IMPROVING CARE IN PRACTICE: LEARNING FROM THE SENIORS' ADVOCATE'S INQUIRY INTO THE DEATH OF A NEW BRUNSWICK NURSING HOME RESIDENT

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Introduction

> For this is our concern: if care practices are not carefully attended to, there is a risk that they will be eroded. If they are only talked about in terms that are not appropriate to their specificities, they will be submitted to rules and regulations that are alien to them. This threatens to take the heart out of care—and along with this not just its kindness but also its effectiveness, its tenacity and its strength.
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> —Annemarie Mol, Ingunn Moser, Jeannette Pols
> ("Care: Putting Practice into Theory," 7)

In January 2022, the New Brunswick Seniors' Advocate (NBSA) released the report of their inquiry into the death of George, a pseudonym for a ninety-one-year-old man who died as a result of an assault in a New Brunswick nursing home (https://www.nbseniorsadvocate.ca/s/NBCYA-SeniorsAdvocateReportEWEB-003.pdf). The NBSA's investigation did a good job identifying errors, denials, and obfuscations at many levels, from management who went so far in its avoidance of responsibility as to illegally evict George, to the Department of Social Development's internal inquiry that was so mystifyingly narrow as to be entirely inadequate.

Yet, despite a revealing inquiry, the NBSA's recommendations were rather predictable, revolving around calls for better regulations and monitoring. Such a reliance on regulations and monitoring—auditing, in other words—to solve problems with care has become common. There is, of course, a place for auditing. And it should come with adequate enforcement. But the degree to which our thinking is captured by auditing demonstrates a troubling lack of creativity about how to improve care. Worse, it demonstrates a failure to attend to the practice of care itself, especially its dynamic and deliberative dimensions.

I want to use the NBSA's report as an opportunity to think through ways of improving care that respects the logic of care. My comments are informed by feminist care theories and particularly scholarship that recognizes that care has a unique logic that needs to be understood and worked with if we are to improve it (Mol, *Logic of Care*; Waerness). This invited essay is also informed by a recently completed, decade-long, international comparative study of promising practices in nursing homes ("Re-imagining Long-term Residential Care: An International Study of Promising Practices" https://reltc.apps01.yorku.ca/). Through this research I had the privilege of learning from exemplary homes across Canada and Scandinavia. My comments are offered in the spirit of the NBSA's report. My aim is not to find fault but to build on the good work of their inquiry to think about how we may improve both the care of nursing home residents and the conditions of work for staff, since the two are intimately connected.

The Incident and Inquiry

First, some background about the incident at the heart of the NBSA's report: the death of George. George was ninety-one years old when he was admitted to the nursing home, which is unnamed in the report. This was not an easy decision for his family to make, but George had been diagnosed with Alzheimer's disease and was no longer able to care for himself. One week after he moved in, his family received a call that he had fallen. The following month, another call informed them that he had fallen again and had been taken to the hospital for stiches. Less than a week later George was hospitalized for a fractured hip, the result of yet another fall. The family was perplexed. George had been walking independently prior to admission. What had happened? They insisted on viewing the surveillance videos. The first video had been deleted. The second and third videos showed George being assaulted by a resident named Tom (also a pseudonym) and then collapsing to the floor. George died two weeks after his hospitalization. The coroner ruled the death a homicide. The Department of Social Development conducted an investigation through its Adult Protection Services and concluded that any claims of neglect and abuse were unsubstantiated.

The NBSA's inquiry told a different story. They found that Tom, who also had dementia, had been involved in at least nine troubling incidents of physical and verbal abuse. Only the altercation resulting in George's hospitalization for a broken hip was reported to the Department of Social Development. Indeed, the NBSA's inquiry found that the managers interpreted these incidents in the narrowest possible manner, such that they could avoid the requirement to report.

Yet clearly management was concerned. Fearful that the family "would blame the nursing home if George died," management evicted George from the nursing home while he was still in the hospital (NBSA 23). This came as a shock to the family. In a letter addressed to George's daughter, management claimed that "her accusatory actions were disrespectful" and her father's stay "unduly endanger[ed] the safety of himself and other residents and staff" (quoted in NBSA 23). As the NBSA rightly observes, the discharge was "uncaring" (24) and in violation of current standards. In the entire matter, George's eviction was the only infraction the home was cited for. The penalty was to produce a plan of action to address the discharge within a month. George's death three days later rendered the requirement irrelevant.

The NBSA's inquiry also found that the Department of Social Development's investigation through its Adult Protection Services was inadequate. The investigation focused only on the incident leading up to the hospitalization. It did not inquire into any history of abuse. It was conducted with incorrect information, given that the staff time sheets that were evaluated to ensure adequate staffing were for the wrong day. Worse, the social worker conducting the investigation interviewed only two managers. She did not speak to other staff or residents.

Unlike the Adult Protection Services investigation, which ignored care workers, the NBSA interviewed them. They treated care workers as the experts they are from a logic-of-care perspective. They found staff knew about the abuse and were concerned. Yet there was a disconnect between problem identification and solution. Care workers had brought the issue of Tom's behaviour to management. But they "felt that their concerns and suggestions 'fell on deaf ears'" (quoted in NBSA 9). Management, by contrast, believed it to be early days, with George still in his "learning phase," part of becoming accustomed to his new home. Why this latter view prevailed is not clear.

The NBSA also reviewed research on violence and identified several strategies that could have been put in place. It is not clear if and how these were discussed by staff and management. The NBSA's investigation does not explore in any significant detail the efforts made to problem solve. They addressed complaints made by family members and rightly recommended an improved complaints process. But such a process would be more appropriate for complaints that cannot be resolved by usual means. Where more exploration would have been beneficial was uncovering the day-to-day process of working through complaints, challenges, and concerns. This is the deliberative, ethical, adaptive dimensions of care.

The NBSA's inquiry does reveal that standard practice involves passing on complaints to the relevant manager, and then all complaints are forwarded to the director of nursing, who then problem solves. It is not clear, however, from the inquiry how this problem solving occurs. Nor is it evident whether outside expertise is solicited or if collective deliberation occurs, and if so, who is involved. Without this information, it seems troubleshooting falls on the shoulders of managers. The investigation also notes that the family was not included, as they should have been, at least in George's initial care conference. Moreover, whether and how staff and management discussed George's safety in this conference remains unclear and would be helpful to understand. More importantly, since Tom had abusive interactions with other residents, it would be useful to know whether and how Tom's behaviour was discussed in his care conference or at any other point.

While the NBSA raised the issue of problem solving, it did not do enough with it. This is not surprising, as problem solving has received limited attention in both research and practice within long-term care. Despite attempts to move beyond the medical model and to personalize care, care still tends to be conceptualized in a mechanical, task-based manner. Standards are stipulated, then supposedly followed. A care plan is determined, then ostensibly implemented. The rationality and ethics of care that feminist scholars have drawn attention to, and the organizational and policy processes that support them, are all but ignored in the analysis of incidents such as this. An opportunity for productive reform was unfortunately missed.

Problem Solving as Quality Improvement

Research on problem solving within care contexts have identified the importance of relational processes that support reflection, collective deliberation, and situated solutions for the improvement of work and care (Banerjee et al.; van der Dam et al.; Vikström and Johansson). I recall visiting one home in Stockholm and having a conversation with a manager about the Canadian tendency to rely on regulation as a means of addressing quality concerns. She smiled knowingly and said that care is dynamic. She mentioned that while they may have a plan for today in place, they may have to throw it out because Ingrid (a pseudonym) had a bad night and is now very agitated. I asked her how they handled this. She took me into a room with a whiteboard, a round table, some chairs, and a coffee maker. The board had all sorts of Swedish writing on it because Ingrid did have a bad night. In such situations, she said the nurse will call an ad hoc meeting, bringing the day's care team together, and they will reconfigure their work plan, balancing responsibilities and whatever other concerns might arise. The meeting gives them a chance to deliberate and come up with a solution together. In another Swedish home I visited, I was told about "safety huddles." These huddles can be called by anyone, not just the nurse, whenever there is a critical incident (Braedley and Szebehely). They allow staff to come together and flesh out the issue, brainstorm solutions, and test them in a timely fashion.

Having arrived in Sweden after attending several sessions on compliance in Ontario that celebrated the use of iPads and the RAI/MDS data management system, these Swedish responses were striking in their simplicity and relationality. Upon further examination, though, the simplicity is misleading. This sort of problem solving is made possible not least by working conditions that ensure that staff have the autonomy and flexibility to call and/or attend a meeting on the spur of the moment (Banerjee and Braedley). They require enough staff to guarantee that some can meet and not be worried about their residents' care. And they require sufficient respect and trust to enable a fruitful discussion. In the Canadian homes I visited, such conditions were the exception. Communication, as Caspar and colleagues have shown, is typically top-down. Bottom-up communication happens in a limited and ad hoc rather than officially supported manner. For instance, concerns are brought by a care aide to a nurse, much as the NBSA report found. This only happens, however, if relations are good enough that staff aren't afraid of the nurse—in which case, staff will remain silent, and problems get swept under the rug. I wonder to what degree this happened in the case of George.

Collective deliberation is not impossible in Canada. One of the most promising practices I encountered was developed in British Columbia (Banerjee et al.). There a health authority had pioneered the use of facilitated reflection meetings to identify, discuss, and collectively resolve problems. A facilitator was brought in to run the meetings precisely because of potentially silencing power dynamics. Staff may not know one another; there may be a culture of fear and blame; staff may be terrified to speak up. Through the reflection process staff are taught to speak and managers are trained to listen. The agenda is determined by staff, and communication flows in a different direction as many said: bottom-up. Once a respectful dynamic is established, managers take over the meeting facilitation, though they still follow the staff's agenda. These meetings run on a weekly basis to catch problems as they emerge, and there are longer bimonthly meetings to grapple with more complex issues. All meetings are interdisciplinary, voluntary, surprisingly empowering, and effective in solving a wide range of problems.

Being aware of such promising practices, I interpreted the findings of the NBSA's inquiry differently. The issue was not safety or violence per se but an ineffective means for raising and resolving problems. I also read the NBSA's recommendations differently. Their recommendations evince a reductionist, mechanical approach, which misses the relational and deliberative practices of caring. Indeed, in many cases they miss care work entirely, leaving workers and managers unsupported, while inserting them in a "you-do-this-or-else" type of logic that is not effective or caring. In what follows, I consider several of the thirteen recommendations proposed by the NBSA to illustrate these points.

Considering Some Examples of Missing the Practice of Care

The NBSA's first and final recommendations offer perfect examples of missing the work of care. Let's begin at the end. The NBSA is impressed with Ontario's Resident Bill of Rights, which contains an aspirational preamble and a set of rights from protection against abuse to the right to be treated with respect and dignity. However, given the inadequacies of the Ontario system, any borrowing of ideas should come with some justification of their effectiveness. Nonetheless, the NBSA was inspired, and as a final recommendation proposed the establishment of a similar set of resident rights. However, the NBSA does not explain how these rights would translate into better care. It is not clear they have in Ontario. Rights do not materialize by themselves. Enacting these rights *is* the work of care. But the NBSA does not address this. To propose a bill of rights without suggesting how they will translate into care is akin to magical thinking. It is care improvement by incantation.

In the case of the NBSA's inquiry, one would presume a key right in question was George's safety and security. Surely, the stipulation of a right is not needed to know that what had happened was problematic. I'm hoping they do not believe staff and management are that stupid. The challenging questions have to do with how the home could have prevented George from being assaulted and ensure something like this doesn't happen again. The recommendations proposed do not achieve this.

Indeed, the first recommendation, which one would assume would be the most important, is so vague as to be meaningless. The NBSA recommends that "the Department of Social Development develop evidence-based safety practices for all nursing homes to implement" (10). After such an interesting inquiry, this is the level of creativity and specificity we are left with. Safety practices? What kind of safety practices exactly? Safety practices are numerous and diverse, but they go entirely unspecified. It seems as if, after the inquiry, the NBSA does not understand what the problems were or what to do about them. Taken together, the first and final recommendations amount to this: residents have a right to be safe, and homes ought to have a practice to ensure their safety. And certainly, while George's right to safety was violated, as I suggested above, the problem was likely not so much to do with safety but with dialogue, deliberation, and problem solving.

More thoughtful analysis surfaces in the preamble for the second recommendation, where the NBSA observes that the Community Governed Nursing Home Society of Nova Scotia suggests establishing knowledge resources for care workers, specifically, "an electronic data base of resources for long-term care facilities and staff across the country to share information and de-escalation techniques" (quoted in NBSA10). This is an excellent idea. If we are paying attention to problem solving, then we should be asking questions about timely access to expertise. What are the processes that nursing homes have in place to access cutting-edge expertise when they have an urgent problem to solve? More broadly, can staff share problems for collective deliberation beyond the facility? Can they learn from their peers, in other words? Can they also share their successes?

The safety huddles I described above were typically facilitated by a staff member who had completed a program on dementia care. This strategy integrated expertise in their deliberations. Another promising strategy I encountered in Stockholm was the reliance on compliance inspectors to serve in an advisory capacity. It makes sense, since they are familiar with the range of problems in their sector and are aware of how different homes have sought to address them. I was told that it was not uncommon for a manager to reach out to a compliance inspector, let them know they were struggling with a particular issue, and solicit advice. Do they know of a home that has struggled with the same thing? What did they do? The interdisciplinary mix of staff in British Columbia's reflection meeting also ensured a diverse assortment of expertise. Participants would also visit other reflection groups to share their knowledge. And in another Canadian home I studied, care workers were sent to conferences.

It is worth paying attention to how this discussion about knowledge sharing and collective problem solving feels. It is creative, inspiring, innovative, and collaborative. This is exciting stuff! Supporting such creative strategies would contribute to a vibrant, innovative, dynamic long-term care system. Is this what the NBSA recommends? Not even remotely.

While the NBSA's analysis for the second recommendation is thoughtful, the actual recommendation itself is less so. The NBSA recommends that the Department of Social Development, in consultation with other stakeholders, "undertake a thorough review of best practices in violence mitigation and develop a comprehensive policy and practice structure" (11). This is about people outside

the home coming up with a practice structure for those in the home to follow. Not only is this recommendation vague (what is a "practice structure"?), but it conceptualizes care in a mechanical, top-down fashion. We, the experts, will determine the best course of action. You follow it.

The neglect of local knowledge production is one of the key contrasts between auditing and the logic of care. In a wonderful essay, aptly titled "Perhaps Tears Should Not Be Counted but Wiped Away," Moser points out that the logic of auditing is about producing knowledge by and for distant centres of power. Incidents are counted, workers are monitored, and managers produce reports that get sent to centres of power. Or, conversely, centres of power, as we see above, determine what needs to be done locally. By contrast, Moser notes that the logic of care aims to understand the complexities of how knowledge is used and produced within care practices so they can be supported.

In the case of George, this would not be about violence mitigation in general or comprehensive practice structures (whatever this might mean), but it would mean figuring out what to do about George and Tom specifically in this nursing home, and at this time. Not least this would require experience, expertise, deliberation, and organizational supports. And it would involve recognizing that whatever solution might work one week may not the next. It involves recognizing that even evidence-based or "best" practices have no guarantee of working here and now. Best practices are best for whom, when, and where? And evidence-based only means that they have been studied somewhere else with some other people and shown to work somewhat well. To understand the logic of care is to understand the work that will need to be done to adapt such expertise and best practices to local conditions to improve care. And to respond when it stops working. It is a process that Mol refers to as "tinkering." This tinkering—experimenting, adapting, and figuring things out—is a normal part of care work. Recommendations would do well to support this practice of care. It likely would have made a difference to George.

I want to clarify that I'm not suggesting auditing is always problematic. I have argued elsewhere that there is an important place for rules and strong enforcement (Banerjee, "The Regulatory Trap"; "Tensions between Principles and Practices"). But auditing should be guided by the logic of care. And we should not expect good care to emerge from poor working conditions. Indeed, auditing is best when it is used to support the conditions of work that are also the conditions of care (e.g., ensuring public or non-profit delivery as well as adequate staffing, resources, and training). When we do not effectively regulate—because it is costly, there is no political will, or our habits of mind are colonized by reductionist, command and control worldviews—we tend to regulate in ways that do not enable care.

We see this mistake made in the NBSA's otherwise good recommendation for training. The inquiry revealed that staff feel unprepared to address violence. In the words of one staff member, when dealing with violent behaviour, "You just have to wing it" (quoted in NBSA 15). While the recommendation for training on violence reduction is helpful, the enforcement is not. To ensure training occurs the NBSA recommends "mandatory reporting to the Department to ensure that all staff have received training" (16). This sort of approach to auditing is, as Mol asserts, about proving not improving (Mol, "Proving or Improving"). This sort of reporting is also easy to game. I have heard of many situations where staff will walk into a training session, sign the attendance form, and then walk right back out. They don't have the time. And I have heard of many instances where staff are trained but do not have the resources to do what they know to do. Following up is a good idea. But rather than mandatory reporting—i.e., "counting" attendance or delivery—perhaps part of the inspection process can include a focus group with staff to learn where they are feeling unprepared, where they need more

training, and whether they have the resources to implement the training they receive. It might not be as easy as counting, but it would contribute useful information about the state of training and how that might be *improved* in an ongoing way.

The requirement for mandatory reporting also ignores a key reason why staff were not trained in the first place—a reason that the inquiry identified. According to one manager interviewed, they simply do not have the budget. One can imagine that if there is a sufficient budget for training, if training happens during work time with additional staff brought in to ensure care is not disrupted (which is also a resource issue), and if the training is a response to staff's needs rather than an imposition from above (which would involve dialogue), it is much more likely staff will engage in training. Rather than hold only the staff and management accountable, it would be preferable to also hold the Department of Social Development accountable for providing adequate resources to ensure staff receive quality, ongoing training as part of their work. This bottom-up auditing—for example, holding those in positions of authority accountable to workers—is missing when we misunderstand the practice of care and treat it as something that can be demanded by fiat.

Finally, contrast the feeling evoked by someone saying "I want to sit with you to see where you are struggling and how we can support you through more training" with "You are required to report the number of training sessions held and staff's attendance in order to demonstrate training has occurred." One is supportive: you are encouraged to open up and reach out. The other is punitive: you are required to prove yourself. Research on auditing has noted that regulations and compliance systems can play a role in shaping workplace culture (Braithwaite et al.). Punitive approaches to regulations can create what has been termed a defensive or ritualistic approach to regulation, where you follow the rules not to provide good care but to avoid getting in trouble. Rules are followed ritualistically with no reflection. The end goal of improving care is lost. In these sorts of workplaces, staff may, in theory, have the autonomy to try something different to support a resident, but they are unlikely to exercise their autonomy. And most certainly they are not going to flag problems. This is a culture where mistakes, problems, and abuse are hidden. Keep your head down and tell them what they want to hear.

From the NBSA's inquiry, it seems that such a culture of fear was present and would have been worth exploring. Why, for instance, did management interpret the incidents of violence so narrowly as to avoid reporting? The NBSA clearly values reporting. Why does reporting matter? How does it improve care? This was never clarified, and it should have been. And what happens when managers report? In particular, what happens that contributes to such an aversion to report in the first place? I can only imagine that if reporting triggered compassion and support, managers would be keen to interpret incidents broadly so that they could be reported. Similarly, why did management classify the first incident between George and Tom as "unwitnessed" and not study the video? Why was the recording not saved? Interestingly, Moser's article discussed above explores the use of video recordings to better understand dementia-related agitation and violence. Video is a tool that is used to capture a moment so it can be studied, supporting staff in figuring out what has happened and helping them determine what to do about it. Video recordings in this context support staff and care improvement; they are not primarily about surveillance (or punishment) as would seem to be the case here.

Did the NBSA recommend obtaining a better understanding of why managers did not report as they should have? Did they recommend that the culture of fear be better understood and transformed? These are big issues, clearly, but they were not considered by the NBSA's recommendations. Rather, their recommendation to address management's failure to meet *existing* requirements to report incidents

of violence was to require the reporting of incidents of violence. You read that right. Except for a minor tweak that is not worth entering into here, the reasoning is entirely circular. This is where NBSA could have been creative and caring. Stipulating that you did not follow the rule, therefore you must follow the rule, is not caring. We need to better understand why reporting did not happen. We need more empathy if we are to understand this issue and facilitate reporting. (Presuming, of course, reporting does something worthwhile, which was never clarified.) We also need to get creative, not double down on rules. There is little empathy or creativity in such recommendations. But there could have been because the inquiry flagged some important issues. It provides something to build upon.

Conclusion

I hope that my remarks in this invited essay point to some directions that may be taken in the future and raise questions that are worth thinking about as we aim to improve care for older adults. The work of the NBSA is important and their inquiry helped bring many issues to light. As the Seniors' Advocate notes in the Foreword, the point is not to find blame or fault but to find ways of improving a complex system that serves vulnerable adults and, I would add, is a place of employment for many New Brunswickers. One way of improving care, as I've tried to show, is to ensure that recommendations for change fit within the relational logic of care and are not colonized by the outdated command and control worldview of reductionist auditing.

To comment on this essay, please write to editorjnbs@stu.ca. Si vous souhaitez réagir à cet essai, veuillez soit nous écrire à editorjnbs@stu.ca.

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Acknowledgement

I would like to acknowledge funding from the New Brunswick Health Research Foundation's Research Chair in Community Health and Aging, which supported the writing of this essay.

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