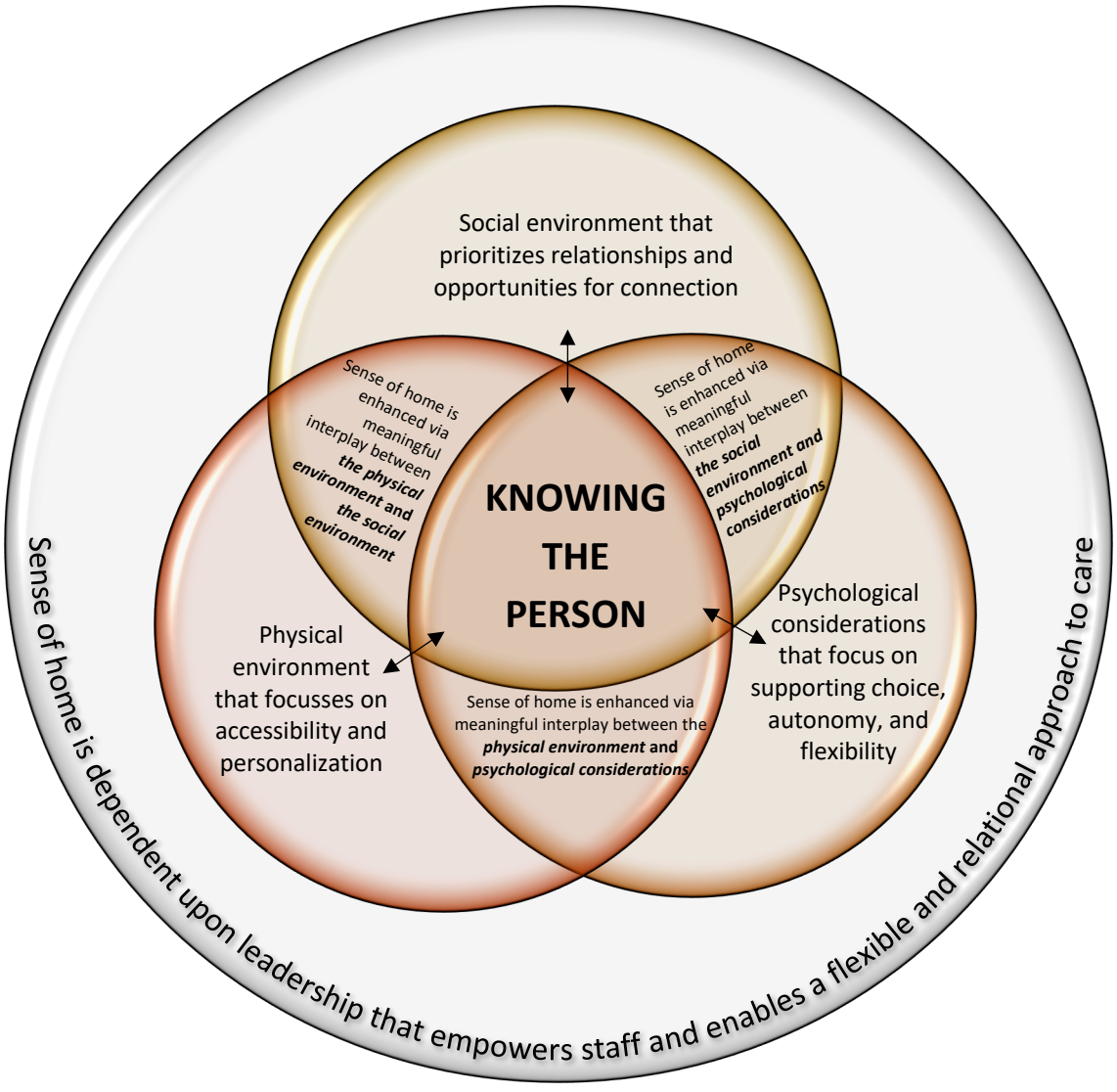

Figure 2: Organizational structures that enable or impede a rural LTC home's ability to actualize the factors that help them feel homelike.

Sense of Home is Dependent Upon Leadership That Empowers Staff and Enables a Flexible and Relational Approach to Care

Through my analysis of the data, I found that supportive, responsive, and appreciative leadership that empowers staff is fundamental to enabling a rural LTC home to actualize the factors that help them to feel homelike. My findings highlight the importance of a non-hierarchical approach to leadership, meaning that all staff, regardless of their job title, are equal members of the team, and that decisions are made using a decentralized and collaborative approach. Site 1 participants repeatedly spoke about the support they received from the manager, who was recognized as being "there for you" and really listened to staff concerns, ideas, and feedback. The manager worked collaboratively with staff members and was supportive and responsive to them. One staff member described the manager in the following way:

> "[manager] is awesome. If there's something - maybe we want to switch a day where we want to come in on a weekend and take people to something or do something special, she's all about that, you know yeah, you guys go ahead and do that." - Recreation Assistant, Site 1

This example showcases that because management at Site 1 was responsive and supportive to staff switching a shift, staff were empowered and able to respond to and support residents in a meaningful way. This was clearly something that the manager intentionally strived towards:

> "I just love being able to make a difference with both patients and with staff, enabling them to feel some ownership in their workplace." - Manager, Site 1

As showcased in this quote, the manager was passionate and excited to empower staff and to positively impact staff and residents. In contrast, at the other sites, it was observed that staff felt unheard, unappreciated, and unrecognized for the work they do.

My findings suggest that when staff feel empowered to have influence over what they do, they are able to more effectively personalize their care and interactions with residents. In turn, there is a flexible and relational approach in how staff work together and in how they provide care. This was exemplified at Site 1 when the housekeeper would read to residents or water the plants, or when the security guard would spend time doing jigsaw puzzles with residents almost every night. These staff members were not expected to do more than their job role; instead, they did these things because they too felt at home there, they genuinely care about the residents, and they felt that they were able to do these things. These staff members were enabled to be more flexible, creative, supportive and person-centred with their job/role; thus, they were able to connect with residents in a meaningful way. Another example observed by the researchers was when the recreation assistant changed the planned recreation program in response to the residents expressing their desire to make fudge:

> "[Resident] has decided she really wants to make fudge. [Recreation assistant] says she's never made fudge before, but that she can find a way. This leads to a lengthy discussion with multiple residents about finding fudge recipes, flavours of fudge, and favourite treats. [Resident] goes and gets her iPad to look up recipes." - Field note, Site 1.

The recreation therapy staff member was empowered by management to respond to the residents' expressed preferences. Rather than feeling forced to stick to a pre-determined

schedule, the recreation assistant was empowered to be flexible in her job and approach (i.e., adjusting the recreation activities based on the interests and requests from residents). In this example, the residents clearly felt that their voice would be heard. Furthermore, this impromptu 'fudge-making' conversation and subsequent recreation program, during which they made and ate fudge, was able to occur without any hesitation. It was relational. This flexibility and relational approach to care was apparent throughout the data from Site 1. My analysis tells me that this is because staff felt empowered. In contrast, at Site 2, strict rules, regulations and policies, were evident throughout the site. For example, at Site 2, there were limited opportunities for creativity or flexibility in the recreation programming because all programs had to be approved by the Recreation Therapy manager who was located in an urban center several hours away. As a result, all recreation programs were pre-planned, time-bound, and very structured.

The Sense of Home is Enhanced via a Meaningful Interplay Between the Physical Environment, the Social Environment, and Psychological Considerations

When leadership empowers staff and enables a flexible and relational approach to care, we see how the physical environment, the social environment, and psychological considerations are effectively able to work together, overlap and interplay with one another. My findings suggest that this back-and-forth interplay creates a virtuous cycle, where the factors that contribute to a sense of home (the physical environment, the social environment, and psychological considerations) each have a positive, meaningful, and continuous effect on each other. The factors identified as being able to contribute to a sense of home are more effective in reaching this important organizational goal when

there is meaningful interplay between them. These interplays were prevalent throughout the data from Site 1.

The Meaningful Interplay Between the Physical Environment and the Social Environment. My findings suggest that the physical environment can influence the continuation of social relationships, and that social relationships can influence the physical environment. For example, the garden courtyard at Site 1 included a sandbox and children's toys, which encourage the involvement of children since there is a physical play space for them. In turn, this helps foster intergenerational social relationships. Furthermore, my findings suggest that when a physical environment is accessible and personable, it creates a space for more natural social interactions amongst residents, staff, and community members (e.g., photos of residents displayed can encourage conversation about the photos). When there are accessible spaces and resources, such as available recreation activities and supplies, this supports meaningful and engaged visits between family, friends and residents. Furthermore, there were no set visiting hours at Site 1; thus, the LTC home was accessible for social visits from family and friends at a variety of times. In contrast, at Site 2, recreation activities and supplies were kept in locked cupboards and rooms; thus, there were no available independent leisure activities for residents to take part in on their own, with each other, or with visitors/family members. There were also limited places for residents to congregate and connect with each other or with visitors/family members. The physical environment at Site 2 seemed to create barriers for social connections to take place.

Similarly, social relationships can also impact the physical environment. For example, there was active involvement from staff and volunteers in maintaining the garden courtyard at Site 1.

> "…the garden project in long term care…we get community members coming out to help clean it…. They say, 'Can we come out and work in the garden too?' and they'll bring their pruning shears and their gloves and go out and work in the garden too." - Unit clerk, Site 1

At Site 1, the social connection and meaningfulness of the relationships amongst residents, staff, and community members/volunteers impacted their personal desire to then contribute to this communal garden space. The presence of strong relationships and social ties meant that people in the community knew the importance of the garden and wanted to continue to contribute to this important part of the home (e.g., community members donating money to put towards the garden, volunteers donating plants and coming to work in the garden with residents and staff). Furthermore, when residents and staff bond, staff have more understanding as to how to make the physical environment more personalized and accessible. Strong social relationships influence staffs' willingness to put energy, time, and resources towards a physical environment that is accessible and personable. Noteworthy is that staff need to feel supported by leadership to develop social bonds with the residents and empowered by management to make changes to the physical environment. Without supportive and responsive leadership that empowers staff and enables a flexible and relational approach to care, this positive interplay is less likely to occur.

The Meaningful Interplay Between the Physical Environment and Psychological Considerations. The physical environment can enable choice, autonomy, and flexibility. To the same extent, enhanced choice, autonomy, and flexibility can support the creation of a physical environment that is accessible and personalized. For example, when a physical environment focusses on personalization, it is better able to support and reinforce personal identity. For example, Site 1 had a lot of rural themed art on the walls, which honoured resident and staff connections to their sense of home and to the larger community, which were both rooted in the rural landscape. Similarly, when a physical environment focusses on accessibility, it is better able to support and reinforce choice and autonomy. For example, residents at Site 1 were able to independently access various spaces of the home, such as the garden courtyard; therefore, they were provided the opportunity to exert choice and demonstrate their autonomy because they were able to independently choose whether they wanted to go out into the courtyard or stay indoors. In contrast, at the other two sites, residents were restricted and not allowed to independently access various indoor and outdoor physical spaces, thus they were not able to exert choice or autonomy. Instead, the physical restrictions reinforced to residents at Sites 2 and 3 that they did not have choice or autonomy, thus minimizing their personal identity.

On the other hand, when there are considerations that support resident choice, autonomy, and flexibility, these also impact what takes place within the physical environment. For example, when residents at Site 1 expressed their desire to have a cat at the LTC home, this resulted in altering the physical environment to accommodate having a cat on the premises.

> "[Staff member] told us the story of Patches the Cat. Patches was dropped off here pregnant 4 years ago and residents lobbied to adopt her. They paid for her spay and her electric fence and everything. The residents really love her." Field note, Site 1

This quote emphasizes how the residents spoke up and advocated to have a cat on the premises. Their voices were heard (i.e., they were empowered) and the physical environment was modified to support this resident request.

Additionally, this back-and-forth interplay between the physical environment and psychological considerations at Site 1 was continuous. For example, residents were supported (with help from staff as needed) to personalize their room (i.e., decorate their room based on their personal preferences and identity). At the same time, by having each resident room personalized and representative of that resident, their sense of self was further reinforced. There was a continuous benefit from one to the other. Resident autonomy was reinforced because of the personalized physical space surrounding them, while at the same time, residents made choices and exerted their autonomy by personalizing their room. This example further emphasizes the importance of a flexible and relational approach to care. Staff at Site 1 were empowered, and thus able to support residents in personalizing their room.

The Meaningful Interplay Between the Social Environment and Psychological Considerations. My findings suggest that the social environment and psychological considerations can have beneficial impact on one another. In my analysis of the data, I found that when there are meaningful connections and relationships amongst staff and residents, there is further emphasis on personal identity and increased

opportunity for residents to exert their autonomy. Similarly, when residents are empowered to share their sense of self, to exert their autonomy, and to voice their preferences, this also provides a window for further social connection. At Site 1, many of the interactions amongst staff and residents were centered around their personal stories and histories, which then reinforced personal identity. At the same time, residents were empowered to exert their autonomy and share their voices and identities with staff, thus helping to guide these social interactions and connections. In the quote below, a researcher notes her observation of this.

> "There is a lot of social engagement between staff and the residents during the evening meal. The unit clerk comes to assist and mainly she is chatting with the residents. The staff engage with the residents when offering them choice of menu items and the social banter that occurs is friendly and fun. The engagement is often centred around the stories of the residents. The LPN who is passing meds is talking at length with a resident about him breaking and riding horses in the past. Since she knows the other residents, she tells this man that he should talk to {resident's name} because he used to break horses too." -Field Note, Site 1

In this quote, we see how a staff member incorporated the mutual interests (horses) of two residents into the conversation, further enabling these two residents to connect with each other. This was possible because the staff member took the time to connect with and develop a relationship with these residents and because these residents were supported to share their interests with this staff member. The social environment and psychological considerations further enhance the positive benefits of each other. In contrast, at Sites 2 and 3, conversations between residents and staff were observed as being more task

focused, and at Site 2 staff were often observed talking over top of the residents and amongst themselves. Thus, at these sites, this positive interplay between the social environment and psychological considerations was not observed.

Furthermore, I found that when resident choice and autonomy are incorporated into the various recreation activities of the LTC home, residents are then more inclined to participate in these activities. This, in turn, provides the residents with an opportunity for further social connection and relationship building. For example, in the following quote we hear how the recreation therapy staff incorporate resident preferences and choices into their meal club—a social and leisure-based group meal:

> "They really like to have something home-cooked… something they would have had at home. And so, I go around to the people who are coming to meal club and ask them what they'd really like. Sometimes they don't care, but sometimes they have specific things…. It's a nice time, it's served family style, everybody can dish up what they want and the amount they want, and we have a little visit, sit and have coffee, you know what you do in your home." - Recreation Assistant, Site 1

Resident preferences are built directly into this recreation program. Furthermore, family members and friends of residents are often encouraged to attend these meal clubs (in addition to many other recreation activities), providing further opportunity for meaningful social connection. This is in stark contrast from Site 2, where recreation programs not only did not incorporate resident preferences but making changes so the programs could be more meaningful were not possible due to the required approvals from management before any changes could be made.

The social environment and psychological considerations can benefit and influence each other when staff are empowered and enabled to provide a flexible and relational approach to care, which was evident at Site 1. In turn, staff are empowered to connect with residents in a meaningful and relational way, thus empowering residents to express their voices and exert their autonomy.

Knowing the Person

Central to the factors that contribute to a sense of home for people living and working in LTC is 'knowing the person.' This refers to staff and residents knowing each other's histories, preferences, interests, and personalities (with the primary focus being on staff knowing the residents). The findings of this study inform us that there are two ways for this to occur: (1) knowing the person via prior relationships from within the broader community, and (2) knowing the person via targeted efforts to understand their histories, interests, preferences, and personalities. Furthermore, there is a reciprocal relationship between knowing the person and the factors that contribute to a sense of home (physical environment, the social environment, and psychological considerations). This is demonstrated by the two-headed arrows in **Figure 2.**

Knowing the person via prior relationships from within the broader community. When the personalities, histories, preferences and interests of residents are known by staff it is easier to personalize the space, to build and provide meaningful social connections, and to know what is necessary to support choice, autonomy, and flexibility. Throughout the data from Site 1, it was evident that the staff and residents knew each other from within the broader community. This was something that they

shared openly and were proud of. Participants repeatedly spoke about why knowing the people they care for from within their community was important. For example:

> "I think it just makes you care more because you know these people. So it's not just some number, it's not room 13, it's Mr. So-and-So who lived down the road and you knew him and it makes a difference." - LPN, Site 1

> "…it doesn't matter what you're doing as a job, if you know the person or someone, you're going to be more – you're invested." - LPN, Site 1

> "I think because you know them and you know their family, and it's just that

> "I think because you know them and you know their family, and it's just that whole small town atmosphere; kind of everyone looks out for everyone." - LPN, Site 1

These quotes indicate how knowing the person via prior relationships from within the broader community provides a deep sense of personal and emotional involvement between staff and residents, as well as accountability in the quality of care provided.

Knowing the person via targeted efforts to understand resident histories, interests, preferences, and personalities. When the space is personalized to the residents, when meaningful social connections are prioritized, and when choice, autonomy, and flexibility are supported, this supports staff in *getting to know* the personalities, histories, preferences, and interests of the residents they are caring for and about. For instance, if staff and residents do not know each other from the broader community, these targeted efforts help to provide a starting point for getting to know each

other. One example of how this was demonstrated at Site 1 was with the use of individualized shadow boxes located outside each residents' room.

> "There are shadow boxes outside each LTC resident's room. These are filled with photos and other small items that help to tell a 'story' of who resides in the room…." - Field note, Site 1

These intentionally made and detailed shadow boxes personalize the physical environment and reinforce resident identity. They are displayed and accessible for other residents, staff members, and community members/visitors of the home to view. In turn, each residents' 'story' is incorporated into the home and recognized. At the same time, these shadow boxes enable social connection and relationships to be built upon (i.e., the shadow boxes provide a sense of understanding who resides in the LTC home, and thus a foundation for connecting). These shadow boxes (which are interwoven with the physical environment, the social environment, and psychological considerations) support staff (as well as family members and other residents) to get to know the personalities, histories, preferences, and interests of the people living in the LTC home. In contrast, at Sites 2 and 3 the shadow boxes were barely noticeable. They were mostly bare or empty, too high for people in wheelchairs to see, and did not incorporate enough detail or personalization. In particular, at Site 2, these shadow boxes only contained a photo of the resident that appeared to be taken upon admission into the LTC home and therefore was not truly representative of the resident's life story. In turn, these shadow boxes did not further enable staff or residents to get to know each other, as they did at Site 1.

My findings suggest that, given the unique LTC setting (i.e., a medical and institutional setting where people who require 24-hour nursing care live communally

together), knowing the person, is vital to creating a homelike environment. As indicated, there are two ways to know the person: (1) via prior relationships from within the broader community, and (2) getting to know the person via targeted efforts. Furthermore, knowing the histories, preferences, interests, and personalities of the residents can be a continuous process and therefore intentional effort to *continue* knowing the person may be necessary in creating and maintaining a sense of home. At the same time, my findings suggest that knowing the person can also self-propel this virtuous cycle amongst the physical environment, the social environment, psychological considerations, and, in turn, further enable knowing the person. This was apparent at Site 1, where the rural context was embraced and recognized as a strength.

My findings highlight that the rural context can provide an especially supportive environment from which to know the person, since those who work and live in the LTC home have often known each other prior to entering the LTC setting. Therefore, residents and staff know each other beyond their role as staff or resident. In turn, it can be somewhat easier and more natural to incorporate the history, preferences, personalities, and interests of the residents because they were known prior to the caregiver and care recipient relationship. The following participants echoed this finding:

> "… I'm lucky because I know most of our long-term care people from living here… I find a connection…" Unit clerk, Site 1
>
> "I know their history. I know their families in a lot of cases or know of them." – Recreation assistant, Site 1

These quotes illuminate how the staff members at Site 1 embraced their rural context. Knowing each other and the residents prior to and beyond the LTC home was

incorporated into the home. In turn, knowing the person was present right from the start. This aligns with recent literature that acknowledges how dual roles can be beneficial, despite the negative connotation they often have (Brassolotto et al., 2021). At Site 1, where these dual roles were embraced, it was easier to know how to personalize the space; how to build and provide meaningful social connections; and know what is necessary to support choice, autonomy, and flexibility. Knowing the person propelled the physical environment, the social environment, and psychological considerations to interact in a virtuous cycle that was instrumental in increasing the sense of home. In turn, knowing the person also further enabled staff and residents to continuously know each other. This continuous back-and-forth relationship demonstrated the ability to positively contribute to a sense of home.

Similar to the other themes, knowing the person is further enabled by leadership that empowers staff. Staff need to be supported and empowered to know each other and the residents. My findings suggest that leadership at Site 1 was responsive to staff and residents because they too knew the staff and residents and were known by them (as compared to Sites 2 and 3, where leadership/management kept themselves at a distance). Again, we see the potential strengths of the rural setting, where being known within the broader community increases one's accountability to follow-up and respond when and where needed, *if* the rural context is embraced and supported.

In summary, three themes addressed the research question, "What organizational structures enable or impede a rural LTC home's ability to actualize the factors that help them feel homelike?" My findings highlight that a homelike environment in LTC is dependent upon leadership that empowers staff and enables a flexible and relational

approach to care; that a sense of home is enhanced via meaningful interplay between the physical environment, the social environment, and psychological considerations; and that knowing the person is central to enabling a homelike environment.

Discussion

With the rising demand for LTC services, the limited research into LTC that incorporates the rural perspective, and consistent public pressure to transform LTC facilities to be more homelike, this study offers relevant and important insight that furthers this body of knowledge. Specifically, this study provides further insight into what factors contribute to a sense of home in LTC and what enables these factors to be actualized.

Consistent with published literature (Carboni, 1990; Rijnaard et al., 2016; Rowles & Chaudhury, 1995) this study's findings reinforce the importance of the physical environment, the social environment, and psychological considerations when looking at the factors that contribute to a sense of home for people living and working in LTC. However, my findings emphasize the specifics within these factors, thus expanding on the existing literature. The physical environment needs to *focus on accessibility and personalization*; the social environment needs to *prioritize relationships and connections*; and psychological considerations need to *support choice, autonomy, and flexibility*.

Previous literature acknowledges the importance of the physical environment; however, this has largely focused on the physical structure and architectural layout of the building (e.g., size and shape of rooms, windows, lighting) (Eijkelenboom et al., 2017). This study challenges this and emphasizes that what is most important is *how* the physical space is used. In addition to a physical environment that focusses on accessibility and

personalization, it is also necessary to take into consideration the context and setting of the home (e.g., rural context/setting, the overarching community that the home is located within, the specific characteristics of the people who live and work in the home). This expands our understanding as to how and why the physical environment matters when attempting to make a LTC facility become more homelike.

Consistent with previous literature, this study affirms the importance of a social environment in contributing to a sense of home in LTC. While this study aligns with previous literature that recognizes the importance of meaningful relationships and connections amongst residents, staff, and family (Nolan et al., 2002; Robinson et al., 2010), my findings extend this to also highlight the importance of community members. The social environment needs to prioritize relationships and connections amongst staff and residents, *and members of the larger community*. Relationships and connections need to be prioritized, valued, and embraced. Furthermore, my findings point out the need for family members, friends, and community members to be included and supported in being a part of the LTC home and connecting with the people who live and work in the home (i.e., providing ample opportunities for community members to be a part of the home). Likewise, residents also need to be supported in connecting to their larger community (beyond the walls of the LTC home). Additionally, my findings reinforce the value of informal roles amongst residents and staff (i.e., relationships that go beyond their structured roles). In turn, there is a relational connection and bond that transfers into more natural day-to-day interactions that resemble an expanded concept of family and a more homelike environment.

The importance of psychological considerations in contributing to a homelike environment is mentioned in previous literature (Briller & Calkins, 2000); however, in comparison to the literature on the importance of the physical environment and the social environment, there is less overall discussion regarding psychological considerations. Thus, my findings enhance our knowledge of this important factor. Specifically, my findings highlight the importance of psychological considerations that support choice, autonomy, and flexibility. In line with previous literature, my findings reinforce that staff in LTC homes need to recognize that home is an individual experience. Therefore, efforts to make these places more homelike requires flexibility to make adaptations in response to the individuality and identity of the residents, thus incorporating resident choice and autonomy.

In addition to understanding what factors contribute to a sense of home in LTC, this study further explored what organizational structures enable or impede a LTC homes' ability to actualize these factors that help them to feel homelike. This study further reinforces and highlights the importance of supportive, responsive, and appreciative leadership that empowers staff and enables a flexible and relational approach to care in enabling a LTC facility to become more homelike. Staff voices need to be heard, they need to feel trusted and appreciated, and they need to be supported in making care decisions and going beyond their designated role or job title. This study suggests that this is foundational in actualizing the factors that contribute to a sense of home in LTC (i.e., physical environment, social environment, psychological considerations).

Furthermore, this study highlights that leadership that empowers staff and enables a flexible and relational approach to care, enables a mutually beneficial relationship and

interplay between the physical environment, the social environment, and psychological considerations. Although previous literature has discussed to some degree the importance of each of these factors, this study further extends our understanding by suggesting that this continuous back-and-forth interaction results in a virtuous cycle that is instrumental in achieving the ultimate outcome of increasing the homelike-ness of the LTC home. This study suggests that the factors identified as being able to contribute to a sense of home (physical environment, social environment, psychological considerations) are more effective in achieving this important organizational goal when there is meaningful interplay between them. While current literature has discussed these factors, they are often discussed in isolation from each other or are more focused on one of these factors. This study expands our knowledge by highlighting the importance of the interplay between these equally important factors.

Central to the factors that contribute to a sense of home for people living and working in LTC is knowing the person. Although the importance of knowing each other has been briefly discussed in previous literature (Robinson et al., 2010), it is often solely interwoven in discussions about the importance of the social environment. Thus, this study furthers our understanding of knowing the person and connects it with the social environment, *as well as the physical environment and psychological considerations*. By knowing the histories, preferences, interests, and identity of the people who reside in LTC, it is easier to know how to personalize the space; how to build and provide meaningful social connection; and know what is necessary to support choice, autonomy, and flexibility. At the same time, through targeted efforts, such as personalizing the

space, building meaningful social connection, and by supporting resident choice and autonomy through a flexible approach, it is further possible to get to know the residents.

In addition, this study highlights the strength and advantage that a rural community can have in creating a sense of home within LTC *when it embraces and values its rural context*. This further expands our limited knowledge of home and the rural context since this combination has not yet been discussed in previous literature. This study highlights how the rural context can intuitively support knowing the person since staff and residents often know each other prior to, and outside of the LTC home. Given the fact that healthcare in Alberta has become increasingly centralized to urban centers (Brassolotto et al., 2018), it is important we also consider the context, unique characteristics, and strengths of rural settings, and not assume that rural healthcare should follow urban based policies and procedures. In addition, this highlights the need for more research based in rural healthcare settings, including LTC, so we can further increase our understanding and gain potential insight from the rural perspective. That said, given the fact that only one of the three rural LTC homes included in this study exemplified a homelike environment, this study aligns with the following statement by Herron and Skinner (2018): "Rural places are distinct in their own right; they are distinct from one another, and they are distinct when compared to urban and metropolitan settings" (p.267). As such, in the effort to make LTC facilities more homelike, it is necessary to respond to the particular needs of a person (or the LTC home in general) instead of applying a one-size-fits-all approach. Site 1 demonstrated what can be possible when the particular needs of the residents, staff, and the LTC home are at the core of what takes place. This study suggests that the ability of LTC homes to become more homelike may be less about the

differences between LTC homes, and more so about whether they respond to *their* particular needs (i.e., their people, their community, their context).

Additionally, throughout the data and intertwined within each of the factors that have been identified as contributing to a sense of home, was the presence of the recreation therapy department. The recreation therapy department at Site 1 was creative, spontaneous, person-centred, and flexible with their approach to recreation programming. As a result, they were able to positively and effectively contribute to a sense of home via the physical environment, the social environment, and psychological considerations. In turn, this suggests that the recreation department of a LTC home has an important role in the process of creating a homelike environment. This further expands our knowledge since there is minimal literature that addresses or explores the role of recreation therapy in contributing to a sense of home in LTC. Although our study did not specifically address this, it emphasizes the need for more research in this area.

Limitations

Some limitations of the study are noted. First, the data analyzed for this study came from an original study that was not designed with the same research question or aim. Therefore, the research questions addressed in this study were not part of the decision-making process during the designing of the study or the collection of data. Second, residents of the LTC homes were not initially included in the collection of data, and as a result, the one LTC home that exemplified a sense of home (Site 1) did not include any data specifically from residents. Therefore, resident voices and words were not able to be analyzed or included during this analysis and are therefore not represented in the findings. Third, the LTC homes involved in this study may not be representative of

all homes in terms of their resident population and size. For example, this study included smaller LTC homes without secure dementia units; thus, additional supports might be needed to address these homelike factors in a larger home with residents who have more complex needs. The study was also conducted in one Canadian province, which may not be representative of other geographical areas.

Conclusion

Despite these limitations, this study furthers our understanding of home in LTC. In sum, supporting a sense of home in LTC is a complex process, yet is very possible. Attempts towards making LTC facilities more homelike have often resulted in the implementation of various care models (e.g., the Butterfly approach, Wellspring collective, Green House). While these practice models attempt to incorporate some promising practices, they have also been found to result in a rigid standardized approach that does not incorporate cultural diversity or take into account contextual considerations (Armstrong & Lowndes, 2018). In the attempt to transition LTC facilities to be more homelike, this study contends that one specific care model may not incorporate the expansive, complex, multilayered, and individualistic understanding of home. Instead, our study highlights the importance and specifics within certain factors (i.e., physical environment, social environment, psychological considerations) that should be taken into account when attempting to make a LTC facility more homelike, yet the exact specifics of what this looks like for each individual LTC home will likely vary.

My findings align with scholars who have noted that culture change is essentially about contextual relationships and community (see for example, Baker, 2007; Dupuis et al., 2016; Hill et al., 2011). The foundation of culture change, and thus how to make an

institutional environment more homelike, needs to be real and contextual for those who live and work in the particular setting. This reinforces why knowing the person is also so central to a homelike environment and why staff need to feel empowered.

In conclusion, as LTC settings attempt to transition away from institutional models of care to more relational, homelike environments, this study provides further insight into what factors contribute to a sense of home for those who live and work in LTC. Creating a sense of home is a complex process, where intentional effort is required. There is not a 'one size fits all' when it comes to creating a homelike environment. Emphasis should be placed on fostering an environment where knowing the person is incorporated and supported. To do so, supportive and responsive leadership that empowers staff needs to be a priority of leadership/management.

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