University of Alberta

Care Aides' Perceptions and Experiences of their Roles and Relationships with Residents in Long-term Care Settings

by

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Abstract

The purpose of this study was to explore care aides' perceptions and experiences of their roles and relationships with residents in long-term care institutions, and how the context, including the organizational philosophy, influenced those perceptions and experiences. The method of exploration was qualitative focused ethnography. Convenience and purposive sampling were used to recruit 22 care aides from five long-term care facilities in a western Canadian city. Data were collected via semi-structured interviews. Data analysis utilized constant comparison to identify themes or patterns within and across participants as well as comparison of new data to data previously analyzed. It emerged that a dominant influence on care aides' perceptions of their roles and relationships was the way they experienced a model of cultural change called the Eden Alternative®. The Eden Alternative® model aims to increase quality of life for institutionalized persons by restructuring delivery of care and transforming institutional environments into more habitable places to live. However, although the care aides believed in an ideal occupational relational purpose or state, they perceived that the model had been incompletely implemented in their facilities, was incompatible with an existing organizational policy, and had eroded after implementation. Instead of feeling supported and reassured by fellowship, most of the care aides worked with the residents alone and without reference to each other. They emphasized what separated them, rather than what united them. Without a shared purpose and collegial connections they felt a reduced relationship to the larger residential community. Meaningful personal

connections with residents no longer assigned to them were lost. They felt overburdened by their expanded responsibilities; they found themselves engaged in conflicts with residents and families; and many felt unsupported by management. As a consequence, they had little time or energy to be compassionate, empathetic partners to the residents permanently assigned to them. This study contributes to the body of knowledge used by registered nurses, nurse educators and nursing home managers/administrators who train and support care aides and may be useful to managers/administrators who make the decisions that shape and affect services provided to residents.

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Chapter One

Introduction

Health care aides are a major resource for the support of residents living in long-term care institutions. They are responsible for providing “basic” care related to activities of daily living yet often have minimal training or education. This dissertation reports the results of my qualitative focused ethnographic research study that sought to explore care aides’ perceptions and experiences of their roles and their relationships with residents in five long-term care institutions in an urban centre in Western Canada. It emerged that a dominant influence on care aides’ perceptions of their roles and relationships was the way they experienced a model of cultural change called the Eden Alternative®. In this chapter, I present background information about staffing patterns in long-term care facilities and the nature of the care aides’ roles to frame my research purpose and questions, and to argue for the significance of the work to nursing knowledge and practice. Following this, I provide a brief preview of the chapters in the dissertation.

Background

By the year 2030, Canada’s aging population will form nearly one-quarter of Canada’s entire population (Statistics Canada Report 2007). *Aging population* is a term that has been loosely defined by Statistics Canada because of ongoing debates about what age actually constitutes old age (Special Senate Committee on Aging, 2009). Increased life expectancy is anticipated to bring many economic, social, political and health care challenges but the greatest of these will be the challenge to provide quality long-term daily living support to increasing numbers of people either in their own homes or in care facilities (Statistics Canada Report, 2007).

In Canada, over the past decade, there have been dramatic shifts in staffing patterns in long-term care facilities. Since 1998, the numbers of registered nurses employed in long-term care settings has declined steadily from 11.8% of all nurses employed in 1998 to 9.6% of all nurses employed in 2009 (Canadian Nurses Association Nursing Workforce Data, 2009). At the same time, care aides have been employed in escalating numbers and now provide 90% of the care to residents who live in long-term care facilities (Castle, 2007; Riggs, & Rantz, 2001). In British Columbia (where this study took place) 19,120 care aides were employed in health care in 2001, but by 2010, this number was 27,390 (Work Futures BC - Occupational Profiles, 2011). Current projections estimate that by the year 2015 there will be 4, 450 new positions with an additional 3,950 openings due to retirements (Work Futures BC - Occupational Profiles, 2011). This increase is related to three important factors: “the need to control health care costs, a current and projected shortage of regulated health care professionals and an ageing population which requires new approaches to health-care delivery” (Canadian Nurses Association - CNA, 2008, p. 2).

Care Aide Role

Care aides provide health care services to Canadians under the direction of a regulated professional (Hospital Employees Union, 2008; Work Futures BC - Occupational Outlooks, 2005). They can carry out their duties under a number of different titles such as “residential care attendant,” “personal support worker,” “geriatric aide,” “physiotherapy aide,” “pharmacy aide,” “residential care aide,” “nurse aide,” or “personal support aide/worker.” In addition to providing health care services in long-term care facilities, a significant number of care aides are employed in other areas such as pharmacies, physiotherapy clinics, acute care hospitals, and home support agencies (CNA, 2008). This study was directed towards exploring the experiences of care aides who work in long-term residential care institutions.

In long-term care institutions, care aides provide residents with foundational daily living support. This includes, but is not limited to, answering calls for assistance; assisting in all activities of daily living (bathing, dressing and grooming, serving meals and feeding residents); taking measurements such as resident’s weight, blood pressure, temperature and pulse; collecting urine and stool specimens; administering suppositories and enemas; administering non prescription medications; emptying ostomies and catheters; applying prosthetics or orthotics; assisting with oxygen equipment; assisting with bi-level positive airway pressure (BIPAP) or continuous positive airway pressure (CPAP); and care of a body after death (BC Ministry of Health, 2007; Work Futures BC - Occupational Outlooks 2005). Basic physical care is complemented or supplemented by the social, emotional and interpersonal relationships that form between care aides and the residents.

There are no Canadian Federal or Provincial standards for the preparation and training of individuals for these roles. The educational training program varies from seven weeks in Ontario (for personal support workers) to 32 weeks in the Northwest Territories (for long-term care attendants). By comparison, in the United States, there is a federally mandated 75 hour training course and certification (Castle, Engberg, Anderson, & Men, 2007), although some states (for example, California) require up to 160 hours of training (Harrington, O'Meara, Collier, & Schnelle, 2003). In British Columbia, ten publicly funded colleges as well as some private colleges follow a 23-week provincial curriculum, which combines resident care aide and home support worker training. Private colleges are not obligated to use the provincial curriculum or meet any standards for English proficiency (Hospital Employees Union, 2008).

Due to concerns about the absence of a legally defined scope of practice, inconsistent provincial competencies, few resources for upgrading, and high patient/resident acuity in all settings, the BC Ministry of Health began to consider initiating provincial standards for job titles and roles as well as formalizing competencies (BC Ministry of Health, 2007). In October 2011 the Ministry established a care aide database. All publicly funded health care employers in BC who employ care aides are now required to employ only individuals who are registered in the database. All care aides who are currently working or seeking employment in a publicly funded facility are required to upload their training certificates, a reference letter from their most current employer with call back details, and a character reference with call back details. International applicants with no Canadian experience must now be evaluated by a third party such as the International Credential Evaluation Service (ICES) at British Columbia Institute of Technology (BCIT) before they can register on the database. The registry was "created to serve and protect vulnerable patients, residents and clients receiving care in publicly funded health care facilities" (BC Care Aide and Community Health Worker Online Registry, 2011, homepage). A BC employer in receipt of public funding must report to the registry "every suspension or termination of an employee for alleged client, patient and/or resident abuse" and any employee "who has been terminated by an employer for alleged abuse" is suspended from the registry and "remains suspended until reinstated either through a grievance procedure/investigation (if in a union) or until the conclusion of an investigation (if not in a union)" (BC Care Aide and Community Health Worker Online Registry - Employer Information page, 2011).

Although almost all training programs contain some instruction about effective communication and conflict resolution, current empirical evidence indicates that many care aides still feel overwhelmed with their responsibilities and unprepared for complex or difficult interpersonal situations (Anderson et al., 2005; Kayser-Jones, 2002; Lin, Yin, & Li, 2002; Riggs & Rantz, 2001; Secrest, Iorio, & Martz, 2005; Sofie, Belza, & Young, 2003). In a recent review of communication training strategies for those who provide care to residents in nursing homes (McGilton et al., 2009), the authors found that there is so much variation in content, mode, and delivery that "it is difficult to determine which (training strategies) are more effective" (p. 157). Interpersonal communication difficulties plus other conflicts between job demands and abilities to meet demands are related to numerous health problems and job dissatisfaction (Landesman, 2003).

Despite the challenges of the role, it is also evident that many care aides desire to provide nurturing, compassionate and empathetic services and be part of, or to create, caring or benevolent relationships with residents (Anderson et al., 2005; Kristiansen, Hellzen, & Asplund, 2006; Secrest et al., 2005). Many care aides enjoy the helping and caring role and feel motivated to stay employed because they feel valued and needed by the residents (Berdes & Eckert, 2001; Bowers, Esmond, & Jacobson, 2000; Hsieh & Su, 2007; Kristiansen et al., 2006; Parsons, Simmons, Penn, & Furlough, 2003).

The Dominant Contextual Influence

In 2002, the local health authority where this study was conducted commissioned a review of long-term care practices in one of the publicly funded facilities accessed in this study (reference removed to protect participants' identities). The reviewer suggested to the authority that a model of resident centered care should be implemented, and the Eden Alternative® was subsequently chosen by the health authority. Since then, the model has been implemented in all four publicly funded facilities.

The Eden Alternative® model/philosophy of care aims to increase the quality of life for institutionalized persons by restructuring the delivery of care and enhancing institutional environments through the introduction of plants, animals and children. The Eden Alternative® model/philosophy of cultural change is supportive of the shifts in staffing patterns towards residential care given primarily by care aides (Thomas & Johansson, 2003). An integral component of the model is permanent assignment of residents to care aides. Permanent assignments replace teams of care aides who used to provide care to all the residents. In theory, permanent assignments foster closer, more intimate relationships between care aides and residents and facilitate familiarity between care aides and families of residents (Thomas & Johansson, 2003). In some organizations, care aides also become cross-trained to dispense medications, do laundry, prepare food, organize social activities and care for the animals, plants, and gardens. They are called "universal or versatile workers" (Kemp, Ball, Hollingsworth, & Lepore, 2009). In theory, companionship grows out of continued close contact between residents and care aides and cross training extends the close contact because the same care aides provide all of the services historically provided by many different people.

One of the main principles of the Eden Alternative® is to avoid rigid scheduling in the lives of residents. In theory, cross trained workers are able to provide more spontaneous services such as unscheduled meal preparation and less rigidly structured medication administration, and they are better able to participate spontaneously in more personalized, unstructured, and unplanned social activities with residents (Thomas, 2003). When cross-trained workers look after the animals and plants, they are providing residents with a more nurturing, home-like habitat. In theory, cross trained workers will feel more fulfilled because they are allowing residents to live in the moment and they are caring for the residents' bodies *and* their spirits (Thomas, 2003). In the facilities my participants worked in, the care aides were not involved in dispensing medications, laundry, food handling, pet care or social activities, but they were expected to do some light housekeeping (cleaning equipment and tidying, garbage disposal, cleaning drawers, folding clothing and linen).

The Eden Alternative® is heavily promoted in the United States as a solution for long-term care institutions currently undergoing reform and restructuring and has become popular in Canada, Europe, and Australia since 2002. More than 400 organizations have embraced the Eden Alternative® philosophy/model including the four public facilities and one private facility from which all of the participants in this study were recruited. Canada has its own training centre located in Saskatoon, Saskatchewan. Current empirical research has focused on resident and family satisfaction with the Eden model (Bergman-Evans, 2004; Mackenzie, 2003; Monkhouse, 2003). There is very limited research evaluating the impact of the model on the care aides' roles and their relationships with residents.

I first became interested in studying the relationships that form between care aides and residents in long term care institutions, when I worked fulltime as a staff nurse in two large (104 bed, 260 bed) urban long-term care nursing facilities. While many of the care aides created conditions of sustained compassion (protecting and caring for the residents), the close association with residents and the constant proximity was not entirely unproblematic. Some of the residents and some of the care aides in both institutions engaged in prolonged, bitter and vigorous disagreements. Conflict was not isolated to one staff member, one resident or one unit in either institution, but the registered nurses were the people who were routinely called to resolve the disputes. At that time, the diversity in staff members seemed to buffer instability and enable staff members to adapt to challenges because a wide variety of staff were able to contribute ideas and suggestions. These experiences have led me to contemplate the consequences of the cultural change models that are being implemented in nursing homes, in light of the components of some models that seem to focus on care given almost entirely by care aides rather than care given by a diverse staff. Within these models, the care aides' experiences could be isolated and connections with professional nursing staff (who can be relational sources of resilience and adaptability) could be reduced. Current cultural change models also seem to contain an expectation of self-reliance on the part of care aides in addition to the components of increased responsibilities for care aides combined with the reduced presence of registered nurses. With fewer regulated professional staff as resources, it is unclear how care aides are coping with their increased responsibilities, and what theories and strategies they are using to resolve challenging situations with residents who sometimes have very complex, multifaceted and challenging personalities.

My interest in the experiences of care aides is bound by my respect and concern for them. I believe in an uncomfortable prospect: that care aides are or will be facing multiple challenges as long-term care grows increasingly complex and unpredictable, and they will be facing these challenges with reduced support from professional nursing staff. I am committed to the care aides as colleagues of professional nurses: people whose feelings and opinions matter, therefore I believe that it is important to identify key processes that will enable care aides to weather the challenges. My attention to the language of care aides (to listening to what they have to say about their roles and working environments) is also bound by my respect and concern for them considering that long-term care practices worldwide are in transformation due to profound social and economic upheavals over recent decades. "An attention to language means also an attention to the life conditions of those dwelling in the language" (Smith, 1994, p. 141). I believe that it is important for nurse researchers to make an attempt to respond to the voices of care aides and to notice what is happening to them because "once the creatures that surround us lose the significance that accrued to their place in the chain of being, they are open to being treated as raw materials or instruments of our projects" (Taylor, 1991, p. 5).

In conclusion, providing personal care is facilitated through kind and helpful approaches and a desire to create caring and connected relationships. However, care aides' assistive and caring roles have expanded considerably. In long-term care facilities, care aides are now the most central or the most accessible/available service providers to residents. As they are always in closest proximity to residents, they are now much more likely to become engaged in multifaceted relationships with residents. However, there is a paucity of empirical evidence that explores and describes how care aides are able to construct and negotiate relationships with residents in the context of their expanding roles and responsibilities and new models of organization of care.

Purpose

The purpose of this qualitative focused ethnography was to gain an in-depth, emic understanding of the experiences and perceptions of care aides' about their roles and relationships with residents. Over the course of the research, it became clear that a dominant influence on care aides' perceptions of their roles and relationships was the way they experienced a model of cultural change called the Eden Alternative®. As noted in the seminal work of James P. Spradley (*The Ethnographic Interview)*, the essential work of an ethnographer is to communicate to the participants that "I want to know what you know in the way that you know it" (Spradley, 1979, p.34). Therefore, the research questions evolved to include a closer exploration of this perceived reality. This work is the first phase of my emerging research program that is oriented toward the education and support of care aides who work in long-term care settings.

Research Questions

The original primary research question guiding this study was, "What are the care aides' perceptions and experiences of their relationships with residents in long-term care settings?" In response to the emerging analysis, the primary research question evolved to include, "How does the context of care influence care aides' experiences and perceptions of their roles, and their relationships with residents?" Secondary research questions were:

1. How do care aides describe good quality/agreeable/enjoyable/pleasant relationships with residents?

2. From the perspective of the care aides, what contextual factors influence the kinds of relationships that care aides can have with residents?
    a. How does the care aide role and residential care routines affect relationships?
    b. How do care aides perceive the organization of care/work as impacting relationships between care aides and residents?
    c. What is the influence of the managers on the relationships between care aides and residents?
    d. What strategies do care aides use to foster positive relationships and ameliorate strained relationships?

Significance

This study is relevant and important to health care and nursing for a number of reasons. First, on a national level, there is limited nursing research about the factors that affect service delivery to Canadians who live in long-term care institutions (McGilton, McGillis Hall, Boscart & Brown, 2007). Canadian human resource planners' and policy makers' understanding of care aides roles and responsibilities has been disputed and there is considerable concern/doubt that care aides are receiving sufficient support to provide safe and effective services (Crawford, 2003; O'Brien-Pallas, Baumann, Birch & Murphy, 2000). Second, residents currently receive most of their care from care aides rather than regulated health professionals and they are in constant interaction with them. Existing studies and reports of future plans for staffing in long-term care make it probable that this situation will persist (Canadian Nurses Association Nursing Workforce Data, 2009; Castle, 2007; Riggs & Rantz, 2001). Third, the work itself is becoming more and more difficult. Each year, Statistics Canada performs a residential care facilities survey and the results indicate that residents in nursing homes in Canada are becoming significantly older and more frail. In 1996, 50% of the residents in Canadian nursing homes were older than age 85, the mean mortality rate for residents was 11%, and only 4% of Canadian nursing homes were populated with 100% of the residents requiring type three care (the highest level of care – residents require 24 hour supervision and management). In 2009, 55% of the residents were older than age 85, the mean mortality rate had increased to 17% and 38% of Canadian nursing homes were populated with 100% of the residents requiring type three care (Statistics Canada Residential Care Facilities Survey, 2011). Fourth, in some provinces, registered nurses and licensed practical nurses who work in long-term care facilities are responsible and accountable for the care delegated to care aides. There are significant risks to workers, residents and organizations as a whole when professional nurses fail to adequately supervise care aides or "unknowingly instruct (them) to work beyond their scope and knowledge base" because they have no knowledge of their educational backgrounds, their roles, their relational practices, their perceptions, theories and strategies (Crawford, 2003, p. 38; McGilton et al., 2007). Fifth, Canadian care aides have been found to be significantly less hardy than Canadian registered nurses and more vulnerable to occupational stressors and burnout (Harrison, Loisselle, Duquette, & Semenic, 2002). In seminal work by Suzanne

Kobasa, hardiness is defined as an optimistic orientation to life, which enables individuals to transform or eliminate stressful situations (Kobasa, Madi, & Kahn, 1982). Challenging patient behaviours and personalities are significant sources of stress for registered nurses (Roche, Diers, Duffield, & Catling-Paull, 2010; Roos, 2005; Taylor & Barling, 2004) so it follows that similar characteristics of residents should be considered to be significant sources of stress for care aides in long-term care. The phenomena that evoke feelings of stress, distress or discomfort in care aides and the underlying structures and perceptions that form the basis for decision-making are significant factors that affect delivery of services. This area has received scant empirical investigation even though it has been argued that research in this area is important (Hillman, 2006; Kayser-Jones, 2002).

One of the more recent developmental processes in nursing, and especially in residential or long-term care, is the increased need for nursing knowledge that supports registered nurses and licensed practical nurses who are placed in supervisory or leadership roles so that safe and effective services are provided (Crawford, 2003; Mackay & Risk, 2001; McGilton et al., 2007). Professional nurses must be able to promote best interactional and relational practices, and be prepared to assist care aides appropriately when challenging situations occur. To lead professionally, nurses must know more about the people they are supervising, specifically what they are likely to be thinking and feeling and the strategies that they are likely to use. When I first met with the Director of Residential and Palliative Services for the local Health Authority in order to obtain a letter of support for the study, the Director stated to me that she was very interested in the study because in her opinion, “care aides tend to go about their work quietly and do not ask for help from their supervisors until situations become unmanageable for them or out of control” (personal conversation with a Director of Nursing and Residential Services, Dec. 2009). Background knowledge may form the basis for preemptive discussions.

This study will contribute knowledge that will benefit the residents and the care aides, as well as new and existing registered nurses or licensed practical nurses who are placed in supervisory positions in nursing homes. In order to understand the personal, situational and environmental factors that affect the relationships that care aides have with challenging or difficult residents, nursing research must access the source. As such, this research is justified, appropriate, and significant.

Conclusion

In Canada, over the past decade, there have been dramatic shifts in staffing patterns in long-term care facilities. Care aides are being employed in escalating numbers and now provide 90% of the care to residents who live in long-term care facilities. Care aides provide residents with foundational daily living support – that is basic physical care complemented or supplemented by the social, emotional and interpersonal relationships that form between care aides and the residents. Current empirical evidence indicates that care aides feel overwhelmed with their responsibilities and unprepared for complex or difficult interpersonal situations. Despite these challenges, many care aides desire to provide nurturing, compassionate and empathetic services and be part of, or to create, caring or benevolent relationships with residents. Although some policy makers have conceptualized the provision of care to residents in long-term care institutions as routine, repetitive work that is of low complexity, purely mechanistic, and neither interactional nor dynamic, in reality, the working environment is based on interactions with human beings so it is dynamic, complex and not completely understood. To acknowledge that care aides play a major role in the care of fragile and vulnerable people but to neglect to investigate their relational experiences, perceptions and practices is to neglect important information that is fundamental to society's ability to meet the needs of our aging population.

This dissertation reports my qualitative focused ethnographic research study that sought to explore care aides' perceptions and experiences of their roles and their relationships with residents in long-term care institutions. Given the major shift in staffing patterns towards residential care given primarily by care aides and the philosophical shift towards resident-centered care, it is timely to explore the experiences and perceptions of care aides in order to inform policy, practice, and education.

Preview of the Chapters

The dissertation has been divided into six chapters. Chapter One set the background for the study (highlighting the shifts in staffing patterns in long-term care facilities) and contained the purpose of the study, research questions, and significance. Chapter Two sets the context of the study via 1) a qualitative metasummary of the most prominent issues that affect care aides globally: lack of job satisfaction (multifactorial), threats to personal safety, excessive workloads and inadequate training; 2) an investigation of broader phenomena: the value of the therapeutic role for care aides, the need for efficiencies, and the effects of strained or difficult relationships with residents; and 3) a more detailed description of the Eden Alternative® and review of articles pertaining to the Eden Alternative®. Chapter Three consists of a description of the method of exploration (focused ethnography), the theoretical underpinning, characteristics of the sample, a description of how the data were analyzed (constant comparison), and how rigor was maintained. The results of my analyses are presented in Chapter Four in six sections that reflect the most important themes that emerged from my analysis: Desiring and Creating Ideal Relationships, Workplace Realities, The Impact of Strained Relationships, Care Aides' Perceptions of Role Identity and Worth, Care Aides' Perceptions of the Organizational Philosophy, and Integrative Thoughts. In Chapter Five, I discuss my results in terms of extant literature, organised into six key components: a) the ideal state, b) work overload, c) alone at work, d) the diverse population of residents, e) conflict with families, and f) the influence of cultural change. Finally, Chapter Six contains implications for long-term care practice, education, and policy, areas for further research, and limitations of the study.

Chapter Two

Literature Review

In this chapter, I review the literature, which establishes the context of the study. There are three sections in this literature review because it was carried out in three different stages. The first section of the literature review is a qualitative metasummary of the most prominent issues that affect care aides globally (see Andersen 2009 for the published metasummary). Qualitative metasummary (also known as mixed research synthesis) was originally developed by Sandelowski, Barroso and Voils (2007). Initially, the method was used exclusively to review and summarize qualitative findings presented in the form of surveys. However, the method has evolved and is now used to synthesize a mixture of qualitative and quantitative reports when the samples converge towards homogeneity. A qualitative metasummary was particularly appropriate to begin the review of the literature concerning care aides because the literature was mixed but predominantly quantitative, the studies relied heavily on surveys or questionnaires, and both qualitative and quantitative studies converged in the homogeneity of the sample composition:

- more than 90% of all care aides world wide are women
- many studies about care aides reported that they belonged to minority groups
- the majority of all care aides world wide belong to low or lower middle income categories

- the majority of research focused on factors related to work satisfaction, work environment and retention issues

In contrast to solely descriptive literature reviews, qualitative metasummaries are analytical as well as descriptive. The method is precise and progressive, and begins with extraction (a comprehensive search using multiple strategies) followed by abstraction and grouping, calculation of frequency effect sizes, and interpretation.

Based on the results of the metasummary which drew attention to the importance of caring relationships and connections between care aides and residents or care aides and families, the second section or stage of the literature review narrowed the focus to the phenomenon of relationships between care aides and residents in long-term care. From this refined perspective, I discuss the therapeutic relationship role for care aides, how the need for efficiencies in care routines impacts these relationships, explain possible outcomes of strained or difficult relationships between care aides and residents, and describe how care aides' lay theories influence their work. In the third and final section or stage of the literature review, I explore how the organization of care through the established philosophy, model, or culture of care, can impact the nature of the care aides' roles and relationships. I have focused on the Eden Alternative® as this was the context of care experienced by my participants.

Qualitative Metasummary of Care aides' Roles, Working Environment, and Work Satisfaction

To understand how and why care aides are able, or choose to foster particular types of relationships, it is necessary to understand the context of their work. In the introductory chapter, I introduced the terminology and general role descriptions and responsibilities of this group of workers. In this section, I explore more specifically the empirical body of literature about their working environments, satisfaction with work, and factors affecting their decisions to choose or leave this kind of work. All of these contextual factors influence how care aides perceive and pursue relationships with long-term care residents. When appropriate, I have compared the results of the metasummary to the known situation in British Columbia where the study took place.

Article Identification or Extraction

Specifically for the qualitative metasummary, I accessed the electronic databases CINAHL (1982 to 2009), MEDLINE (1966 to 2009), EMBASE (1988 to 2009) and AARP (1978 to 2009) using a combination of the different titles used to represent care aides who work in long-term care institutions namely: residential care attendant, certified nursing assistant, personal care aide/worker, geriatric aide, residential care aide, nurse aide, and personal support aide/worker. Searches were restricted to English language articles focused on the experiences and working environments of care aides employed in long-term care facilities. Research and non-research based articles were included. Articles that focused on the experiences and working environments of care aides employed in assisted living facilities or home care were appraised but excluded from the qualitative metasummary because the health as well as the level of dependency of the clients cared for, the environmental context (available resources, coordination of activities), and the goals of care aides employed in assisted living or home care are fundamentally different from those of care aides employed in long-term care facilities. Eight trade and organizational papers were included because they were helpful to define the context of the work. Forty-six journal articles were identified at first. A separate search of key journals followed, and a ‘snowball’ search of references contained within previously obtained empirical papers completed the process.

A total of 146 articles/reports were identified, including 138 articles and eight trade or organizational reports. Of these, 18 were published in the 1980s, 60 were published in the 1990s and 68 were published from 2000 onwards. One hundred and four articles were written by American authors, 15 articles were British, 13 were Canadian, two were Australian, five were Swedish, one was Dutch, four articles were from Taiwan and two were from the Netherlands. Twenty-six were qualitative studies, 72 were quantitative studies, six were mixed methods, ten were literature reviews, 24 were descriptive or opinion papers (including articles theorizing about the practice or modeling the practice of care aides) and eight were trade or organizational reports.

In a qualitative metasummary, the bias is towards inclusion rather than exclusion of reports (Sandelowski et al., 2007), therefore, three unpublished dissertations and nine unpublished theses were also retrieved and read. However, those unpublished dissertations and theses were excluded from the actual abstraction and grouping process that formed the first step of the qualitatitve metasummary because they could not be fairly or justly reduced to one annotated page or less (a requirement within the qualitative metasummary process).

Abstraction and Grouping

After an initial reading each primary source was annotated (reduced to a single page or less of single spaced type). This approach facilitated systematic comparison of specific issues, variables or sample characteristics (Whittemore & Knafl, 2005). The next step was "data display" meaning that I grouped the annotations by gathering comparable studies together. This allowed me to "visualize patterns and relationships within and across primary data sources" (Whittemore & Knafl, 2005, p.551).

Frequency Effect Sizes

To assess the relative magnitude of the abstracted findings when appropriate, I calculated frequency effect sizes. I followed the process suggested by Sandelowski et al. (2007). I took:

> the number of reports containing a finding (minus any reports derived from a common parent study and representing a duplication of the same finding) and divid(ed) this number by the total number of reports (minus any reports derived from a common parent study and representing a duplication of the same finding) (p.107).

Frequency effect sizes enabled me to "move (my) interpretive effort from the description of patterns and relationships to higher levels of abstraction"

(Whittemore & Knafl, 2005, p.551). Frequency effect sizes are described in percentages. For example, a frequency effect size of 15% indicates that 15% of the reviewed articles contained a conclusion related to that theme or issue.

Interpretation

My metasummary analysis revealed five prominent issues that best represent care aides' experiences in long-term care institutions: factors that promote job satisfaction, factors that reduce job satisfaction, threats to personal safety, excessive workloads, and inadequate training. The metasummary draws attention to the importance of caring collegial connections and caring relationships between care aides and residents or care aides and families as the primary means to ameliorate negative experiences.

Factors promoting job satisfaction. Care aides who remained in their employed positions cited a number of factors as contributing to their decisions to stay; being around elderly people – helping and caring for them, being part of a team, feeling valued and needed by the residents and feeling virtuous. All of these factors were motivational factors (Berdes & Eckert, 2001; Douglas et al., 1996; Hsieh & Su, 2007; Kristiansen et al., 2006). Several investigators found that a uniform culture (religious, ethnic, social and/or economic) between residents/families and staff contributed to harmony and/or decreased staff turnover (Berdes & Eckert, 2001; Jervis, 2002a). Satisfied care aides felt respected and supported (Friedman, Daub, Cresci, & Keyser, 1999). They believed that they were competent and that they were able to affect residents (Parsons et al., 2003).

Care aides who stayed were also more likely to be older and of the same social, cultural, religious or ethnic background as the residents and their families (Grau & Wellin, 1992). They became involved in care planning and decision-making and they were more likely to feel that their contributions were valued and acknowledged by the residents, families and supervisors – frequency effect size 14.9%. This frequency effect size means that 14.9% of the 138 articles and eight trade reports in the qualitative metasummary contained a conclusion that *feelings* more strongly determined whether aides were dissatisfied than the more objective features of the job. Care aides were more likely to be retained by their employers if they reported *feeling* valued and acknowledged by others at work. As a consequence, they felt that they were able to provide care in a way that was like family (Bowers et al., 2000). In sum, the pertinent factors that led to increased job satisfaction were stability of workplace culture, harmony, inclusion, respect for all staff members, and a feeling of valued contribution to the wellbeing of the residents.

Factors reducing job satisfaction. Researchers in 25 studies investigated various aspects of job dissatisfaction. Eighteen of these studies were from the United States. Investigators observed that organizational factors, the working environment, facility characteristics, the supervisory style, and the aides' feelings or beliefs all influenced the degree to which care aides were dissatisfied with their jobs. Most were employed in highly structured, complex, hierarchical systems that resisted change (frequency effect size 37.3%). This frequency effect size means that more than 37% of the 138 articles and eight trade reports in the qualitative metasummary described the work force as sharply divided and the supervisors as dismissive and demeaning. Care aides reported that they often felt undervalued and unappreciated by their supervisors. More than 17% of the articles contained a statement or finding that care aides perceived that their efforts were unrecognized by their supervisors (frequency effect size 17.2%) (Anderson et al., 2005; Bowers et al., 2000; Jervis, 2002a; Moyle, Skinner, Rowe, & Gork, 2003). Collectively, 20% of the 138 articles and eight trade reports concluded that care aides felt dissatisfied with rigid care routines and time constraints that inhibited them from providing personalized care (frequency effect size 20.1%). They were unable to make changes or improvements that they felt would benefit the residents because they lacked any decision-making authority (Parson, Simmons, Penn, & Furlough, 2003).

All of these factors led to significant attrition and retention difficulties in many long-term care institutions. Care aides who left blamed inadequate staffing levels, excessive workloads, lack of training and lack of problem-solving skills necessary to cope with demands (Lin et al., 2002; Riggs & Rantz, 2001). Almost fifteen percent of the authors/researchers concluded that the care aides did not feel adequately informed about the residents' conditions (frequency effect size 14.9%). Care aides who left the job described constant noise (Kristiansen, Hellzen, & Asplund, 2006), multiple, simultaneous demands (Eaton, 2000) and frequent, wide ranging complaints from residents and/or their families (Anderson et al., 2005; Jervis, 2002b; Secrest et al., 2005).

The culture of care appears to have a parallel effect in the Canadian context. Similar situations have been reported in the province of British Columbia to the Hospital Employees Union (HEU), which represents approximately 60% of the province's care aides. Union grievances indicate that many Canadian care aides feel unsupported by other members of the health care team. According to a report written by the HEU (2008), the union suggests that care aides are often excluded from care planning and team meetings and when they observe and report changes in resident conditions their observations are often overlooked or deemed unworthy of investigation. In the same report, additional stressors for care aides are also put forward, including excessive workloads, "unpredictable and unstable" patients/residents, short staffing, lack of time necessary to provide quality care (in life and after a resident's death) and the fact that they have been asked by regulated workers to perform tasks formally assigned only to professionals (Hospital Employees Union, 2008, p. 52).

In the United States, many care aides also leave because their wages are less than a living wage and not competitive with the fast food industry (Harrington et al., 2003). Low wages have been associated with reduced quality of care (Jervis, 2002a) and very high annual turnover rates averaging 78% in the United States (Bowers et al., 2000; Harrington & Swan, 2003). Concern about low wages was also reported in Taiwan, where the monthly wage is also less than service industries (Hsieh & Su, 2007), and in Mexico, where the average salary per day is just adequate for necessities (Douglas, Meleis, Eribes, & Kim, 1996). More than a third of the 138 articles and eight trade reports highlighted the lack of financial compensation and rewards as a primary factor that shaped much of the general job dissatisfaction (frequency effect size 38.0%). In Canada wages vary slightly between provinces but in British Columbia, care aides currently earn $20.46 per hour (as per the Hospital Employees Union Facilities Subsector Wage Schedule, 2006-2010). This is more than double the current minimum wage in British Columbia ($9.50 per hour) (BC Minimum Wage Factsheet, 2011) but less than the current average wage ($23.35 per hour for persons age 15 years and older) and much less than the current average wage for persons employed in health occupations ($28.00 per hour) (Statistics Canada, 2011).

In summary, the working environment is challenging and job satisfaction tends to be low. Care aides are regarded as the lowest category of skill in the health care team; they have little autonomy or control over care routine decisions, and often perceive their work as unrecognized and undervalued.

Threats to personal safety. Nineteen articles were focused specifically on factors that threatened the personal safety of some of the care aides. These authors suggested that aides who experience either psychological or physical threats while working in long-term care institutions feel isolated and demoralized because of their experiences**.** Psychological threats can come from residents or family members. For example, some authors described how aides endured demeaning remarks made by family members (Berdes & Eckert, 2001) or aides who were treated by families or residents as servants (Grau & Wellin, 1992). Other threats such as shouting, name calling, intimidation and inappropriate sexual remarks were significantly related to aides' feelings of reduced personal accomplishment and feelings of emotional exhaustion (Brodaty, Draper, & Low, 2003; Evers, Tomic, & Brouwers, 2002; Gates, Fitzwater, & Succop, 2003; Kristiansen et al., 2006; Ramirez, Teresi, & Holmes, 2006).

Physical violence also threatened the personal safety of some care aides (Gates et al., 2003; Kristiansen et al., 2006). More than half of all aides reported receiving an injury from a resident at some point during their employment (Fitzwater & Gates, 2002). These authors found that physical assault "was regarded as a very trying and unpleasant part of the job" (p.248) and resulted in feelings of humiliation. Whether physical or verbal assault was intentional or not, many care aides regarded it as violence (Gates et al., 2003) and sometimes viewed the residents' aberrant behaviour as deliberate (Brodaty et al., 2003). Considerable attention to concern about threats to the personal safety of aides can be seen in the frequency effect size of 36.6%.

Excessive workload. Twenty percent of the articles contained a conclusion that there was not enough time in the day for care aides to get everything done (frequency effect size 20.1%). Workload was affected by a high ratio of residents to aides, a high acuity level of the residents, inadequate equipment, or lack of supplies, which prevented aides from doing their job effectively (Bowers et al., 2000; Kovach & Krejci, 1998; Mercer, Heacock, & Beck, 1993). In order to save time, some care aides made choices for residents who took too much time. They hurried their dressing, cut back on grooming, eliminated oral care or abbreviated their baths (Bowers et al., 2000). Experienced aides found ways to get the job done by integrating demands, maximizing efficiency through organization and knowing when to safely cut corners (Bowers & Becker, 1992). “They’ll get washed up, they’re kept dry and turned over, but they don’t get lotion, they don’t get the one on ones, they don’t get walks” (quote from aide, Bowers et al., 2000, p.60).

Inadequate training. It was well documented that many care aides lacked basic mental health training and the skills to understand and manage challenging behaviours (frequency effect size 26.8%). In a salient but older study, three quarters of all care aides indicated that they felt inadequately trained for the job (Mercer et al., 1993). Due to heavy workloads and time constraints, aides receive varied and limited orientations and limited in-service education (Eaton, 2000; Evers et al., 2002; Lin et al., 2002). Many experienced exhaustion, tension and burn-out due to turmoil and disruption (Chappell & Novak, 1994; Dougherty, Bolger, Preston, Jones, & Payne, 1992).

The importance of supportive relationships. Although only 22 articles focused (to a certain extent) on the relational practices of care aides, the frequency effect size was greatest for the importance of caring relationships, connections between care aides and residents or care aides and families, and collegial connections as factors that reduce turnover rates and increase quality of care (44.8%). Generally, aides expressed strong feelings of mutuality with their co-workers. “My work-mates are the most positive thing about working here…you are never alone” (quote from support worker, Kristiansen et al., 2006, p.251). Job tasks and job processes were less important to institutional loyalty than the warmth, friendliness, support and caring of co-workers and superiors (Jervis, 2002a). Many care aides were committed and motivated to remain on the job even though the working conditions appeared to be deplorable. These workers were not motivated solely by wages or the working environment but by a combination of intrinsic factors such as a belief that their job was important (Parsons et al., 2003) or a belief that they were needed (Monahan & McCarthy, 1992).

In summary, the dominance of US based studies in the metasummary was a limitation, but there appeared to be general agreement across eight countries that employment in long-term care settings can be arduous, demanding and demoralizing. At the same time, given the constraints that most care aides seem to endure, many care greatly about the residents and are very concerned about the quality of care that they are able to provide. As a group, however, care aides were rarely directly consulted about their opinions and experiences.

Relationships Between Care Aides and Residents

Thus far, I have used the method of qualitative metasummary to explore a number of significant issues that affect care aides globally (lack of job satisfaction, threats to personal safety, excessive workloads, and inadequate training) and I have revealed that caring collegial relationships and caring connections between care aides and residents or care aides and families are the most frequently cited means to alleviate some of these issues. This forms the first section or stage of the literature review. Given the high levels of aggrieved feelings and dissatisfaction, in a frequently cited but older study, Tellis-Nayak and Tellis-Nayak (1989) asked a crucial and troubling question: “How can residents be assured of caring and sympathetic concern from (care aides)?" (p. 307). This question, plus the results from my metasummary led me to narrow the focus of the review to the phenomenon of relationships between care aides and residents in long-term care. From this refined perspective, in the second section of the review, I discuss the therapeutic relationship role for care aides and how the need for efficiencies in care routines impacts their abilities to achieve a therapeutic role. I also explore possible roots and consequences of strained or difficult relationships such as dependency, lack of trust, psychiatric illnesses, and the influence of care aides' lay theories.

A Therapeutic Role for the Care Aides

Several researchers have found that the ability of a caregiver (such as a care aide) to feel satisfied that he or she is helping a person in need is crucial to positive feelings about care giving activities (Cohen, Colantonio, & Vernich, 2002; Kuuppelomaki, Sasaki, Yamada, Asakawa, & Shimanouchi, 2004; Tarlow et al., 2004). Failure of persons receiving care to reciprocate or validate the therapeutic role of a caregiver by expressing gratitude or appreciation for the skills, expertise and care work can generate negative feelings and stress in the caregiver (Adler, 2006; Elliott & Shewchuk, 2002; Hillman, 2006). Negative feelings from unvalidated or undermined interactive caring efforts include feelings of defeat, frustration or anger and negative labeling (Adler, 2006; Koekkoek, van Meijel, & Hutschemaekers, 2006). Because caregivers desire to receive validation for their efforts as well as to give, stress and distress for care aides could potentially be rooted in loss of reciprocity, residents rejecting help or residents demonstrating withdrawn behaviours (for example, residents who are depressed, residents requiring intensive encouragement to participate in activities or requiring repeated reassurance or comforting.

The Effect of the Need for Efficiencies

Long-term care institutions perform a custodial function in society and many, (but not all) value efficiency (Berta, Laporte, & Kachan, 2010; Bowers et al., 2000; de Blok, Luijkx, Meijboom, & Schols, 2010). A variety of factors reinforce this need for efficiency. First, federal and provincial governments are facing tremendous health care cost pressures. The number of long-term care beds in Canada today is 280,000, but in 2038, that number is predicted to reach 690,000 (World Alzheimer Report, 2009). In 2008, the federal economic burden for long-term care in Canada was $15 billion, but by 2038, the cost of long-term care is predicted to increase to $153 billion (World Alzheimer Report, 2009). In order to reduce overall health costs, governments are attempting to make the best use of expensive human health resources.

Second, on a theoretical level, long-term care institutions may have several overarching humanitarian goals related to physical, social and mental well-being of residents. However, care aides may be unable to make conceptual distinctions between the overarching goals of the institution and objective measures of personal success. In order to feel personally successful, care aides may require more precise definitions of what they must accomplish each day within the institution (criteria of success or failure). When less abstract, more immediate goals come to exist either through economic or personal reasons, care aides will try to implement them. Care giving activities can be evaluated by care aides as to how quickly a specified end can be accomplished. Thus, in most long-term care facilities, care aides generally value and expect cooperation from residents since for them time management is of the essence.

When situations at work are familiar or common, care aides can feel satisfied, competent and confident about what they have been able to accomplish, but when situations are less familiar, aides are deprived of traditional cues for action, leaving each aide to speculate about what to do. Residents who do not conform to expected patient roles, express wishes for care and attention that the staff cannot fulfill, who are perceived as disrupting routines, not cooperating, or who consume disproportionate amounts of time have been discussed as more likely to create stress/distress because less time is available for care aides to care for all of the other residents (Goergen, 2001; Hillman, 2006; Rosowsky & Smyer, 1999). As Rosowsky & Smyer (1999) note:

> Any system strives to maintain homeostasis (therefore any) deviance in the resident is regarded as pathology; pathology in the system is perceived as a threat to the homeostasis of the system and is experienced as a threat to its integrity.
>
> (p. 264)

Residents who feel vulnerable and powerless (such as residents with mood disorders, maladaptive personality traits or personality disorders) are the most likely residents to disrupt routines and consume disproportionate amounts of time

(Hillman, 2006; McCarthy, Blow, & Kales, 2004; Rose, Soares, & Joseph, 1993; Spring, Rowe, & Kelly, 2009).

Strained or Difficult Relationships

There are multiple ways of categorizing or characterizing strained or difficult relationships. One overall term for the phenomenon is elusive because what is challenging or stressful in a relationship for one person may not be challenging or stressful for another. There is also considerable discomfort about possibly negatively labelling a person receiving care resulting in judicious use of descriptors.

A *relationship* implies that two people form a connection in some way via verbal expression, nonverbal expression, direct physical action, or a combination of all these modes. Several factors facilitate the development of positive relationships: empathy, warmth, respect, understanding, compassion and so on, while other factors seem to facilitate the development of strained or difficult relationships: lack of involvement, lack of responsiveness, lack of commitment, or lack of sensitivity.

These interpersonal factors are also compounded by environmental and/or organizational factors such as excessive workload and time constraints: “Well, you have to hurry ‘em through everything and if it’s a person that has a routine and you hurry ‘em through it, it messes up their whole day…they feel like they’ve been rushed and they have been” (Bowers et al., 2000, p.59).

Rigid care routines, lack of training, noise, multiple simultaneous demands, and high ratios of residents to aides result in significant worker fatigue:

"Before I used to feel job satisfaction…but I don't any more. We are working faster and faster, running and running, trying to do everything, but you don't feel that you manage to do anything lasting…it's like fighting fire" (Kristiansen, Hellzen, & Asplund, 2006, p.249). Some care aides set firm boundaries: "I will do no more and no less. I'm not going up and above my way because y'all ain't gonna pay me for it" (quote from certified nurse aide, Jervis, 2002a, p.19).

In some way, strained or difficult relationships lack one or more important elements such as compassion or connectedness, understanding, helping, or caring. The result is that one or both people struggle and become emotionally disillusioned, disappointed or dissatisfied by the experience. A strained or difficult relationship is an unpleasant experience.

The *interactions* between two people provide feedback about the relationship and influence the relationship. People interact continuously through verbal and nonverbal modes – behaviours such as posture, eye contact, facial expression and energy level. Each person in the relationship perceives something (interprets something) about the relationship via the interactions.

In nursing, we ideally assume that nurses "will continue to respond in an empathetic, helping fashion, regardless of the patient's response" (Baer & Lowery, 1987, p. 302). Relatively little nursing knowledge exists of the reverse: strained or conflictual relationships between regulated professionals (or care aides) and those who rely on them for care (even though strained relationships occur in many nursing situations).

Dependency and its effect on relationships. A significant number of residents in nursing homes are admitted because they suffer from physical disabilities making them *dependent* on care providers for activities of daily living. The ability of an adult to adapt to becoming dependent is contingent on whether he or she feels *worthy of care* and that others are *trustworthy* to provide it (Tan, Zimmerman & Rodin, 2005). According to these authors, a resident will be more likely to form secure attachments to care aides if he or she feels worthy of care or secure, therefore able to ask for and accept care. A resident will be less likely to form secure attachments to care aides if he or she feels unworthy of care or insecure. Insecure residents are much more likely to have life-long low self-esteem or to be emotionally unstable. Some may worry constantly because they cannot trust the people providing care. Therefore they may send out “constant distress signals” (p. 144). Others are the opposite; they tend to remain detached because they cannot trust the people providing care, therefore they may disengage and avoid close relationships (Tan et al., 2005). These same authors conclude that care aides may have enormous difficulties understanding these residents’ emotional needs. Either they may minimize them (because of the resident’s apparent self sufficiency) or they may become engulfed by them (because of the over-dependency) (Tan et al., 2005).

Psychiatric illnesses and their effects on relationships. Some residents have physical disabilities and co-morbid psychiatric illnesses excluding dementia that can have a profound effect on relationships and the proportion of residents with these disabilities and illnesses in long-term care settings is increasing

(Adelsky, Bowie, Goldberg, & Serper, 2011; Fullerton, McGuire, Feng, Mor, & Grabowski, 2009; Hartz, Brennan, Aulakh, & Estrin, 2010; Lemke & Schaefer, 2010; McCarthy et al., 2004). These psychiatric illnesses include schizophrenia, mood, anxiety and substance related disorders and personality disorders. People who suffer from schizophrenia have disturbed perceptions of reality and may experience hallucinations, delusions, paranoia and disorganized speech or thinking. Mood disorders are a group of diagnoses and include: major depressive disorder which is characterized by all encompassing melancholy, helplessness and hopelessness; dysthymia which is chronic low grade depression; bipolar disorders which are characterized by cycles of depression and mania; and substance induced depressive disorder typically characterized by alcohol-dependent residents who have elevated depressive symptoms. Anxiety disorders are abnormal or pathological fears and anxieties and include generalized anxiety disorder, obsessive compulsive disorder, panic attacks and phobias. All of these conditions can impair effective social interactions and distort perceptions.

Two less frequently investigated psychiatric illnesses that affect relationships on many different levels are maladaptive personality traits and personality disorders. In the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV-TR), personality traits are defined as enduring patterns of perceiving and relating to the environment and the self. When these traits are enduring, inflexible or maladaptive and cause significant distress or impairment, they are said to represent personality disorders. Personality disorders of young adults are investigated much more frequently than personality disorders of older adults. Despite the scarcity of literature on personality disorders in later life, epidemiological research indicates that approximately ten to twenty percent of people over the age of 50 display characteristics of personality disorders (Abrams, 2006; Abrams and Bromberg, 2007; Abrams & Horowitz, 1999). Pharmacological and psychotherapeutic treatment is limited because older adults with personality disorders are more inclined to discontinue their medications or psychotherapy because they see no reason to take medication or attend psychotherapy sessions. They are also likely to exaggerate the side effects of the drugs and threaten litigation, or otherwise undermine efforts at pharmacologic therapy (Abrams, 2006).

The vast majority of research exploring responses to disruptive, strained or difficult relationships is constrained to the context of residents with dementia-related illness. Almost no research attention has been paid to the manifestations of older adults who have maladaptive personality traits and/or symptoms of personality disorders and who also live in nursing home settings. Residents with symptoms of personality disorders would be more likely to manifest unstable moods, impulsivity, chronic anxiety, self destructive behaviours, chronic anger or irritability, polypharmacy, narcotic dependency, rigidity, obsessiveness and excess disability (Himelick & Walsh, 2002). Therefore, these residents would be more likely than other residents to provoke staff members towards outright confrontations (Himelick & Walsh, 2002; Sofie et al., 2003).

Psychiatric illnesses, maladaptive personality traits and personality disorders negatively affect crucial family or other psychosocial support networks, therefore some residents with these illnesses, traits, or disorders are admitted to long-term care institutions with impaired or no family/psychosocial support systems and/or resources. Lack of support/resources makes them especially vulnerable to external stressors. They may resist or have no desire for any close relationships because they may fear becoming engulfed by another person or they may fear rejection by another person (Rose et al., 1993). An important intimate (close, friendly) relationship (such as a relationship between a care aide and a resident) may be hampered, impaired or not achievable even though a resident's need for a support system has intensified. Older people with these symptoms often have significant difficulties adjusting to nursing home life; their physical illnesses, disabilities and increased dependence compound their pre-existing maladaptive traits (Himelick & Walsh, 2002).

Consequences of strained or difficult relationships. Most researchers agree that when relationships between paid caregivers and the people who rely on them for care are strained, there is a high probability of the paid caregivers responding in an unprofessional way (Berlin-Hallrup, Heikkilä, & Bengtsson-Tops, 2010; Cudré-Mauroux, 2011; Johnston, 2010; Lindbloom, Brandt, Hough, & Meadows, 2007; MacDonald, 2007; Rosowsky & Smyer, 1999). In older but frequently cited studies specific to nursing homes, workers have been shown to respond to conflictual relationships with residents by becoming resentful, frustrated, irritated or angry (Hallberg & Norberg, 1990; Kuremyr, Kihlgren, Norberg, Aström, & Karlson, 1994; Novak & Chappell, 1996). Other negative emotions include feeling useless or powerless, insufficient, guilty, or fatigued

(Hallberg & Norberg, 1990). Common coping mechanisms for stress, strain or distress related to challenging residents are to consider that residents are not well, therefore not in control of their behaviours; to concentrate on tasks; to reduce feelings of ambition, commitment or engagement in care and give minimal care only; to avoid the assignment; to rehearse stock statements; to talk with colleagues, family members, friends or superiors; to report sick or late for duty; to dissociate from work obligations by daydreaming, using cigarettes, alcohol or drugs; to use jokes/humour; to hope for a miracle or to pray (Goergen, 2001; Jervis, 2002b; Rosowsky & Smyer, 1999). Residents may be denied opportunities for personal choice in bathing, dressing, and meals or "traded" or "passed" to other workers when stress levels become excessive (McGrew, 1999, p. 162).

Caregivers who have high levels of conflict with residents are more likely to engage in even more serious forms of maltreatment of residents. For example, physical restraints may be used more often or medications may be withheld or administered inappropriately. This is defined as "solving the problem pharmacologically" (Joshi & Flaherty, 2005; Lindbloom et al., 2007; McGrew, 1999, p. 166). Everitt, Fields, Soumerai, & Avorn, (1991) discretely referred to "a delicate balance between (resident) behaviour, staff reaction and (psychoactive) medication use" (p. 797). A very important predictor of stress levels in nursing homes is the staff's ability to correctly appraise the level of threat (Rodney, 2000). More than a few workers feel threatened by unpredictable residents and are frightened by them (Aström, Karlsson, & Sandvide, 2004; Goodridge, Johnston & Thomson, 1996). Some workers describe having “extreme emotional strain, problems relaxing after work (and/or) ….emotional outbursts at home and at work” (Hallberg & Norberg, 1990, pp. 301, 303). This response was first described in 1985 as psycho-geriatric workload stress (Leatt & Schneck, 1985). The level of stress in some workers has been found to meet the criteria for psychological distress or disturbance. Nursing home staff who meet the criteria for psychological disturbance are significantly more likely to report shouting at residents than staff members who do not meet the criteria for psychological disturbance ($p = < 0.02$) (MacPherson, Eastley, Richards, & Mian, 1994, p. 383).

Care aides’ lay theories. Relationships between residents and care aides affect the culture of a nursing home and the quality of life for all nursing home residents (those in relationship, and those who bear witness). Given a pressing need to make sense of challenging resident actions or behaviours, in a frequently cited study, care aides were shown to resort to their own “idiosyncratic theories” (also called folk theories or lay theories) to assist them in their work (Bower, 1998, p. 156). It has been hypothesized that lay theories help aides to reduce the complexity of observed behaviours, rationalize actions of residents and predict future behaviours (Bower, 1998). Lay theories can be widely shared amongst the group, can influence workers’ assumptions, observations and caring behaviours and may become tacit and automatic through frequent use (Bower, 1998; Jervis, 2002b). Several examples are found in scholarly works by Jeanie Kayser-Jones – a distinguished nurse researcher focused on major factors that influence the care of terminally ill nursing home residents. In studies of dysphagia, and malnutrition in nursing homes, Kayser-Jones found that care aides often misunderstood dysphagic residents' responses to their feeding attempts. They theorized that residents who turned their heads away or kept food in their mouths for long periods of time were being purposefully "difficult…uncooperative, lazy, or combative." They strategized by using feeding methods that were "ethically questionable and dangerous" (Kayser-Jones, 2000; Kayser-Jones & Pengilly, 1999, p.79; Kayser-Jones & Schell, 1997; Porter, Schell, Kayser-Jones, & Paul, 1999, p.1446). Given these examples, it is highly likely that care aides also form lay theories and strategies about residents who present with challenging or difficult personalities. Idiosyncratic or lay theories have received very scant empirical investigation even though they may form important catalysts between care aides' relational practices and quality of life for residents who have complex, challenging or difficult personalities.

The Organizational Philosophy: The Eden Alternative®

In this third and final stage or section of the literature review, I explore the concept that emerged when I began my fieldwork, and overshadowed the intra and interpersonal factors. This was the impact of a specific culture of care, organized according to a explicit model.

Historical Overview of Models of Care

Historically, residents in long-term care institutions lived in buildings that featured centralized nursing stations and corridors lined on both sides with residential rooms. Residents were cared for by a team consisting of an RN who administered medications, performed treatments, and delegated residential care activities to one or more LPNs, and several care aides. This type of care tended to be task focused because the personal preferences and needs of many of the residents were often overlooked in favour of routines and efficiencies driven by the organization. For example, care aides might begin at one end of a hallway and move through all of the residents as they dressed them, bathed them, made the beds and so on. Residents would wait in the hallways to be transported to the main dining room. Residents who lived at the farthest end of the hallway would wait the longest for care. Routines such as bowel routines, toileting routines and scheduled bath days were common. Contemporary approaches tend to be more *client centered or resident centered* (Robinson & Rosher, 2006). These philosophical approaches emphasize the unique needs of the individuals over the needs of the organization. Themes consistent with client centered or resident centered care include increased privacy for residents, improved options for bathing or meals, smaller dining areas, changes to medication administration policies, care conferences, individualized care plans and care profiles for residents (small lists of each resident's needs and preferences - often posted in bathrooms) (Gould, 2001; Grimes, 2010; Radcliffe & Grosso, 2011). A similar approach is the *social model* of care (Caspar et al., 2009; Cooney & McClintock, 2006). This model focuses on improving the physical features of nursing homes so that residents feel more at home, improving the aesthetics of the nursing homes, and garnering family members' opinions and preferences thereby increasing the family members' levels of satisfaction. Resident centered, client centered, and social models are often referred to as *cultural change models* (Caspar et al., 2009).

The Philosophy, the Model, and Empirical Support

The Eden Alternative® is an American cultural change/transformational model based on the assumption/ belief that residents living in long-term care facilities are suffering spiritually from loneliness, helplessness, and boredom (Thomas & Johansson, 2003). The Eden Alternative® is also a business aimed at helping long-term care facilities worldwide to restructure the delivery of care in order to reduce the suffering and increase the quality of life for institutionalized people. The Eden model is heavily promoted in the United States as a solution when troubled institutions are required to reform their practices. Promotional information about the Eden Alternative® (aimed at families, residents and managers of long-term care organizations) is easily accessible online.

The Eden Alternative® began in 1992 as a grant project funded by the New York State Department of Health (Thomas, 2003). This first project was conducted to improve the physical and social environment and the care and the treatment of residents in one New York State nursing home. Benefits for staff and residents such as “improvements in staff turnover, resident infections, polypharmacy, and resident longevity” were associated with the environmental and philosophical changes (Thomas, 2003, p. 144). As a result, from 1994 to 1995 a “replication project” was initiated (p. 144) and three more nursing homes in New York were assisted to change their practices. By all accounts, the replication project was not as successful as the first project, due to “defensive” reactions to change (p. 145) ("defensive" not defined by the author). To counteract wasted efforts and resources and improve the replication process, a three-day training program was developed that included copious training materials drawing on the garden of Eden theme and using gardening metaphors such as 'planting the seeds' or 'tending the garden'. In 1999, Dr. Thomas and his associates traveled to 27 cities on a promotional tour – the "Eden Across America Tour" (Thomas, 2003, p. 145). The United States and Canada were divided into 12 regions, each with its own Eden educator. Since then, more than 400 organizations have embraced the Eden Alternative® philosophy/model including the four public facilities from which the majority of participants in this study were recruited. The following is a brief overview summarized from the training manual given to me by an Eden Associate, the Eden Alternative® promotional websites, and research articles.

The basic principle behind the Eden Alternative® is that people who live in long-term care facilities are receiving adequate assistance for their physical ailments, but they are receiving inadequate assistance for their spiritual ailments (Thomas, 2003). Residents feel lonely because they do not have true companionship, which is close, genuine, and continuous. They feel helpless because they receive care but are never able to reciprocate; and they feel bored because the institutional environments lack variety, the activities are meaningless to the residents, and are deliberate rather than spontaneous (Barba, Tesh, & Courts, 2002). The intent of the Eden Alternative® model and business is bring about solutions to the lack of spiritual assistance by enriching the culture of nursing homes and turning them into places “where something can live and thrive – not a place to just sit and wait to die” (Eden Alternative® Associate Training Manual, 2006, p. 9).

To counteract spiritual suffering, environmental transformations (Alternatives) that support and promote nature, gardens, and paradise (Eden) are introduced into the facilities (Barba et al., 2002). To reduce loneliness, residents are provided with easy access to bird and/or animal companionship, children are invited into the facilities, and close, continuous contact with care aides is established through permanent assignment of care aides to groups of residents (called families). To ease helplessness, residents are encouraged to do what they can for themselves without having to work within time constraints. Residents are encouraged to interact with the children, participate in planning for meals and other social events, and to help with ordinary activities such as shopping for food and food preparation. To lessen boredom, spontaneity and variety are enhanced and predictability is reduced. Rigid schedules for meals, bathing, medications, shift changes, bowel care, sleeping/waking and other activities are eliminated. The Eden Alternative® requires shifts in perspectives, organization and culture of care. A transition towards the Eden Alternative® model involves significant changes in job duties and routines for all staff members.

The Transition towards the Eden Model

The Eden Alternative® model is based on the conviction that organizational models of long term-care range in quality from lowest to highest. The lowest quality of care is provided in a traditional institutional model which subscribes to hierarchical practices and traditions such as consistent meal times, medication times, assigned bath days, assignment sheets for staff, and specific job descriptions, while the highest quality of care is provided in the Eden Household or Green House models (Thomas, 2003). In a household model, an entire nursing home is renovated to ensure that clusters of bedrooms surround multiple kitchens, dining rooms and living rooms. Based on the renovation possibilities, nine to twenty residents live in each cluster called a household. In contrast, green houses are stand-alone physical structures that house six to ten residents. Both the household model and the green house model employ cross-trained "universal or versatile workers". Thomas also proposed that each green house be "staffed by a licensed practical nurse around the clock (with) a specially trained RN available by phone or video with no more than a ten-minute response time when paged" (p. 153). In this model, residents plan their own meals; they participate in ordering groceries, shopping for food, and preparing the meals; or they can request a meal prepared to order by a cross-trained staff member. According to the ultimate design, each person living in a green house receives six hours of care per day (Thomas, 2003, p. 147).

In comparison with the ultimate Eden model, the target hours of care per resident - per day in a traditional institutional model is three hours in the United States (Harrington et al., 2000). In Canada, most provinces have target levels but the targets vary between provinces and some provinces have no targets. According to the most current available statistics, residents in British Columbia receive an average of 3.1 hours of care per day in publicly funded facilities but there is no target; in Manitoba, residents receive 3.3 hours of care but the target is 3.6 hours; in Ontario, residents receive 2.85 hours of care but the target is 3.26 (Hospital Employees Union, 2009). In the four publicly funded facilities accessed in this study, the last available calculated number of hours of care per resident per day was 2.94 (reference removed to protect participants' identities).

According to the ultimate design, when an organization is transitioning towards the Eden Alternative®, the nursing staff (care aides, LPNs and RNs) are permanently assigned to certain units or wings. Other departments (housekeeping, dietary) may also be permanently assigned. The residents begin to become more involved in social planning and activities and are provided with more food choices and flexible meal times depending on resources available. This model is called the early neighbourhood model. In the more developed neighbourhood model, everyone in the organization belongs to a 'neighbourhood'. The residents participate in social and care planning and eat, sleep and bath as they wish. Dining innovations in the more developed model include buffet style meals, continental breakfasts, room service and open pantries stocked with residents' favorites.

When a Canadian organization decides to implement the Eden Alternative®, two or three people are chosen to travel to Saskatoon Saskatchewan where the three day training program is offered at the Sherbrooke Community Centre. After training, these people are certified and receive the designation 'Eden Associate'. They are responsible for implementing changes in the workplace consistent with the Eden Alternative® starting with the introduction of animals, birds, plants and gardens, and permanent assignments of groups of residents to care aides. Organizations who register with the Eden Alternative® pay $995.00 USD initially and $995.00 biennially for evaluation and re-registration (Eden Alternative® Associate Training Manual 2006, p. 33). This cost as well as the benefits listed below are not referred to in any scholarly articles. All organizations display the trademark Eden Tree and I observed this tree when I was recruiting my participants. The organizations must comply with seventeen registry criteria but receive benefits such as: a listing in the registry and on the website, an Eden Tree plaque for display purposes, a copy of the ten principles suitable for framing, a brochure for customers and marketing purposes, access to the website and catalogue emporium, and the ability to use the registered Eden Alternative® name and logo for "publications and marketing" (p. 23).

Based on the description of the models, the five facilities accessed for the study were following the "early neighbourhood" model. The care aides had permanent assignments of residents called families. The care aides' families consisted of ten to eleven residents. The medications were administered by LPNs and one RN floated from unit to unit. The residents were assigned one bath per week on a specific day. Meals were prepared in a central kitchen and were served at specific times to residents. Residents had assigned seating places in a central dining room that contained multiple tables. Residents who required help to eat were assigned to specific tables.

Specific Resident, Family, and Staff Outcomes

There is a great deal of anecdotal and a small amount of empirical support for the Eden Alternative® philosophy and model. According to Mackenzie (2003) changes consistent with the Eden model led to improvements in the lives of residents in one nursing home (greater happiness, greater independence, and more meaningful relationships with staff and other residents) and that the staff (universal or versatile workers) became more empowered and satisfied. Schmidt and Beatty (2005) found that the philosophy allowed them to strengthen their visions for quality improvements in one nursing home and they reflected the philosophy in their organizational principles.

Some authors who have written about the model note its potential for fiscal benefits. The philosophy/model is specific about the value of cross-training the care aides so that they can do other tasks. These care aides are called universal or versatile workers. When the Eden Alternative® was initiated in one Alberta facility, the care aides took on extra duties such as dispensing of prescription medications, light housekeeping and laundry (Ricciotti, 2009). Widdes (1996) praised the model for its "increased efficiency in staffing…while the caregiver is assisting a resident with his bathing, dressing and so on, he or she may also be able to perform other duties, rather than having to call someone to dust off a countertop or clean a bathroom" (p. 4).

When a facility functions as described in the Eden Alternative® literature and the versatile workers take on more roles, it becomes no longer the ideal or even desirable for an RN to be continuously present. Instead, the RNs become visiting professionals who visit intermittently to provide skilled services. The implication is that the number of RNs can be drastically reduced. The model has already been implemented in several nursing homes in Switzerland because of the potential to reduce costs (Monkhouse, 2003). The focus in these Swiss homes was on “clients’ needs and the continuous improvement of services by empowering residents and employees” (p. 342) but changes were “intended to also result in cost effectiveness” (p. 342). Monkhouse (2003) reported that the philosophy provided a “missing link” (p. 340) for a quality assurance program when two nursing homes were undergoing financial and care quality crises.

Other authors focus on the benefits for residents. Kane, Lum, Cutler, Degenholtz, and Yu (2007) aimed to determine the effect of the Eden green house model on quality of care and quality of life for residents by comparing a green house model home to two conventional nursing homes (A and B). These authors found that residents living in the green house (n = 39) reported better quality of life on seven of 11 quality of life subscales compared to conventional home A (n = 64) and four of the 11 quality of life subscales compared to conventional home B (n = 37). Residents living in the green house also reported significantly higher satisfaction with the home than residents of homes A and B. The authors conclude that the green house model is achieving its goals.

Recently though, some authors have suggested that the benefits and limitations of models of culture change such as the Eden Alternative® have not been explored adequately or carefully enough (Petersen & Warbuton, 2010; Rahman & Schnelle, 2008). According to Rahman and Schnelle, “the culture-change movement is spreading in advance of a solid research base to support its quality-of-life improvement claims" (p. 147). Of the empirical research focusing on the outcomes (staff, resident, family, economic) of implementation of the Eden Alternative® model, much of the evidence fails to support its effectiveness. For example, Coleman et al. (2002) chose to investigate whether or not the Eden Alternative® would have a beneficial effect on infection rates, functional status and cost of care after one year. The investigators obtained baseline data from the medical records of permanent residents at two American facilities located in one southern state. One facility had 126 beds and began implementing the Eden Alternative by introducing plants, eight dogs, 12 cats, 15 birds and one rabbit. The control facility (located in the same state) had 114 beds and continued traditional care. Only data from residents who were not terminally ill were included in the study. Baseline data were obtained from the MDS data set. After one year, follow up data were gathered. After controlling for baseline differences the investigators found no statistically significant differences in infection rates, no statistically significant improvements in functional status, and no statistically significant differences in cost of care. Although the care aide workforce at each facility remained relatively unstable, the investigators found that staff turnover tended to increase during the period of implementation at the Eden facility.

When Caspar, O'Rourke, and Gutman (2009) evaluated the effects of three different organizational models (Eden Alternative®, GentleCare, and Facility Specific Social Model) on employees in 54 long-term care facilities in British Columbia, they found that none of the culture change models enhanced

RNs' abilities to provide individualized care to residents. The care aides working in facilities that had implemented the Eden Alternative® had no increase in their abilities to provide individualized care to residents when compared to care aides working in facilities with no culture change models. The lowest levels of ability to provide individualized care to residents were reported by LPNs working in facilities that had implemented the Eden Alternative®. These authors suggest that their results correspond "to previous empirical research suggesting limited utility of the Eden Alternative®" (p. 173). In their study aimed at determining preferred staff assignments in nursing homes (rotating or permanent assignments for care aides similar to the Eden model), Burgio, Fisher, Fairchild, Scilley, and Hardin (2004) found few differences in quality of care outcome indicators for residents between rotating assignments and permanent assignments. Rosher and Robinson (2005) aimed to determine the impact of the Eden Alternative® model on family satisfaction by providing families in one 150 bed nursing home with a family questionnaire prior to and after the Eden Alternative had been implemented in the home. The 21 item family questionnaire had high reliability (Cronbach's alpha 0.94). These researchers found that although 17 of the items increased, only three items were statistically more positive after implementation of the Eden Alternative® (more respectful staff, more opportunity to interact with animals, and the welcoming of children into the home). Bergman-Evans (2004) designed a study to assess the impact of implementation of the Eden Alternative® on levels of loneliness, boredom and helplessness. Twenty-one cognitively intact residents in a state veterans home were compared with 13 residents in a private nursing home. After implementation of the Eden Alternative® in the veterans home, residents reported significantly lower levels of boredom ($p = 0.01$) and helplessness ($p = 0.03$) but no changes in loneliness.

Conclusion

The literature review has set the context of the study via a qualitative metasummary, an investigation of broader phenomena, and a detailed description of the Eden Alternative® model of cultural change. Based on the results of the metasummary, the most prominent issues that affect care aides globally are lack of job satisfaction, threats to personal safety, excessive workloads and inadequate training. The metasummary draws attention to the importance of caring relationships and connections between care aides and residents or care aides and families as the primary means to ameliorate these prominent issues. Various intrapersonal factors, such as dependency/lack of trust or psychiatric illness can influence the quality of relationships between care aides and residents. However, a far broader concept overshadows intra and interpersonal factors. This is the impact of a specific culture of care organized according to an explicit model.

The Eden Alternative® is an American *cultural change model* based on the assumption/ belief that residents living in long-term care facilities are receiving adequate assistance for their physical ailments, but they are receiving inadequate assistance for their spiritual ailments. To counteract spiritual suffering, environmental transformations (Alternatives) that support and promote nature, gardens, and paradise (Eden) are introduced into the facilities. The Eden Alternative® requires shifts in perspectives, organization and culture of care. A transition towards the Eden Alternative® model involves significant changes in job duties and routines for all staff members.

There is a great deal of anecdotal and a small amount of empirical support for the Eden Alternative® philosophy and model. The philosophy has allowed some administrators of nursing homes to strengthen their visions for quality improvements. Some authors have noted potential fiscal benefits for organizations considering implementing the Eden Alternative®. Changes consistent with the Eden model have led to improvements in the lives of residents in a number of nursing homes. Recently though, some authors have suggested that the benefits and limitations of models of culture change such as the Eden Alternative® have not been explored adequately or carefully enough. Much of the empirical research focusing on the outcomes (staff, resident, family, economic) of implementation of the Eden Alternative® model fails to support its effectiveness.

There is a paucity of empirical evidence that explores and describes how care aides are able to construct and negotiate relationships with residents in the context of their expanding roles and responsibilities and new models of organization of care. This research can help fill that gap through a closer exploration of the experiences and perceptions of care aides about their roles, their relationships with residents, and the impact of a specific culture of care organized according to a explicit model.

Chapter Three

Methods

The aim of this chapter is to provide the reader with a clear understanding of the research processes I employed to explore the nature of care aides' relationships with residents in long-term care. I outline the methodological perspective, my theoretical assumptions and conceptual lens which underpinned my research approach, and then describe the research strategies used to answer my research questions. I discuss the strategies I used within the iterative processes of sampling which involved identification and recruitment of participants, data collection and data analysis. Finally, I describe the provisions I incorporated to ensure rigor in the research. Throughout each section, I include ethical considerations.

The method of exploration in this study was based on the principles of qualitative focused ethnography. Ethnography means "learning from people…to inform understanding" of shared cultural norms, values and expectations that guide behaviours (Hodgson, 2000, ¶ 4) therefore it was an ideal method to explore how care aides think, talk, and strategize (make decisions) about their roles and relationships with residents. There are four primary goals in qualitative ethnography: the first is to illuminate human behaviours and experiences that occur in specific cultural contexts; the second is to gather many different points of view (Agar, 2006); the third is to determine consistencies and variations in experiences and patterns of thought and behaviour (Hodgson, 2000; Savage, 2000); and the fourth is to progress beyond the description and analyze the results to obtain insight or understanding about certain events and how people experience them (Agar, 2006; Hammersley, 1990).

Very early anthropological (classical) ethnographers emphasized fieldwork, observation and description. Investigators traveled to societies very different from their own, lived within these societies, but did not interact with the members (natives) to any great extent. Rather, they observed member behaviours and then theorized about the observations. These classical ethnographies were written from an etic or outsider's perspective. Newer ethnographers tend to give preference to data collection derived from interaction: communication and collaboration with members of a culture to expose the members' perspectives, their explanations for their behaviours, the meanings of rituals, and their ways of communicating with each other and with outsiders (Agar, 2006). These ethnographies are written from an emic or insider perspective. The most important elements are "encounters with different points of view" (Agar, 2006, ¶88). Through description and analysis, ethnographers learn "what is going on" (¶128).

Focused Ethnography

In nursing and other social sciences, focused ethnography has been adopted as a method to focus on specific phenomena or contexts. While the method adheres to the principles of qualitative inquiry, such as emic, cyclical, researcher as instrument, concurrent data collection and analysis (Hammersley, 1990), it does have a number of distinct features described below.

While no single form of focused ethnography exists, focused ethnographies are usually characterized by a limited number of data collection techniques that are used to explore the experiences of a limited number of participants who hold specific knowledge about a particular issue or phenomenon that is occurring within a specific cultural context (Agar, 2006). A focused ethnographer begins his or her study with an actual phenomenon in mind. Usually, the ethnographer is highly *motivated* by his or her own interests (Agar, 2006) based on familiarity with the culture and a certain amount of pre-existing implicit and explicit knowledge (Knoblauch, 2005). In this case, I am very familiar with the culture because I began my nursing career as a care aide. At first, I was employed by an agency that provided basic personal care services (bathing, cleaning, laundry, meal preparation) to people in their homes. After one year, I left that agency and became employed in a long-term care/rehabilitation facility. I worked on weekends and in the summer as a care aide while I was going to nursing school. After graduation, I continued to work in the same facility, for several more years until I became employed in acute care. After a decade in acute care, I returned to long-term care where I worked full-time for six years. Now, as a clinical instructor, I teach a first year practicum in a several long-term care facilities. I have been able to observe and reflect on the many changes that have occurred in long-term care since I was first employed as a care aide.

Focused ethnographers are also very *selective*. Data collection is aimed towards obtaining only certain elements of knowledge (Knoblauch, 2005) such as one question or aspect of the culture under investigation. In this case my primary research question was focused on the care aides' perceptions of their roles and their relationships with residents.

Selectivity also privileges only one form of *intense* data collection via a recording device (in this case digital voice recorded interviews) rather than several forms of data collection such as observation, interviews, and printed media/written field notes characteristic of more classical ethnographies (Adams St. Pierre, 1999; Agar, 2006; Hammersley, 1990; Knoblauch, 2005). Participant observation is not a requirement (Higginbottom, 2011) and is often not feasible due to the sensitivities and/or vulnerabilities of the participants and/or their discomfort with observational strategies that are characteristic of classical ethnographies. Many focused ethnographers have gathered rich descriptions of cultural contexts by interviewing their participants in locations that are private and separate from the context. This technique provides a means for participants, who might ordinarily feel hesitant to share their stories, to contribute valid experiential knowledge. Current examples of focused ethnographies that have data collection techniques similar to the data collection techniques used in my study are outlined in Table 1.

Table 1

Focused Ethnographies with Similar Data Collection Strategies

Authors	Title	Data Collection Technique
Higginbottom (2011)	The transitioning experiences of internationally-educated nurses into a Canadian health care system: A focused ethnography	Semi-structured interviews with 23 internationally educated nurses
Sedgwick & Yonge (2008)	Undergraduate nursing students' preparedness to "go rural"	Interviews with 24 nursing students, one focus group with 5 hospital staff members
Bruno Maddocks (2008) (dissertation)	Women's decisions to seek specialty substance abuse treatment: A focused ethnography	Interviews with 7 women engaged in specialty substance abuse treatment
Rose (2007) (dissertation)	Exploring the concept of respect in forensic psychiatric nursing: A focused ethnography	Interviews with 13 RNs and 2 RPNs. Follow-up interviews with 7 RNs and 2 RPNs
Green, Meaux, Huett, & Ainley (2011)	"It has its ups and downs": adolescents'quality of life after heart transplantation	Interviews with 14 adolescents who had received a heart transplant
Secor-Turner, Sieving, Garwick, Spratt, & Duke (2010)	Culturally sensitive community engaged research with African American young women: Lessons learned	20 low income African American adolescents involved in a focus group and individual interviews
Hill Bailey, Montgomery, & McMillan Boyles (2009)	COPD stories of complex causal 'truths' 'Sure I've smoked all my life/but I also put in 37 years at the mine'	Semi structured interviews with 25 patients with lung disease (combined samples from 2 focused ethnographies)

Although some could argue that this study is an organizational ethnography, this focused ethnography differs from organizational ethnography in three ways. Although organizational processes (chains of command, levels of responsibility, policies and procedures etc.) impact relationships between care aides and residents, I did not set out to *specifically* investigate organizational logic (the broad sets of institutional values, rules or scripts). Nor did I access organizational documents such as charts, reports and meeting summaries, that are characteristic of (and an integral part of) organizational ethnographies (Yanow, 2009). An organizational ethnography would also aim towards transparency of institutional relations by obtaining multi levels of relational experiences (rather than just one level) in order to understand how organizational or administrative processes work.

Others could argue that this is a critical ethnography because I attempted to hear the voices and the experiences of people who are seem oppressed and whose stories have been restrained in some way. However, critical ethnographers begin with conditions of unfairness or injustice and then make contributions towards changing those conditions by empowering or liberating the participants.

The goals of this qualitative approach and focused design were *acquisition of background knowledge* (specific to an emic understanding of care aides' experiences of cultural changes), thick description (a cultural portrait) and interpretation. A focused ethnography is most applicable for this study because the emphasis is on the relationship between the culture of long-term care and the behaviours and experiences of the care aides. It is meant to be an "analytical description of social scenes and groups that (will) recreate for the reader the shared beliefs, practices, folk knowledge and behaviours" of the group (the care aides who work in long-term care facilities) (Goetz & LeCompte, 1984, p. 2-3).

Focused ethnography assumes mastery of efficient collection of data (Hendwerker, 2001). This means that a focused ethnographer must be able to effectively interact/form a rapport with participants over a very short period of time (the interview), and during that time, a focused ethnographer must have the skills to reduce participants' initial anxieties, help them to feel comfortable quickly, communicate to them that he or she is interested in them, pay attention to details such as emotions, and ask questions about specific events, people, relationships, patterns, culture, and experiences - all in a non threatening manner (Hendwerker, 2001). Because an ethnographer's goal is to understand (Hammersley, 1998), a focused ethnographer must have the skills to *rapidly* create a rapport with participants in order to understand. Therefore, the process is intense. This design would not be a good fit for a researcher who is not used to employing specific techniques to ensure the rapid establishment of close and personal relationship with others (via conversation) in order to learn how others feel, think and make decisions, but it was a good fit for me because of my 30 years experience as a nurse.

According to Hammersley (1998), the focus is "usually a small number of cases, perhaps a single setting or group of people, of relatively small scale…the focus may even be a single individual" (p. 2). The focused design is applicable because the focus is on care aides only. Residents, families, and professional nursing personnel were excluded as participants.

This study is intended to be the first phase of a research program aimed at developing an emic understanding of workers' experiences. This information may then be used to develop supportive training or clinical interventions.

Reflexivity

In collaboration with my participants, I generated data and to some extent, my interpretation/analysis is a reflection of who I am as a person, a professional and a scholar. Therefore, it is important to articulate my assumptions and conceptual lens guiding my work (Cohen & Crabtree, 2008). The study was not meant to be a judgment of individuals, but a description of individual experiences and perceptions in order to determine if patterns exist. My preconceptions, my motivations, and my ways of understanding shaped the entire research process. The following assumptions remained constant throughout the study as I came to understand the emic perspective of my participants:

1. The role of the care aide is dynamic and interactive
2. Relationships between care aides and residents are close and familiar
3. Care aides' perceptions of residents will influence their responses to residents
4. The characteristics of residents affect service provision (enhance or impede the health care services provided) by care aides and others in the health care team
5. Care aides' experiences at work will influence their perceptions of their roles

6. Care aides' perceptions of their roles will influence their responses to residents
7. Care aides acquire patterns of responding to residents

Theoretical Underpinning of the Study

My conceptual lens in this research was influenced by Swanson's theory of caring (Swanson, 1991). Swanson defined caring as "a nurturing way of relating to a valued other toward whom one who has a personal sense of commitment and responsibility" (p.162). The theory is comprised of five caring processes (maintaining belief, knowing, being with, enabling, and doing for) all aimed towards supporting and promoting the well-being of valued others.

The Five Caring Processes

"Maintaining belief" means being optimistic and hopeful or having faith in other people's abilities. In this study, "maintaining belief" refers to my belief that care aides are competent or will become competent if given appropriate resources and that they do have the capacities to be successful. The process of "knowing" is striving to understand events that occur in the lives of others because those events have great meaning for others (Swanson, 1998, p.9). In this case, "knowing" was the research process. It was to avoid assumptions about the care aides and to thoroughly assess all aspects of their experiences. The process of "knowing" acknowledges that people experience similar events differently and that some people will feel vulnerable during certain events even though others feel secure. The process of "being with" refers to being authentically present. During the investigation, "being with" meant that it was important for me to take the time to listen carefully to what care aides had to say about their experiences, and to convey to them that what they were experiencing truly mattered. The process of "being with" or the reverse "not being with" was characterized by the manner in which I listened. The process of "enabling" is to "validate other people's feelings…to focus on their concerns…and to generate alternatives" (Swanson, 1991, p. 164). A large component of "enabling" was to avoid struggling to maintain the focus of the interviews on my preferred topic of strained or difficult relationships when it quickly became obvious that care aides wanted and needed to talk most about the impact of cultural change (The Eden Alternative®). "Doing for" is the action component - what happens after I have conveyed the message to others that what care aides are experiencing is important and relevant. Many nurse researchers have explored the practices of care aides by obtaining other people's opinions about them (for example, the opinions of registered nurses or managers) or by examining turnover rates, work satisfaction scales and management practices. In this study, "to do for" was to consult the care aides directly.

Sample

I used both convenience sampling (non-random and based on convenient access to study participants) and purposive sampling (non-random and based on selecting participants who were known to have the needed information) in this study (Strauss & Corbin, 1998). I recruited 22 participants from one privately funded and four publicly funded long-term care facilities in a western Canadian city. The facilities ranged in size from 65 residents to 213 residents. The decision to access multiple settings was an attempt to account for the possibility of idiosyncratic differences between institutional cultures in the individual facilities. The settings were chosen based on the interest expressed by the Director of Residential and Palliative Services for the local health authority. I also approached four managers, first by telephone, and then in person in order to obtain their permission to access the facilities and begin recruitment of participants.

Inclusion/Exclusion Criteria

The focus of the study was on the emic experiences and perceptions of care aides, so registered nurses, licensed practical nurses, managers, residents and their family members were excluded as participants. I focused on recruiting participants who were fluent in English, able to reflect on and articulate their experiences and opinions, and had worked in the facility for six months or more. However, considering that the ultimate aim of ethnographic sampling is to gather many different points of view, I did not exclude any care aide who indicated willingness to participate and one participant was significantly less fluent in English than the other participants.

Sample Size

In qualitative focused ethnographic research, the sample size is ultimately determined by analytic saturation, or the point at which continuing analysis is redundant (Strauss & Corbin, 1998). I stopped interviewing when no new themes emerged. My final sample size was consistent with the average sample sizes of seven generic qualitative studies of nurse aides, nine focused ethnographies, and four unpublished dissertations using focused ethnography as the method. These studies are described in Appendix A.

Recruitment

A key concept that underpinned my approach was ethical recruitment. Approval for the proposal was obtained from:

a) The Health Research Ethics Board (HREB) at the University of Alberta, Edmonton, Alberta. HREB administers the ethics review process for all faculty, staff, and students at the University of Alberta

b) The local Health Research Ethics Board which administers the ethics review process for individuals who conduct research involving employees working locally

I met with the Director of Residential and Palliative Services for the local Health Authority and obtained a letter of support (See Appendix B). I also had introductory meetings with the managers of the long-term care facilities. After I obtained ethical approval from the University of Alberta and the local Health Authority, I met again with the Director and all of the managers. I reviewed the research process, obtained formal written permission to meet with nursing unit supervisors and posted several announcements (brief information sheets outlining the research process) (See Appendix C). Then, I met with each individual nursing unit supervisor and arranged a convenient time to give one or two short (ten minute) presentations to the staff on each unit.

Originally, I had planned to present the research project to care aides during their regularly scheduled staff meetings. However, the Director kindly suggested that single and short presentations would be better received by staff and more acceptable than extending the time of the regularly scheduled staff meetings. At each presentation, I explained the general nature and purpose of the research, the consent process, the confidential nature of the interviews, honorariums and time commitments required. In addition, all possible participants were advised that participation in the study was voluntary, and that no identifying information would be divulged to anyone other than my supervisor. My name and a cellular phone number were supplied to all possible participants in the brief information sheet, but it was up to each individual to contact me. If an individual indicated that he or she was willing to participate, and I confirmed that the individual was eligible, an interview was scheduled at a mutually convenient time and place - a place that was safe for both the participant and for me, and suitable for audio-recording (for further details, please refer to "Interviews").

Characteristics of the Sample

Twenty-two care aides participated in the study (twenty female and two male). Twenty of the participants attended the interviews as scheduled. Two of the participants asked to reschedule. There was no attrition. Nine of the participants identified themselves as non-Canadian ethnic heritage, and 13 self-identified as Canadian. All of the participants worked full time. Two participants worked in a private long-term care facility while 20 participants worked in the four publicly funded facilities. It is, therefore, within this cultural context that the results should be considered. Demographic data were collected at the start of the interview with each participant (see the demographic questionnaire in Appendix D). Key demographics are contained in Table 2.

Table 2

Characteristics of the Sample

Characteristic	n = 22
Age	
▪ 20-30 years	3
▪ 31-50 years	16
▪ 51-60 years	3
Nationality	
▪ Non-Canadian ethnic heritage (actual nationalities deleted to protect identities)	9
▪ Canadian	13
Training	
▪ Completed part of a BSN program and dropped out	2
▪ Completed part of an LPN program and dropped out	1
▪ Certified on the job after completing training modules	1
▪ Completed a 5-9 month college program	18
History of involvement in care aide work	
▪ Needed a job / a well paying job	19
▪ Previous work in dietary	2
▪ Looked for job requiring a short training program	1
Years of Experience	
▪ 1 year	2
▪ 2-5 years	3
▪ 6-10 years	1
▪ 11-15 years	4
▪ 16-20 years	2
▪ 21-25 years	8
▪ 26-30 years	1
▪ >30 years	1

Data Collection

Data collection continued over a period of seven months from November 2010 to May 2011(see timeline Appendix E). Data were generated through semi-structured interviews. Written consent procedures and compilation of demographics preceded each interview. Each of these aspects is outlined in further detail below.

Ethics and Consent Process

Anonymity and confidentiality of participants was maintained throughout the research study through the use of pseudonyms. Each participant was assigned to a pseudonym from a prearranged list of potential pseudonyms (See Appendix F). The participants were advised that anonymity could not be guaranteed when direct quotes were used during data analysis and dissemination of results; however, all identifying information was removed from quotes. For example, the name of the agency was replaced with "facility". Participants were advised that they did not have to answer a question if they did not want to; they could withdraw from the study at any point and they could request that digital recording be stopped at any time. All notes, transcripts and digitally recorded files are being stored in a secure locked filing cabinet for seven years as per HREB protocol requirements. Consent forms (see Appendix G) and the master list linking the pseudonyms to the participants are being stored in a separate locked filing cabinet at a different location for seven years.

Interviews

Care aides have been shown to be less willing to participate in research studies than regulated workers due to feelings of vulnerability and insecurity (Aström, Nissen, Norber, & Winblad, 1990). In order to accommodate a wide range of interactive styles, the impact of cultural differences, varied personalities and mixed needs, I used five specific strategies designed to reduce power differentials and to help the participants feel as safe and as comfortable as possible during interviews.

1. Neutral location: Neutral locations were important to help participants feel more in control (Nunkoosing, 2005). Interviews occurred away from work sites at locations that were convenient, comfortable, neutral, quiet, and safe for the participants and for me.
2. Support: Two participants were interviewed together if they so desired. This occurred twice during the study. This strategy was aimed at increasing participant comfort by reducing feelings of pressure and scrutiny. The participants determined who they wished to buddy with, as long as that buddy was another care aide. When two participants chose this option, I included a statement in the consent form that participants would hear each other's experiences, but must keep any information heard in the interview confidential. While two people could be considered to be a very small focus group (VSFG) (Toner, 2009), I did not analyze dyadic data any differently from individual interviews.

3. Choice: Although face-to-face interviews were preferable, telephone interviews were offered as an alternative. Only one participant chose this alternative. I used a separate telephone information sheet and consent for the telephone interview (See Appendix H).
4. Follow-up: All participants were offered the opportunity to follow-up in person, by telephone, or by email in case they thought of something else they wished they had said. No participant chose to follow-up.
5. Acknowledgement for time and effort: Each participant was offered a $30.00 honorarium in the form of a gift certificate to a local merchant as acknowledgement for his or her time and effort. Thirty dollars was equivalent to 1-½ hours of work. All participants accepted the honorarium. The most popular gift certificates were for Walmart or Real Canadian Superstore. Honorariums were based on the principle of the need for reciprocity. As a researcher, I felt the need to reciprocate. An honorarium is an "act of respect, acknowledging the essential nature of (participants') contributions, their expertise, and their wisdom as critical component(s) of (the) research" (Morse, 2005, p. 727). The study was self-financed. The budget is detailed in Appendix I.

The interviews did not begin until the participants confirmed that all of their questions or concerns had been satisfactorily addressed. I began each interview with casual conversation designed to set the participant(s) at ease and to further my understanding of the participant(s) as a person, as well as the context of his or her work and role. Following this, I employed a general "grand tour question" and referred to my guiding questions when appropriate (see Appendix J). Rather than trying to maintain the focus of the interviews on the guiding questions, I encouraged participants to talk in depth and at length about what was most meaningful and concerning to them. This is consistent with the theoretical underpinning of the study - Swanson's theory of caring (Swanson, 1991) and the emic principles of focused ethnography. I found quickly that the participants wanted and needed to talk most about the impact of cultural change (the implementation of The Eden Alternative®). As the study progressed, I presented my emerging ideas to later participants in order to determine if my emerging ideas sounded appropriate or resonated with them. The approach was intended to be flexible in order to allow the discussion to flow in a way that seemed natural. Participants were assured that there were no preferable responses. "I would like to understand what your experiences are like. Your experiences will be different from other people's experiences." All participants agreed to allow the interviews to be digitally recorded. Interviews varied in length according to the desires and energy levels of each participant but averaged 70 minutes.

Data Management

Audio data was transferred from the recorder to my computer on the same day as it was recorded and then backed up immediately by copying the file to a compact disc. I transcribed each digitally recorded interview verbatim. Word documents were stored on my computer and on a removable flash memory card. Word documents were checked for accuracy and identifying information was removed before they were printed for analysis. Compact discs, the memory card, the demographics, paper files of transcripts, and my notes were stored in a locked filing cabinet. The consent forms and master list linking the pseudonyms with the participants were held in a separate locked filing cabinet in another location: my locked office at the post secondary institution where I work. I used qualitative software (NVivo 8) to manage the data.

Data Analysis and Interpretation

The constant comparative method was used for data analysis. This method of analysis is rooted in grounded theory but together with theoretical sampling, it is widely used in the analysis of qualitative data (Charmaz, 2006). The principle of constant comparison is that in order to properly analyze data, a researcher must analyze data that he or she has already gathered, reflect on the analysis, and then decide what data needs to be gathered next in order to answer certain questions that have arisen from the analysis and the reflection (Corbin & Strauss, 2008). Constant comparison is a cycle that is completed over and over until the researcher feels that his or her questions have been answered and that continuing to interview new participants will reveal no new information.

Following the approach described by Charmaz (2006) and Boeije (2002), I read the first transcript very carefully looking for ideas or meanings within sections of text. Each section of text was highlighted and assigned a label. The labels consisted of the actual words used by the participant (in-vivo codes) or my own words. This process is called open coding or “fragmentation” because pieces are “lifted” out of each interview (Boeije, 2002, p.394). Every passage of the first interview was examined and coded. I used Qualitative software (Nvivo 8) to track codes. When the second interview was completed, the categories within it were also carefully coded. When new codes emerged, all previously coded data was reviewed to see if it contained any examples of the new codes (Hammersley and Atkinson, 2002) and so on. For example, during open coding of the fourth interview, I became aware that the participants were using labels so I developed a new code 'labeling' and I reviewed interviews one through three to see if they contained examples of 'labeling' that I previously missed. The coding process was dynamic and codes changed slightly with time (Agar, 2006). In addition, there was no requirement that items of data be assigned to one and only one code. Each segment of data was stored under all the codes to which it was deemed relevant. At the end of the study, I had 151 codes. Codes that appeared related or linked were placed into clusters of codes called categories. This process is called axial coding (Boeije, 2002). Categories were then further refined until I had 29 sub-themes. This number of sub-themes was broad enough to support the large number of codes and categories, but small enough to track practically (Morse & Field, 1995). The process of identifying lay theories was more intuitive. The language of the participants was examined carefully for indirect statements, assumptions, explanations or illustrative stories that impressed an emerging lay theory. Finally, six overarching themes evolved from further conceptualization of the sub-themes and represent the highest level of abstraction. The themes ultimately provided answers to my research questions.

Rigor

Every ethnographic project is a distinct project. If different ethnographers study the same phenomenon, they are likely to produce different but equally valid accounts (Adams St. Pierre, 1999; Agar, 2006; Hammersley, 1990). A qualitative ethnography therefore, is an interpretation – one interpretation is not necessarily truer than another (Adams St. Pierre, 1999; Agar, 2006). Nevertheless, rigor is an essential concern in the conduct of academic and clinical research. Rigor demonstrates to those who read the results of qualitative research that the final product closely represents the experiences of the people studied (Guba & Lincoln, 1994). My primary goals for this study were to produce a rich, meaningful and substantive account of the experiences of care aides and to provide strong evidence for my inferences, my ways of understanding, and my conclusions. To ensure rigor, I chose to follow the model of verification, beginning with sample selection and ending at dissemination (Morse, Barrett, Maya, Olson, & Spiers, 2002). Investigator responsiveness, methodological coherence, sampling adequacy, an active analytic stance, and saturation are components of the model of verification.

Investigator Responsiveness

During analysis, I made every effort to be careful, conscientious, self reflective and attentive to the decisions that I made. I tried to remain open-minded and I concentrated on listening to what the participants said, without forcing any preconceived assumptions. This is consistent with two caring processes - “Being With” and “Enabling” (Swanson, 1991). Responsiveness continued throughout the analysis including when I revisited the data to ascertain support for my analytic interpretations.

Methodological Coherence

I used the method of constant comparison (Corbin & Strauss, 2008). Constant comparison strategies consist of a recursive process of checking analytic categorizations and assertions with the data (Boeije, 2002; Morse et al., 2002). "If completed properly, (constant comparison) checks or verifies the accuracy of the work through the comparison itself" (Walker & Myrick, 2006, p. 555).

Sampling Adequacy and Saturation

During sample selection, I targeted/selected certain participants in order to follow leads according to the themes or ideas that emerged during analysis. For example, I became aware that cultural factors impacted relationships between the participants and residents, so I recruited participants from varied cultures. The ability to amend or adjust my sample according to what was revealed allowed me to arrive at a more complete understanding and this, in itself, is a verification strategy (Morse, 2008). Analytical saturation meant that I continued to recruit until I found recurring patterns in the interviews and the codes remained constant with no new codes emerging from interviews with new participants.

Active Analytic Stance

Morse et al. (2002) suggest that qualitative researchers should "inch forward" when analyzing data, and refrain from making "large cognitive leaps" (p.13). This is called the macro-micro perspective. After four transcripts had been coded, I sent my supervisor a report generated by NVivo 8 that contained all of the emerging codes. Later, I sent the eleventh transcript to my supervisor as a word document and I coded it by highlighting text and inserting the codes so that my decision-making processes could be confirmed and so that the consistency of my inferences and the development of codes could be checked. I also sent several particularly moving pieces of text to my supervisor, which I analyzed separately. As the study progressed, I presented my emerging ideas to later participants in order to determine if my emerging ideas sounded appropriate or resonated with them. Finally, consistent with the perspective that realities are fluid and multiple, I have provided multiple data excerpts for readers. This verification strategy "let(s) the data speak (for itself)" (Walker & Myrick, 2006, p. 553). Readers will be able to discern for themselves whether or not my inferences, my ways of understanding, and my conclusions are verifiable. I did not perform routine member checks (returning to participants routinely for a second interview) after the data analysis was complete. Several scholars have pointed out that routine member checks are not a reliable verification strategy because the final themes are not really recognizable to individual participants. Instead, final themes are "higher ordered insights" (Cohen & Crabtree, 2008, p 335), "synthesized, decontextualized, and abstracted from" multiple participants (Morse et al., 2002, p.7).

I used the method of constant comparison (Corbin & Strauss, 2008), which I have described above. I analyzed the data as I collected it. This means that I did not approach the data collection and analysis in a structured way. For example, I did not begin the study with a detailed plan to analyze all the data from the participants employed at one facility and then recruit from another facility and analyze all the data from the participants at the second facility and so on. Nor did I try to balance the number of participants between facilities. Rather, I recruited participants from all five facilities, and I waited until the participants contacted me. Once a participant contacted me, I arranged an interview. This does not mean that my research was unsystematic. Hammersley (1998) argues that the best approach to ethnographic data collection is *unstructured* and that data should be collected on “as wide a front as feasible” (p. 2). This is what I attempted to do.

During the analysis, I coded the data. As I have described above, I sent multiple reports to my supervisor so that my decision-making processes could be confirmed and so that the consistency of my inferences and the development of codes could be checked. My supervisor and I discussed the themes that were emerging as I continued to collect data. As described above, I did target certain participants in order to follow leads according to the themes or ideas that emerged during my analysis. My supervisor and I had many discussions about the six themes that eventually emerged.

Hammersley (1998) argues that there is no guarantee that everyone’s judgments about rigor will be consensual due to many differing views about how to maintain rigor, therefore, an ethnography should really be judged on the “likelihood of error” (p. 67). According to Hammersley, there should be just three steps in assessing any ethnographic claims:

1. Given what is already known and well established, how likely is it that the results are probably true?

2. Given the phenomena concerned, the circumstances, and the characteristics of the researcher, how likely is it that the researcher’s judgments are accurate?
3. If the answers to both questions are “not likely”, then further evidence is needed to support the claims (Hammersley, 1998).

Audit Trail

I used memos and field notes to document my activities, circumstances and thoughts. Memos were key words, interesting thoughts, hypotheses, short sentences or quotes discreetly written on a small notepad during each interview for the purpose of stimulating my memory later in the interview or during the production of field notes. Field notes were written immediately after each interview and consisted of short but descriptive notes about the interview. Memos and field notes are evidence of my own values, attitude and agenda; therefore they were also useful for self-reflection.

Field notes were unpolished notes, kept only for myself. They included descriptions of how I negotiated the interview, descriptions of the environment or the participant, impressions and incidental observations. Sometimes they were brief notations about things that I thought I ought do differently during the next interviews. For example, after the first few interviews, I had a number of notations about noise levels and proximity of tables in local coffee shops. At one particular location, one of the participants and I attracted the attention of two lonely older customers who wondered what we were doing with the papers and recorder. They attempted to join our table and our conversation. In subsequent interviews, I avoided scheduling interviews in locations where we were more likely to be interrupted. Sometimes the field notes included questions that I wished to ask subsequent participants. For example, after two participants spoke with enthusiasm and in great detail about their Christmas party, I made a note to ask other participants about their Christmas parties. Comparisons of Christmas party experiences subsequently formed an important component of my analysis. Other field notes contained my impressions of the interviews. For example, to my surprise, many of my participants were much more committed to attending the interviews than I originally expected them to be. Most were very punctual and reliable. Several were so enthusiastic about the study that they made extraordinary efforts to attend the interviews. For example, one participant didn't drive, so she asked her husband and son to drive her to the interview. Then, they waited in the truck in a parking lot so that she was able to complete the interview. Another participant had been asked by her daughter to babysit her child during the afternoon scheduled for the interview. Rather than miss the interview, this participant brought the child with her and together we diverted the child with fish and chips while we talked.

My field notes also contained descriptions of the way the participants interacted with me: whether they appeared apprehensive or whether they appeared confident and secure when meeting me. I noted the strong emotions that surfaced at different moments such as feelings of anger, disappointment, helplessness, and guilt. I noted that two participants cried during the interviews. While driving home after these two interviews, I also cried. When my participants spoke of the symbolic representations of the culture change model (the Eden tree, the plants, and pets) I reflected that I had also seen and made note of the same symbols during the recruitment phase.

Although my data collection did not contain a component of direct observation of my participants' behaviours and practices on their nursing units, I was still able to reflect on the non-verbal information conveyed to me during the interviews. Many of my participants commented how much they valued and appreciated my interest in them. My field notes of my observations and impressions about the interviews became an important part of my analysis because they allowed me to recapture or re-live some of the important emotional pieces of interviews as I sat at my computer. For me, my notes also became an important motivational tool. My notes of the convictions and emotions of my participants reminded me of my own humility and my devotion to capturing and clarifying their stories. The participants needed to explain their roles and their experiences to me in a way that made them central, and therefore made them matter.

Conclusion

The purpose of this study was to explore care aides' perceptions and experiences of their roles and relationships with residents in long-term care institutions, and how the context, including the organizational philosophy, influenced those perceptions and experiences. My intent was not to paint a broad picture of work in a long-term care setting from the perspective of the multiple stakeholders, but to delve into the perceptions, understandings, and beliefs of the care aides themselves. For this reason, the research strategies I employed in this project deliberately privileged the care aides' self reported reflections and accounts. This is critical because care aides are central to the provision of quality care for residents in long-term settings, yet historically they feel marginalized in their ability to voice their views in health care organizational research. My objectives in this study were to respect, encourage, hear and articulate their unique perspectives. This means that while the results are a rich description of their stories, they are but one part of a collective consciousness.

Chapter Four

Results

In this research, I sought to develop an understanding about care aides' experiences of their relationships with the residents and the factors that impacted those relationships in the long-term care setting. The care aides' experiences depended on four factors: 1) contextual factors that may have influenced their experiences, 2) their own thoughts and feelings about the situations they found themselves in, 3) their thoughts and feelings as they communicated with the residents, and 4) the perceptions they had about the thoughts and feelings of the residents and others such as management, colleagues, and families.

Contextual factors that may have influenced my participants' experiences include: increasing average age and levels of frailty of residents on admission to long-term care facilities in Canada (Statistics Canada Residential Care Facilities Survey, 2011; Wilson & Truman, 2004); increasing care needs of residents in the facilities (Wilson & Truman, 2004); increasing reliance on employment of immigrant care workers in Canadian home care and long-term care facilities (Bourgeault, Atanackovic, Rashid, & Parpia, 2010; Denton, Zeytinoglu, Davies, & Lian, 2002); and the changing professional/occupational mix and allocation of tasks in long-term care (Daly & Szebehely, 2012).

According to the Statistics Canada residential care facilities survey (performed yearly across Canada), residents in nursing homes in Canada are becoming significantly older and more frail. In 1996, 50% of the residents in Canadian nursing homes were older than age 85, the mean mortality rate for residents was 11%, and only 4% of Canadian nursing homes were populated with 100% of the residents requiring type three care (the highest level of care – residents require 24 hour supervision and management). In 2009, 55% of the residents were older than age 85, the mean mortality rate had increased to 17% and 38% of Canadian nursing homes were populated with 100% of the residents requiring type three care (Statistics Canada Residential Care Facilities Survey, 2011).

Wilson and Truman (2004) who investigated trends in demographics and care requirements over 12 years in one province also noted rising acuity levels. These researchers found that the population of residents admitted to long-term care facilities have increasing care needs such as urinary or bowel incontinence, dependency on others for feeding and dressing, and increasing numbers of residents who require security and safety precautions. For Canadian care aides, these changes mean that the work is gradually becoming more and more complex.

In this study, nine of the twenty-two participants were of non-Canadian ethnic heritage. In Canada, as in other countries, employment of more immigrant workers is one of many results of the restructuring of Canadian health care due to federal and provincial deficits and debts that have led to stringent cost cutting measures (Daly & Szebehely, 2011).

Bourgeault et al. (2010) secured interviews with multiple care workers from a range of ethnic backgrounds, who provided care to older adults in a range of Canadian health care institutions in three provinces. These authors found that the language difficulties and cultural differences between patients/residents and workers had a significant negative impact on the quality of relationships between the patients/residents and workers. Both factors also significantly reduced the patients/residents' perceptions of the immigrant workers' abilities to provide adequate care. These authors suggest that "more anti-racist education and campaigns should be introduced to families and clients of home care and long-term care services" in Canada (p. 116).

Some of the more recent changes in the professional/occupational mix and allocation of tasks in long-term care may also influence care aides' experiences of the their work and roles (Daly & Szebehely, 2012). Daly and Szebehely (2012) recently compared the experiences of Canadian care aides employed in long-term residential care for older people, to the experiences of care workers in several countries with similar political economies, health care perspectives and priorities (Sweden, Denmark, Finland, and Norway). These authors found that the division of labour between care aides and the LPNs is much more pronounced in Canada than it is in Scandinavian care homes. In Sweden, for example, the care aides and the LPNs shared the responsibilities and performed many of the same duties with the exception of insulin administration.

Daly and Szebehely (2012) also noted that Canadian care aides were absorbing tasks normally associated with other workers and that they were responsible for, on average, "more than twice as many residents…than were the Swedish care workers" (p. 144). Although workers in both countries valued social relationships with residents and stressed the importance of "relational care work" (p. 145), more than half of the Canadian care aides expressed a simple wish for more time to do just the basic personal care such as feeding and toileting residents. These authors conclude that Canadian care aides feel unable to meet even minimum essential care needs of residents and that their work is “more task oriented than relational” resulting mostly from a high degree of differentiated work, too many residents, and too little time (p. 146).

Although there was considerable variation in types of relationships that my participants described, the care aides, the residents, managerial staff and families all played an active part in how the relationships were developed and maintained. The results chapter is presented in six sections that reflect the most important themes that emerged from my analysis.

The first theme is “Desiring and Creating Ideal Relationships”. In this first section, I describe what my participants valued in their relationships with residents and how they strived to develop relationships with residents that were of good quality for both parties (relationships that were agreeable, enjoyable or pleasant). Routines were an important component of agreeable relationships, therefore details of some routines of everyday life and the relationship between routines and the giving and receiving of supportive exchanges are described. I also describe specific contributions made by my participants to support successful relationships and what they received in return from them. There are nine sub-themes that contribute to an overall understanding of how care aides conceptualized their relationships with residents: the nature of the ideal state and ideal relationship, negotiating a new relationship, the evolving relationship, the value of knowing, the importance of routines, providing protection, assuming a surrogate family role, received in return, and feeling guilty.

The next theme is “Workplace Realities”. In this section, I describe workplace realities that negatively impacted the relationships between care aides and residents (from their perspectives). There are four sub-themes: the pressures of increased responsibilities, organizational expectations of unattainable efficiencies, inability to obtain help, and weathering persistent stress.

In the next section, I focus on the theme “The Impact of Strained Relationships”. I asked participants to describe specific situations or events. This helped me to form a deeper understanding of the personal, situational and environmental factors that determined strained relationships. For clarity, I have organized this section into separate parts, each with its own sub-themes:

1. Part one is devoted to the participants’ descriptions of the residents who evoked feelings of stress, distress or discomfort in them and is composed of the following sub-themes: feeling uneasy, always on edge, and coping with the facets of cognitive dysfunction.
2. In part two, I move to a broader view to encompass how the care aides’ interactions with residents’ families influenced their perceptions and experiences of their relationships with residents. The sub-themes in part two are: managing complaints, hypervigilant families, never a compliment, coping with threats, contrasting visions of care, and cultural conflicts.

3. In part three, the narratives which typify managerial methods as perceived and experienced by the care aides are offered. The sub-themes found in these narratives are: nurturance, protection, and guidance, and feeling neglected.

In the following section, I focus on the theme “Care Aides’ Perceptions of Role Identity and Worth”. Almost all aides spoke pessimistically about their experiences of power and prestige with the majority indicating that they felt very low in power and low in prestige. Multiple processes led to care aides’ feelings of powerlessness and subservience represented by two sub-themes: desirable versus undesirable tasks and rewarding versus unrewarding tasks.

The fifth theme is “Care Aides’ Perceptions of the Organizational Philosophy”. Here I discuss the importance of the organizational philosophy and the implications of an organizational philosophy on care aides. A central and pervasive sub-theme in this section is ‘working alone’. Instead of feeling supported and reassured by fellowship, most of the care aides did their work without reference to each other. They emphasized what separated them, rather than what united them. This section also contains a portrayal of care aides’ attitudes towards and experiences of the Eden Alternative® philosophy and their perceptions of a paradoxical relationship between the Eden Alternative® and their abilities to develop and maintain meaningful relationships with residents.

My participants described working without many external resources. They relied most on their own internal resources, and some felt better able to cope with the demands of the environment because they formed their own work teams.

Care aides working together to complete care is not in alignment with the Eden Alternative® interpretation of teamwork but in very general terms, the experienced care aides recalled collegial support systems that helped them to moderate or buffer the effects of stressful events or work environment. Three sub-themes are represented in this section: faith in Eden, erosion of Eden, and alone in Eden.

The final section is centered on the theme “Integrative Thoughts”. It is a description of the lay theories and strategies formulated by care aides to account for some of the aspects of strained or difficult relationships between them and the residents.

Theme One

Desiring and Creating Ideal Relationships

In this first section I provide a description of successful relationships between residents and care aides, from the perspectives of my participants. It is important to understand the salient elements of successful relationships because they provide the reference points for comparison to less successful relationships. All of the care aides in the study indicated that they had formed many constructive, positive relationships with residents but some participants were more articulate in this area than others. Some care aides focused their descriptions on issues of respect and pragmatic concern for the residents while others provided rich, detailed descriptions of residents, circumstances, expectations, and ideal goals.

This description of successful relationships begins with their general ideology or ideal state, which was shared by the majority of care aides (giving, sharing, loving, helping, being a friend or confidant, caring, and being a nurse). All participants started with this general ideology in the interviews. When they felt sure I understood the nature of the ideal state and ideal relationship, they went on to describe how they negotiated new relationships.

Developing a new relationship involved gathering many details about the residents' lives prior to institutionalization and the participant's exploration of these details led to intimacy, discoveries and disclosures. During this time, almost all participants placed a high value on conversations with residents.

The success of the relationships could be measured by duration and consistency of thought and concern for the residents - when the care aides indicated that they thought almost constantly about the well being of the residents. Further elements of successful relationships included: knowing how to time certain aspects of care, knowing that unexpected changes could occur, and creating conditions that fit with the residents' attitudes and preferences.

In reality, the care aides in this study all provided services to any and all residents allocated to them. None of the care aides indicated that they had any choice about their assignments. The average assignment was eleven residents per care aide for a day shift. This meant that there was considerable negotiating work involved in finding and establishing mutual expectations and norms when caring for a new resident. Sub-themes and categories related to "Desiring and Creating Ideal Relationships" are outlined in Table 3.

Table 3.

Desiring and Creating Ideal Relationships: Characteristics of Successful Relationships

Sub Theme	Categories
The Nature of the Ideal State and Ideal Relationship	▪ Being able to give, share, love, help ▪ Being a friend or confidant ▪ Caring ▪ Being a nurse
Negotiating New Relationships	▪ Assessing each other ▪ Growing accustomed to each other ▪ Exploratory testing ▪ Negotiations ▪ Gathering details via conversations
The Evolving Relationship	▪ Increasing degrees of intimacy ▪ Discoveries ▪ Disclosures ▪ Shared privacies ▪ Duration and consistency of thought and concern
The Value of Knowing	▪ Timing aspects of care ▪ Knowing what will work best ▪ The value of experiential knowledge
The Importance of Routines	▪ Routines for satisfaction and contentment ▪ Routines to reduce stress and alleviate anticipated problems ▪ Routines designed collaboratively

The Nature of the Ideal State and Ideal Relationship

To set a context for discussing successful relationships with residents, each participant in my study shared several ideals or taken-for-granted values and assumptions about what an ideal relationship with residents ought to resemble. This ideology involved humanitarian ideals and values of inclusion, occupational ideals such as altruism and compassion, and included explanations of why they chose this work in the first place or why they continued to stay in the role. The ideology is important because it enabled the care aides to make sense of their work:

> *You have to share a little bit of yourself beyond your skills. I think that is part of it. You have to give a little bit of yourself to them….We are the nurses and when you talk to a resident, you say, 'I will be your nurse today' because that is what the residents know….In our eyes, we are nurses. (Betty)*
>
> *You are their friend or confidant. You are there for them....You love your residents no matter who they are. (Susan)*
>
> *Some of them are totally helpless so you are there for them....You can make a difference when you go in there (Linda)*
>
> *I just decide, in my life that I want to look (after), care for patients. (Joanne)*
>
> *I want the best for them. (Mary)*
>
> *I mean, we are in this business. We are the carers. The caregivers. (Jane)*

The ideology often contrasted greatly with their descriptions of what they were actually required to do within the organizational care philosophy. Their ideals functioned to help motivate them and energize them when they doubted their occupational self worth and contributions:

> *I need to make sure that I can help people. (Mary)*

> *I want it so that there is nothing but good days. (Kathy)*

Within this context of their beliefs about the essential components of ideal relationships with residents was the effort involved in creating a relationship with a new resident.

Negotiating a New Relationship

There was a general consensus that the development of new relationships with residents was a process that required effort from both parties. Care aides and residents needed time to assess each other and grow accustomed to each other's particular ways of doing things. Care aides needed to observe the new resident for a period of time in order to gain knowledge about his or her feelings, needs, and condition:

> *You meet them, and within four or five days, you kind of know where they are at. And you can kind of 'eye' them. (Cheryl)*

Learning about the new resident was not so much about learning about what they needed, but how best to provide it. Some participants noted that some residents took a little more time than others to become accustomed to communicating with the care aides and conveying their preferences, habits, and patterns so that the care aides could learn about them:

> *Some residents take a little more time to learn about how to communicate…what makes them comfortable…what their patterns are…how to approach them. (Linda)*
>
> *It is almost as if…we are coming to terms with each other and trying to blend in and not get that friction you know….You don't always get to know who the tough person is, it takes some time to adjust to them, to get used to them, to get to know what their daily habits are and all that kind of stuff. So you are kind of having to go through the process of assessing this person…So it is a learning curve. (Kathy)*

Learning about what the new residents' preferences, habits, and patterns was then followed by a period of either passive or active adjustments or negotiations - adjustments by care aides and the residents, to each other and to the culture of care within the facility. This occurred because although the new resident may have conveyed his or her preferences, habits, and patterns adequately to the care aides, his or her wishes/requirements still had to fit within the constraints of what the care aides and the institution as a whole were able to provide. Thus, negotiations with a new resident did not always go smoothly.

The following narrative details a particularly difficult early exploration and negotiation and demonstrates not only the extent to which new residents have to conform to institutional expectations and norms, but how care aides would endeavor to make this transition as easy as possible. Jane responds in the most gentle and non-confrontational manner possible to a new resident who was used to raising his voice and/or refusing to eat in order to obtain what he wanted:

> *I have one particular fellow. He is just brand new. He has only been in a couple of weeks. And he is difficult. He has been pampered (by his family) his entire life. He said, 'Jump' and they said, 'Is this high enough?' And of course, he has come into a facility and we don't have the time for that.....And we had a big flare up. Oh, we actually had two! And we have had a couple of set-tos. He doesn't understand why we can't jump. And he is very strong in his opinions…And his wife – actually his wife said, 'I am no longer looking after him and I am going to #### for three weeks and I am not coming back until he is in care!'....He has had a stroke and she just couldn't look after him any more. She had had it. And he just screams at the top of his lungs to her, the whole married life. So of course, he thinks he can do the same. No! And so he has to learn new habits all over again. Like, no you can't scream that way because that is not the way it works. You know? You are not supposed to raise your voice, never mind screaming!...I went into his room to call him for supper and the door was closed. I knocked on the door and opened it and he said, 'Get out of here! I don't want to talk to you! I want nothing to do with you! If you don't get out I am calling the police!' And I went, 'I came to*

> *ask you if you wanted to come for dinner. That was all.' And he said, 'I am not talking to you!' And I said, 'OK, that is fine! Fair enough!' And I went out and shut the door….I went down again in about an hour and a half. Well, I peeked in before that, but quietly. And he was just sitting there. But it was a good hour. Anyway, I went back and I said to him, 'Ah, would you like something to eat?' And he said, 'No I am not hungry but I would like to go to bed.' And I said, 'All right. Once you are in bed, I will bring you a couple of little sandwiches and some cheese.' And he said, 'Oh OK. That would be good.' And so that is what diffused it all. (Jane)*

Exploratory testing was not limited to the new resident. It also extended to the new resident's family because the family members sometimes had very different perspectives from the resident, and they also had their own preferences, habits, patterns, and ways of interacting and communicating their needs to the care aides. Occasionally, as indicated in the next narrative, family members' perspectives/preferences conflicted with what the residents expressed to the care aides:

> *I think that I take the time to keep a look out and assess the families. And I don't know even what it is. But I keep a look out. Some are different...Sometimes residents will tell you things that their families don't know. Because they remember the person as they were, and then they are frustrated now. Like, there is this lady who wants a visitor in, and her son says, no. He says she never liked visitors. She never ever wanted a visitor when she was at home alone and she wouldn't have liked that so why would she want someone in now. To sit and talk with her. Families seem to remember how they were, not their needs at present so much, you know? (Susan)*

One of the complicating factors in fostering new relationships was the fact that a new resident generally meant that a previously established relationship had ended through death or transfer. Participants needed to accommodate their own feelings while simultaneously being open to the new resident and family:

> *You have a new resident coming in on the heels of somebody. And sometimes it is the very next day.*

> *Is it? (Interviewer)*
>
> *Oh, absolutely! And you are still trying to mourn the person that is gone. And accept the new one that has taken their place. Who could be so different! Totally different. And you are like - Oh, OK! And then, all their family! It is never just the resident! It is the entire group, you know? (Linda)*

Care aides who were most proficient at early successful relationships seemed to have gathered many details about the residents' lives prior to institutionalization. Therefore, they were aware of things that had previously mattered in the residents' lives, and more concerned about what the new residents might be thinking about, interested in, or worried about:

> *A new resident just came in and of course, she is worried. Not so much that she is abandoned, but does the family know she is there? And, should she be there, or should she be at home?...She used to ride in the Stampede. The Calgary Stampede. She was a real rodeo rider! So that is a nice thing to distract her with. When she starts to get a bit anxious, I will sort of say to my co-worker, 'Oh did you realize that she used to be a rodeo girl?' And then she takes it from there. And then it is a happier moment for her too. (Jane)*

Almost all care aides placed a high value on conversations with residents as distinct from interactions oriented toward providing physical care. This made the relationships individual and personal:

> *It was so wonderful to be around her because you could just sit with her and talk to her. All you have to do to have good relationships for me is to sit and talk to them and they are usually happy. Don't touch them or don't ask them if their pad is wet. Just sit and talk. Relationships like that are easy for me. (Mary)*
>
> *She was 89 or 90 when she passed away. Yeah. I used to sit with her. She would say, 'Will you sit with me? – Will you sit and talk?' Yeah, yeah. (Susan)*

Conversations stimulated care aides' interest in residents and helped them to persevere when relationships were strained:

> *So if I stayed my ground, and just stayed completely polite with him, but stayed my ground, and he couldn't figure out how to hurt me, he would actually be pretty nice and we could have a nice conversation. He was actually a really nice guy but he couldn't deal with his disease. It was not easy for him. (Allison)*

Care aides who formed agreeable/pleasant relationships with residents were committed to forging relationships based on mutual negotiations about the constraints of institutional life. They were also able to perceive and acknowledge the residents' own appraisals and/or definitions of their situations and they had few doubts about what they heard and observed. They understood that there were no unitary methods for developing new relationships. One resident might need encouragement, while another might need support and acceptance. It all depended on the situation and all had to be carefully diagnosed. For example:

> *He was a very, very sweet man. Beautiful sense of humour. And he went to stand up one day. Because the first week he was there he could stand up with a little help. And he said, 'You know, this isn't me!' And I said, 'It isn't hey?' And he said, 'No.' I bet it isn't! I bet it isn't. And when he started to go downhill quite quickly, I sort of thought – you don't want to be here. And we do do that. We decide not to be here. And you have got to give them that. You know? You have to be able to say - not 'OK go at it!' But just quietly accept it. And let them do their own thing. (Jane)*

> *I think for the most part he is not in a place where he wants to be. He wanted to be on this other unit where this (other) unit has all young people. He is kind of in a place where all the residents he is with are older and I don't think he feels like he fits in…because a lot of them are confused and a lot of them can't have conversations or whatever. So yeah, that was kind of like his first choice. (Kathy)*

The Evolving Relationship

As relationships evolved, the degrees of intimacy increased. Conversations often led to a discovery or a disclosure, and then to a shared privacy. The following narrative about a participant's relationship with a particular resident illustrates the entire process of exploring, negotiating, discovering, disclosure, and shared privacies. To enhance clarity of the complex narrative, it has been broken into its component parts (relevant to this section). Susan's story illustrates how her relationship with a "fussy" resident grew after she negotiated with the resident about what was doable and what was not; how she discovered that the resident was really very interesting to talk to; and how powerful the disclosures and shared privacies were to cement the relationship.

Susan's Story

Narrative	Process
She was just this little lady and she was so fussy and very sharp mentally. So it was things like if her pillow was here, that was the wrong spot. This was where it belonged and it had to be just in the right place. Everything had to be just in the right place and nobody wanted to do it. When you did her bath everything was ultra picky, picky. She would complain a lot too; to the head RN or whatever if it wasn't the way she liked it. People found her very difficult in that way so nobody wanted that work and I need the position and I will take it.	Description of Situation
At first I dreaded going into her. Oh my goodness, here we go,	Exploring
and then I found she was the most wonderful little lady.	Discovery
She said to me, 'Move this here'. I said, 'That is a newspaper over on your table. Is it really going to make a difference? You can't reach it. You are in your bed and you don't need it. Does it make a difference if it is there or if it is there?' I said, 'If it was something for your physical comfort or made a difference to you, I would happily do it but it will not make any difference to you.' And she kept doing little things like this. I said, 'I think you just like to see me', and she said, 'Well can you blame me?' and I said, 'No, not really' and I said, 'If you don't ring the bell for ten minutes and when I have time at the end of the shift I will come	Negotiations

and sit with you' and she said, 'All right'	
and then she was really good about that and then I would sit and chat with her you know…I just grew to love her. Then we used to sit because at that time we were working until eleven by the last half hour. And she had some really interesting stories. She was just a wonderful little lady.	Discovery
The things she had gone through that she told me that I have never told anyone…I said, 'It was not your fault that these things happened to you. You needn't feel ashamed.' And she said, 'Well yes.' Nobody really understands how someone gets the way they are.	Disclosure
She had been raped by a group of soldiers from the army camp in her little town. And it went to court because she was a feisty one. She told me all the details. She told me all how it went. I said, ' Did they ever get them?' And she said, 'Oh yes because it happened in the army camp. I had to go to court.' The thing is she said, 'They took them away and they went to prison or whatever and they came back to the same camp.'	Shared Privacy
The things that people don't know what makes someone the way they are…She is my favorite.	Discovery

In many cases, the success of the relationships could be determined by duration and consistency of thought or concern - when the care aides indicated that they kept the well-being of the resident almost constantly in mind:

> *I also have a fellow who is really not well at all. And I was worried about him this morning because he wasn't waking. He didn't have breakfast. He is a very fragile diabetic. So there is all of that to worry about and my LPN was a casual…. Well, I said to her that I was pretty concerned. And then I went down. And she said, 'Oh, he is awake now.' And he actually ate some of his breakfast, which was at 11:00 by then, hey? And then I went down and I talked to him and I said, 'How are you feeling?' And he said, 'Oh yeah, OK.' I said, 'Did you eat?' And he said, 'Well yeah, I had my cornflakes so I probably won't have lunch.' But then again, he did. Cause I took it down. And I said, 'I just gave you a bit in case you wanted it.' 'Oh yeah, that looks really good!' So he did eat it. And then I managed to give him his bath afterwards. I said to him, 'You really should have a bath.' He has got wounds that are draining. And, he is leaking. I think it is urine. And now he is in bed, and it is going into the wounds and it is a total mess. So I said to him, 'You will feel better, bathing, you know, after your hair wash and clean up.' And he said 'Yeah'. So anyways, he was fine but yeah, there is a lot that goes on. Even for nine people. It is amazing. (Jane)*

This resident was perceived by the care aide as someone who merited continuous concern and support. The care aide felt that she did not trust the LPN to monitor the resident consistently; therefore she needed to take action. The resident felt that his difficulties were appreciated. The outcome was enhanced when the resident's responses implied that he accepted that he merited continuous concern and support from the care aide.

In addition to thinking about and responding to residents' needs and concerns throughout the day at work, some care aides continued to think/worry about the residents at home after working hours:

> *Often times, I find myself at home thinking, oh they should be doing this by now. I have phoned back to the unit a couple of times saying, the resident wanted this or that. (Susan)*
>
> *And it is even the nights. When I am leaving in the evening I always let the night girl know, oh so and so went to bed later, even if I hadn't written it down, so they will probably sleep well tonight. Or, they went to bed really early, so if they wake up they might need a drink and a little sandwich or something like that. Just a little heads up. (Jane)*

The extent to which the care aides ought to be continuously concerned about the status of the residents compared to the supervisory nurse was not always clearly articulated. Some participants experienced discrepancies between their own expectations and those of their supervising nurses. This could occur, for example, when a resident was moved out of the facility for some reason. For example, when Linda's resident was admitted to hospital, she tried but could not obtain information during working hours about the resident. This caused Linda considerable distress. She felt that she spent more time thinking about the resident than the LPN and RN and it upset her when she perceived that the LPN and RN rebuffed her requests for information and she perceived that they reacted to the illness of the resident in a nonchalant manner. They did not expect Linda to think continuously about or be interested in the health of a resident who was absent from the facility, and she perceived that they were blasé in their efforts at obtaining the information that she sought:

> *Today I went into work and one of my girls (a resident) was in hospital….And I guess she was throwing up. She has been having trouble. She hasn't been feeling good. But it is kind of a shock when you go in and the bed is empty. And, 'Oh well, she is at (acute care facility).' And no update on her! Did anybody phone? Well, nobody has phoned. So you don't know! And you don't know how long she is going to be there. And like I sort of said, 'You know, do you think she will be in – do you think she will be in long?' 'Well, if she comes home!' And I said, 'Well, I certainly hope she comes home!'*
>
> *Are you able to phone (acute care facility) and ask about your family member? On your own? (Interviewer)*
>
> *I can ask the LPN to or the nurse – the RN – to do it. Which I did today, but they didn't have time.*
>
> *Oh! So you are still thinking about this person. (Interviewer)*
>
> *Oh, I will, yeah! And I will make sure that it is an issue tomorrow. I have got to find out. (Linda)*

This story indicates that when care aides feel that a successful relationship has been established, it doesn't matter to them whether the residents are present or not. Conversely, the supervisory staff (LPN and RN) in the story did not appear to the care aide to be too concerned about a resident who was absent from the facility. From the aide's perspective, the supervisors expected care aides to focus on work, and the residents who were present. It was difficult for the care aide to realize that the supervisory staff did not value her relationship with the resident – that it was not significant enough to spend time on a phone call. In addition, the supervisory staff were perceived as not supporting the care aide's need to know. The story illustrates a hierarchy of ability to obtain information, which leads to the next major category in characteristics of good relationships – the value of knowing.

The Value of Knowing

The value of knowing refers to the strong belief of the majority of participants that an enhanced knowledge of certain things would greatly enhance their chances of forming successful relationships with residents. They needed to know, they wanted to know, and they took pride in knowing as much as possible about the residents. For example, Linda spoke specifically about the value of knowing how to time certain aspects of care and the value of knowing that unexpected changes could occur:

> *When you go on the floor you have to look at the whole picture, your whole evening and you have to know each resident and you have to know when it would be a good time to do things, when to bathe them, to take them to the bathroom, to …you have to have it all timed kind of, not just to have a general idea. You have to be really organized and at the same time you have to be really adaptable in case of changes or unforeseen things happening. (Linda)*

Participants felt confident that they knew what would work best for each resident and they would remark, *"I know what will work."* They knew the individual routines for each resident. Knowing enabled them to give better, more thorough care than the casual aides:

> *There was a casual on that family the other day and she (a resident) was ringing….I said, 'She needs to be turned and her blanket taken off.' And the care aide goes down there and she did that and she came back and I said, 'I just know what they need.' I know what they need. I know that at this particular time, she is going to ring and that is what she wants. Or this lady down here, she will ring at 8 o'clock and she wants her snack.*

> *So I go get it and I take it to her because I know that is what she wants. (Betty)*

They described how they knew more about the residents than the supervisory staff:

> *Certain family members, they will come to me before they go to the LPN….And certain LPNs will ask, 'Why are they asking you?' And I say, 'Because I am the one. I know more about them than you. You don't know too much.' (Doris)*

Knowing about the resident was very highly valued among participants and was a primary contributor to a feeling of satisfaction at work:

> *I know everything about them. I like that aspect of my care because I know exactly what works for them. I know what mood they are in. I know what I can do. I know when I can bath them because you get to know them so well….And then the casuals come and sometimes they don't know what to do for certain people….I will show you how to do it because we know these residents so well. (Doris)*

Knowing assured that the care aides would not give up when the work was difficult to navigate. Knowing what would work allowed care aides to have more pleasant, less confrontational interactions with certain residents:

> *I have a resident…she is a little difficult, because certain staff members can't give her a bath at all. Because she will strike out at them….Some staff members, they will walk away. But I just don't walk away. I come back and I come back again. And there are times she will say, 'No, I told you I don't want a bath.' So I go back and I say, 'Today is your special day and you know what? I have a spa waiting for you. You have got to come and see this.' 'A what?' she will say. And I say, 'You have got to come and see this big giant tub full of bubbles!' And as soon as she walks in, I will say, 'Smell that lavender?' But there are certain staff members, if the resident refuses, they don't go back and try it. Like I said, you get to know them, and you get to know what works every time. (Doris)*

Knowing about the residents means that over time, the care aides had tried and refined various strategies to overcome obstacles, such as a resistance to bathing described by Doris. This is experiential knowledge that was very personal and individual. In fact, according to some of the care aides in my study, the formal documented nursing care plans developed by the RNs were not useful guides for them:

> *Families come to us. They know who is looking after mum and who knows how she really is. If they talk to the RN, the RN doesn't know. She will call us up and ask us all the questions. And it is the RNs who are the ones who do up all the care plans. And they don't know these people. I don't understand that part.*
>
> *So you are not involved in the care planning at all? (Interviewer)*
>
> *No! They are asking us, 'Should she lie down in the afternoon?' Should she this? Should she that? Cause they are not doing the care…We are doing the care, and they are just writing down what they know or what sounds good. (Cheryl)*

Many care aides did not bother to access the care plans at all, but quietly gleaned extensive information about the residents as they tried to create conditions that fit with the residents' attitudes and preferences. They felt proud that their experiential knowledge about the residents was more useful, informative or meaningful than the information in the care plans:

> *We don't even know what the care plan is.*
>
> *You don't even know what it is? (Interviewer)*
>
> *I haven't had time to read it. It is pages and pages and pages.*
>
> *How do you know how to follow it then? (Interviewer)*
>
> *I just do what I know what to do. (Diane)*

The Importance of Routines

Routines were an important contextual element in many of the successful and enduring relationships my participants shared with me. Some residents responded best to care aides who knew and followed routines. Consistency in actions seemed to facilitate satisfaction and contentment:

> *It is better for the resident now that you get to know their little routine. And you know them and they know you. They recognize you. And you look forward to going down there and having a routine and getting them up. (Judy)*
>
> *We go in and we give each other a hug and have a little chat and that kind of almost made the day, it was a good day for them and you. (Linda)*

The routines as they were described conveyed something about the nature of the relationships themselves. Some routines were designed purely for pleasure, others were designed to reduce stress caused by undesirable behaviours, while others were designed collaboratively (care aide and resident):

> *Like the one lady, I always take down her yogurt in the evening, with a snack…Watermelon or something. And I will say to her, 'I brought your yogurt down.' And she does talk. People might not think she does, but she does talk. If you leave her long enough she will answer you. And I will say, 'Oh look and see what is on TV.' So that is our time. I will give her, her yogurt and her snack and we will do a little talk. Probably 10 or 15 minutes with her, you know. Yeah. And then I will put her into bed. And a little bit later, the nurse will give her, her meds and I will usually say, 'Good night ####!' and she will say, 'Good night! (high pitched)' And it is always so sweet. And it warms your heart when she answers you. (Jane)*

This routine – part of a nurturing relationship – is comforting, intensely personal, and contains rewarding functions. Every time this routine was performed it induced or reinforced affection between the two.

Routines to alleviate anticipated problems. The next two routines I describe are typical of guarded relationships. In the face of present and future difficulties, sometimes the most appropriate and least distressing adjustment was to follow a routine:

> *I remember…this one lady in particular….Just mean! Down right mean! And I thought wow! Just everything. From laying out her clothes to the way you handled her walker when you gave it to her…preparing her snack when she went to bed. You had to put the plate out on the counter. And you know, of course I want to do the right thing for these people. Anyways, so the second time (assigned to the resident) I was almost sick! Cause I had never really had such a difficult time that I didn't feel that I could handle. Anyways…I sat down at report. And I sat down with another girl who was familiar with her care and I wrote down step by step instructions of everything that had to be done….There was a little round thing that the Tylenol had to go in. And it had to be put on the edge. Not in the center of this little dish. So…where the clothes went, where the socks were to be laid on the edge of the chair. Everything….And then at the end of that second night, she thought that I had worked there for a long time. She didn't see me looking at the paper, which was great! But she was really mean about everything. Like there was just nothing you could do right. Even if you said, 'Oh, OK I am sorry, you tell me where this goes.' 'Well, I shouldn't have to tell you! You should know these things!' But anyways, so by the end of the second shift I had mastered that. So I wasn't new anymore and it was great. But definitely, step by step. Notes of exactly how to do everything right down to that Tylenol that sat on the edge of the plate. How you handed it to her. (Paula)*

In this relationship, the resident needed or expected a very specific routine to be enacted by the care aide, irrespective of who that care aide happened to be for that shift. Rather than forcing or negotiating an individual relationship with the resident, it was easier for the aide to conform to the resident's expectations of purely mechanistic interactions. Another participant told me how she would use the same morning routine to start the day for a resident who often found waking an ordeal:

> *I used to go into one fellow who could be…very difficult. But it was always 'Good morning sunshine! How are you? Look at the beautiful day that I have ordered for you!' And I would always go in early, early and open the blinds. So that the natural light would wake him rather than anything else. And I would start off like that. Make sure that I leaned over and – not close. Just over so that he could see me. And 'How are you today? I have just come to help you get up.' I would say virtually the same thing every morning. With very little variance in it…It didn't matter if it was rain. I would say, 'Oh, it is a beautiful day that I have ordered*

> *for us! – a little rain for the flowers.' And, start getting him dressed that way. And that would sort of give him a calming time. (Jane)*

Both Paula and Jane were compelled by conviction and circumstances to decide beforehand what they were going to do and say because they were assigned to residents whose behaviours/actions were either difficult or unpredictable. The primary motivation behind the routines was to reduce the potential for distress. Every day the residents were acknowledged as before, with the same concern as before, with the same compassion as before, with the same patience as before, with the same tenderness and grace as before. The routine supported Paula and Jane to maintain their composure and do their best work. The residents' dignity was preserved and peace, tranquility, and efficiency were promoted. Jane used *sunshine* and *beautiful day* as metaphors for goodwill and peacefulness.

Betty described a third type of routine developed in a cooperative but friendly relationship – a routine based on a good working partnership facilitated by efficiencies:

> *I know exactly what he likes. If you don't know his routine, it is up to an hour, because he will walk you through everything - how to do this, how to do that. But now I just do it and we just talk while I am doing everything, so it goes quickly. We are friends….You have to follow the routine…if he gets a casual, he gets very frustrated. They don't know how he likes things, and he has to explain each detail to them.*
>
> *So what is his routine? (Interviewer)*
>
> *The first thing I do is start the water because his water has to be hot, then I empty his catheter. And then I take his pillows out….And then I start with his face – very hot water. And his underarms, belly, and then I move down towards his catheter site. And I have to do the care there…And then I get down to his feet and I have to put cream on his feet and do care with his feet because he has problems with his feet. And then do his socks. And*

> *then I get help at that point because I need to turn him….So then we turn him and do the same thing on the other side. And at that point, I am alone again. Then I put him in his chair, adjust him in his chair, so that he is perfect and then I put his shirt on…do his teeth and then I put a towel on his lap – it has to be a certain way. And his slippers, adjust his feet, adjust him, takes like sometimes for quite a while, and then put his catheter and hang it on his chair, put his blow gun where he needs it, put his tray on, his glasses, then he is good to go.*
>
> *So how long does it take you to do that routine? (Interviewer)*
>
> *Half an hour. Because I know his routine. (Betty)*

In summary, the process of forming successful relationships with residents begins at the very first encounter between a resident, the resident's family, and the care aide. The care aides in this study were best able to form successful relationships with residents if they were able to:

a) Gather many details about the residents' lives prior to institutionalization so that they were aware of things that had previously mattered in the residents' lives.
b) Converse with residents which stimulated their interest in residents and helped them to persevere.
c) Negotiate with the resident about the constraints of institutional life.
d) Perceive and acknowledge the residents' own appraisals and/or definitions of their situations.
e) Successfully diagnose the resident's situation and determine what the resident needed most (encouragement, support or acceptance etc.).

Established relationships were marked by the following characteristics:

a) Keeping the well-being of the resident almost constantly in mind while at work.

b) Continuing to think/worry about the residents at home after working hours.

c) Concern for the resident whether or not the resident was actually present in the facility.

d) Pride in experiential knowledge of the residents such as individual routines for residents designed purely for pleasure, or to reduce stress and preserve peace, tranquility, and efficiency, or strategies designed to overcome predictable obstacles such as a resistance to bathing.

Care Aides' Contributions to Successful Relationships

I move now to the second part of the first theme "Desiring and Creating Ideal Relationships". This is a description of the care aides' individual contributions to successful relationships, which consisted of provision of protection for vulnerable residents and assuming a surrogate family role. Many participants persevered with their contributions because of the satisfaction they gained from successful relationships. However, a negative outcome (guilt) occurred due to discrepancies between what the care aides knew was desirable (what would best promote a resident's wellbeing), and their abilities to obtain what was desirable. Sub-themes are outlined in Table 4.

Table 4.

Desiring and Creating Ideal Relationships:
Care Aides' Contributions to Successful Relationships

Sub-Theme	Categories
Providing Protection	▪ From insults ▪ From inadequate or incorrect care ▪ From organizational constraints/cost cutting strategies ▪ From technological innovation ▪ From painful information
Assuming a Surrogate Family Role	▪ Alternative family member for a resident ▪ Alternative family member for a resident's spouse
Received in Return	▪ Recognition ▪ Acknowledgment ▪ Appreciation
Feeling Guilty	▪ Struggling with inappropriate placement ▪ Struggling with inadequate resources ▪ Constrained by managerial decisions

Providing Protection

In this section, I focus on care aides as protective resources - what they were actually able to provide when they chose to ease a difficult situation for a vulnerable resident, whether they offered their skills, their knowledge, or themselves in relationship. When care aides were asked which residents they felt closest to, some of the participants reported that they felt particularly close and dedicated to the residents who were rejected, alienated, neglected or forsaken in some way by others, often, as the examples below illustrate, because a resident was overtly perceived by others as difficult:

> *Sometimes too if you latch onto residents…that other people don't have patience for…if they are really attention seeking, other people just tend…try to avoid them maybe or they just do the minimum to get away because they are very trying, calling out, and sometimes if you get a fondness for them that really helps them and they really do settle down. (Linda)*
>
> *I have one lady…she has all kinds of problems…When she first came, everyone was terrified of her. She was screaming and yelling and tearing around the unit in her wheelchair and crashing into things….People were scared of her. She is a scary looking woman. You know how you get used to residents, but (she) is a scary, big headed woman. Her hair is really thinning and her face is really big. I don't know what is really wrong with her and you get used to her, but you don't realize that other people are really scared of her when they first see her. And I just love her. (Susan)*

They often provided vulnerable residents with protection from insults. For example, during an election, one of the facilities was used as polling station. The manager asked Susan to remove the resident she described above from the polling area:

> *The manager came, and she said, 'Oh, would you mind going to get ####. She is up at the front and the people (running the election) are coming in and I don't want them to see her.' Well, that is rather rude! I don't want them to see her? That is rude, you know. She lives here. This is her home. She can go there if she wants to. Yeah!*
>
> *You sound kind of protective of her, really. (Interviewer)*
>
> *Yeah. We have a care aide, and he said, 'Oh there are some people that I won't be sorry when it is their time to go.' And he kind of looked sideways at me and I said, 'Don't you even go there!' And the other care aide said,*

> *'Don't do that! That is Susan's favorite!' He said, 'Really?' And I said, 'Yup. Don't be saying anything bad about her!' (Susan)*

In addition to protecting such a resident from insults, a care aide might protect a vulnerable resident if he or she did not perceive that the LPN was providing adequate or correct care:

> *So, some of them (LPNs) don't know….They don't know the people…They don't know the tricks. Like one lady is quite resistive to taking her medicine. And they are like 'Well, she won't open her mouth!' And this and that. And I will say, 'Well, just give me a minute and I will get some yogurt because she loves yogurt. So then she will open her mouth for the yogurt and you slide in the medicine'…You know that part too is demanding! Because you are trying to cover and help them. (Jane)*
>
> *We have had people who haven't eaten for five days and on day three they (the LPNs) start freaking out and are going to give them the suppositories. And we have had people given suppositories and then we have had to transfer them (to acute care) and then they have died. Like that is their priority. You can't send off this person if they haven't had bowel care. That is their priority. And we are saying to them (the LPNs), 'Don't give them that!' (Cheryl)*

At other times, care aides protected residents from managerial decisions perceived as unfair towards, or particularly harsh for residents. For example, even though Judy was told not to use the expensive cream for her resident, she obtained the expensive cream anyway:

> *To me (the management) don't care. They do not care about the residents, they just care about the budget. They even tried to take our Kleenex away!*
>
> *So you are well aware of the budget. (Interviewer)*
>
> *Yeah. And I said, 'What are we going to do without Kleenex? Put a role of toilet paper on every table?' (laughter). So they did end up giving us the Kleenex back. But with certain people, like we have one lady who has such fragile skin, but 'You can't use that (cream). It is very expensive.' But you know, we use it anyway! And they will say, 'Just take a little bit!' I just go and take it. I don't care! You know, they (the residents) deserve that! And there has got to be money for that!" (Judy)*

They described how they were willing to go to some lengths to find the resources needed by their residents. In the following example, when Cheryl was told that her resident had used up her supply of special incontinence pads and could have no more, she described the measures she had to take to ensure that her resident had the incontinence pads that she needed:

> *They are now counting pads. And pads are kept under lock and key.*
>
> *They are under lock and key? (Interviewer)*
>
> *Well, the little white pads are. The little white ones. Certain people are designated to count them out. They are locked in the med room…I have to knock on the door and finally it will open and I say, 'I need some day-lites'. And she (the LPN) doesn't want to give me them for our little 103 year old! That is all she needs. Because they are so terrorized by the manager…and she debates. And I say, 'Are you going to go down there and tell her that she can't have any more until the day after tomorrow? Or are you just going to give me six?' And she was really debating what to do…Horrible. They need it. And it is not like I am asking for gold – well maybe! (Cheryl)*

During another interview, Carol and Brenda described their disgust and reactions to policies implemented to cut down on the number of incontinence pads used by residents:

> *So one day, I took this poopy pad off the resident. I have the pad in my hand. I brought it out to put it in the garbage. (Carol)*
>
> *Hmm mmm. (Interviewer)*
>
> *My boss walked in. There was like this much poop on the pad. A smear. It wasn't full. But there was…(Carol)*
>
> *A smear. (Interviewer)*
>
> *Yeah. So anyways, I have it in my hand and I am throwing it in the garbage. She says, 'What are you doing?' I say, 'I am just cleaning somebody.' She says, 'Hold on to that pad!' So I am holding on. I knew what she was doing, because she did that a million times. She came in.*

> *She opened the pad. She goes, 'This pad costs $1.25. This pad could be on the resident for another five hours. You took this pad off. It costs the company a lot of money.' 'But there is poop in the pad.' She says, 'Not enough!' Not enough. You know what? I throw that pad and I said 'I quit this job! (Carol)*
>
> *This is true! (Brenda)*

Carol, Brenda and Cheryl all tried to protect their residents from organizational restraints imposed by cost cutting strategies enacted by the management. Some resources for residents were under lock and key, suggesting that managerial staff did not consider care aides to be legitimate sources of knowledge of residents' needs for resources.

Care aides also found themselves shielding residents in several other ways. Multiple participants described their frustrations with the new "no restraint" policy implemented to ensure that residents' movements or behaviours are not restrained in any way. For example, all residents were provided with new beds without side rails because bed rails that cannot be opened by a resident are considered to constitute a restraint. Judy was especially angry when one of her residents fell out of bed and suffered an injury:

> *We have these new beds, which are supposed to be more home-like. No rails. Live at risk. We have had this lady in there for seven years who was in a bed with two rails and never fallen out what ever. And I told the OT, 'That is not good for her! Can't you give her ½ rails?' And she said, 'Oh no! Everybody is going to these new beds.' And she (the resident) kept leaning over. The woman falls out of bed, hits her head on the dresser. Stitches all through….And she is still black and blue. And I was really mad! (Judy)*

Doris described how freeing one resident from a lap belt must be balanced against the needs of all the other residents (the workload). She felt that the "no restraint" policy had put one resident in danger of falling out of her wheelchair.

This resident could not be watched closely if she was in her own room or in the dining room because the care aides were busy looking after the needs of all the other residents in other rooms. As a result, the care aides felt frustrated with the policy:

> *And you cannot take her to the room because she will fall out of the chair. She will put her feet up on the ledge and try to get out….You have got to understand what we are going through. There are two of us down there. We are down there, in the hall. She is in the dining room. She is going to fall out of the chair because you don't have one-on-one…. How do you think we are going to be down there bathing, getting people ready, and still keep an eye on her because she is constantly getting out of the chair? She fell so many times! It is so frustrating! (Doris)*

To reduce the risks for falls and elopements, bed alarms and wheelchair alarms (wander-guards) were introduced. To reduce the risk for fractures, special pants with hip protectors were introduced. However, the participants felt that these alarm devices and clothing options did not offer significant additional protection from injury and actually reduced the residents' quality of life:

> *Live at your own risk! But they have all got alarms hooked up to them…We have got these bed alarms….but it is not good for the resident because when they move it makes this huge loud noise. It wakes them up and it wakes the whole room up. They (management) just do not get it!...They (the residents) have got these big pants with big pads. And half of the residents are going, 'What are these?' They don't want them! Would you like to be walking around with pants like that? (Judy)*

The participants expressed a considerable amount of concern that the real dangers/risks faced by residents were obscured by technological innovation. Even if technology had been implemented to safeguard the residents, the responsibility for the residents still fell on the aides. In this next example, Jennifer recalled a resident who tended to wander away:

> *The doors are supposed to block her, but they won't. They won't. They absolutely won't…and they have the wander-guard on the chair, but she is so fast….She gets through and then the doors lock. And then she is out the second set of doors….What are we to do? Cause there are flaws in the system….the monitor is right there, so you can see the lobby. But you can only see to the doors. That is it. You can't see outside.*
>
> *So if you look at the door, she is already past it? (Interviewer)*
>
> *Yes. It is scary.*
>
> *Who looks after (this resident) when you are in the tub room – bathing someone? (Interviewer)*
>
> *Who looks after her any other time? I can't take her along with me. The general public has no clue what we do, what we go through, and what kind of risks their people are at being in there….Anything can happen. (Jennifer)*

The participants indicated that technological innovation could not take the place of timely care according to residents' routines:

> *I try to get them up. Because if certain people, if they are not up, they will crawl out. They get out. They go to the edge. So then the bell rings. So it is better for us to get them up. (Doris)*

Lastly, sometimes care aides protected residents from information that they perceived would be too painful for the resident to bear. For example, Jane had particularly close relationships with several vulnerable residents. She described how she had protected two of them from the truth by evading questions or lying. For example, one of these residents had had a "hard life". When he started to bleed through his catheter, she "came up" with an explanation to protect him from worry:

> *He was having a bath, and then he sat up and all the blood rushed into his catheter – he was scared! And he said, 'Oh my God!' And I said, 'Oh, it is OK. It is probably from the back splash or something.' I came up with. You know? You know. Like, Jesus! I was like, Oh my God! You*

> *know?....So we are close. I mean, you worry about him. And he has had a very, very hard life. (Jane)*

In the following poignant narrative she described to me how she had consoled another very vulnerable resident by protecting him from a truth:

> *And I had one fellow…He was new and he said, 'I can't believe it!' He said, 'Everything is gone! Everything is gone!' And he said, 'My grandson came in and I said that I wanted to go by the house. And he said it is all gone grandpa. It is all sold! Everything is gone.' And he is telling me this at 10 o'clock at night. And the moon was bright. I was on rounds and I went in and he was just laying there. And I said, 'Oh, can't you sleep?' And then he started to sit up. And thank God I had time. And I sat down. What do you say to somebody like that? You can't say it is all right, because it is not! You know?*
>
> *Hmm mmm. (Interviewer)*
>
> *And you know, his wife of 68 years wasn't with him. Still alive but in a different facility. And he said, 'Somebody said that she has Alzheimer's and she won't remember me.' And I said, 'You know what? That is not true!' I said, 'I looked after a lady and she never forgot. She always remembered him.' And he said, 'Really?' And I said, 'Absolutely!' And I crossed my fingers! Sometimes you lie! To be kind, you lie! And he never saw her again, so I am glad that I did lie!*
>
> *He died? (Interviewer)*
>
> *Yeah. Very unexpectedly. I think that he just gave up. You know, sometimes you see that in their eyes. They don't want to be here anymore. (Jane)*

In summary, the care aides in my study often acted as protective resources for more vulnerable residents. They were able to provide these residents with protection from insults and often tried to protect them from perceived inadequate care by other health care professionals. At times, care aides protected residents from managerial decisions perceived as unfair or particularly harsh for residents. They described how they were willing to go to some lengths to find the resources needed by their residents.

Several participants described their frustrations with new policies and technology such as bed alarms and wander-guard alarms. They complained that the real dangers/risks faced by residents were obscured by technological innovation and that they felt the brunt of the responsibility for residents' safety.

Lastly, sometimes care aides protected residents from information that they perceived would be too painful for a resident to bear. In the next section, I describe how care aides often went beyond their work role expectations, which was to provide care using the organizational or resident resources, and took it upon themselves as individuals to seek out creative ways to enhance their residents' quality of life.

Assuming a Surrogate Family Role

In a number of ways, care aides willingly became alternative family members for the residents, especially when the residents had no relatives, their relatives were non-responsive, or their relatives were living far away:

> *I have a lady that has no one. Well, she does have family, but not in town. But I pick up shampoo, and things like that. Little shopping things. Yeah, we do that. And I don't even know if we are allowed. I never ask for permission. Little Christmas things. A blanket for one fellow who didn't have any family. Little things like that….Like the one fellow who I bought the blanket for, calls me mum. He started calling me mum. And I used to look after him all the time and he is one of the ones that I pick up now when the short shift goes home. And he will call down the hall or he will actually phone the front desk 'Tell mum I need her.' And some of the girls think 'What?' So, yeah. I don't know why he started it. And he actually feels really close in that relationship. And he almost relies on me a certain amount. Even though I don't do his actual care anymore. And he will ring after hours. He will know that I am on. And so I will go down. It is more to talk to him. Yeah. And he will say, his sister phoned. Or this or that hey? (Jane)*

Rather than being objective about their work, most of the care aides in my study were very committed to forming relationships with residents that were full of feeling, and they truly attempted to serve all of their residents' needs as they would their own family member:

> *I think that a lot of us are very fond of certain people. The other care aide that I work with quite often, she has a younger lady with MS and she will do special things for her like colour her hair. (Susan)*

Judy and Jane thought about some of their residents as their own family members, which they demonstrated by recalling a family or insider joke, or by sharing family stories with the residents, or on occasion, actually referring to themselves as a member of a resident's "family". These close relationships gave the care aides a lot of pleasure and satisfaction in return:

> *Like for instance, this guy, like I guess he was living in a van when he came into (the facility)…I ride my bike to work every morning and I touch him with my cold hands and he says, 'So you rode your horse today did you?' And then, like I brought him in last week a pair of gloves. 'Here you go.' Cause he likes to go outside. So I brought him a pair of gloves. Stuff like that. It is like a family right? (Judy)*
>
> *And, like with this fellow that is sick now. We are very close. And he calls and he says, 'I have never had so many mothers in my life.'…And I will say to him, 'That is no way to be doing that! You are going to be ending up sick or something like that.' And I will say, 'You know mother knows best!' And he just laughs and goes along with it. But we are very close too…..I talk about my family at home and share that part of my life with them which I think is important. And my grandson said – he will be eight next month – and he has got a little girlfriend. And they went swimming. And I made sure that I told, the ones like the fellow who is not feeling well and that. 'Oh, you will never guess what the youngest one did.' And I go on about the girlfriend and that she wore this little hat. And her pink leopard skin coat – at seven. And they laugh and they enjoy it! And they will say, 'Well how is so and so doing?' And then they will tell me about their family or their grandchildren. And that is part of it too. You have to share a little bit of yourself beyond your skills. I think that is part of it. You have to give a little bit of yourself to them" (Jane)*

Many other care aides offered small gifts to certain residents such as personal products, bath products or clothing. These care aides were centered on the residents' whole situation and were working for the residents out of bounds of what they were contracted to do by the organization:

> *We have so many care aides who will bring stuff in for the residents…Like they will bring body lotions and stuff that the residents need…My mum passed away two years ago and I brought in all her clothes for my one lady. And we will go to the laundry to find things. Like we just 'shop' ourselves…We have a lot of people who don't have anything. (Judy)*
>
> *Sometimes I bring these products like the lavender out of my own home. And I have asked to family members to bring, but you wait and wait. Tooth brush, tooth paste, I bring that out of my own home. (Doris)*
>
> *Because you can't wait any longer? (Interviewer)*
>
> *No. (Doris)*

These types of familial relationships contrasted greatly with the objective, distanced organizational expectations of relationships. When a wing in one of the facilities was divided and the residents were transferred or re-assigned, I asked one of the participants:

> *Did you have any choice about which people were going to be in your family (assignment)? (Interviewer)*
>
> *They divided the whole unit up. And they only started it at one end and first aide went to one family and the next aide went and it was… What if you had a really good relationship with #### and you said, I want to keep ####… That didn't happen. That didn't happen. You ought to love them all right? I had a couple of residents who were a little annoyed and said, 'Why aren't you with me anymore?' And I said, 'Well that is the way they divided the wing and that is the way it is.' Occasionally if you have time and they would say, 'Oh can you come and help me?' and you would go when you had time. No there was no choice in residents or anything like that. (Susan)*

I put the same question to another participant in a slightly different way:

> *Do others understand the significance of the close relationships between you and the residents? (Interviewer)*
>
> *Sometimes they (the RNs) don't remember that you have become close to people. And it is kind of harsh! It is like when people die. You know? 'Well, could you get some boxes and pack it up because we have got somebody else coming in and we need to clean up the room.' And you are like, 'Excuse me!!!' You know, I looked after the one lady for the eight years! You know? And it was kind of hard. 'OK, let's get her room packed up!' And I am like, 'Geeeezz! She is just - this is still her room!' You know? And that is…it is part of your job and of course you accept it, but they don't give you time to really accept it....We had an RN come in one night and we said, 'Oh the lady just died and ah'…it wasn't in my family but I knew her, 'just died on the other side' and she said, 'Oh have you bagged her?' and I went, 'Pardon me?' And she said, 'Oh, I hope you didn't take offence, but I work (in acute care)', and I thought you bet I took offence! You bet I did! And I am sure it showed on my face because she sort of stopped in her tracks. Like what are you talking about? How callous! I don't care if you do work (in acute care). You're talking about people and you are talking to people that looked after them. You don't talk like that! (Jane)*

I have described how many of the participants formed close relationships with residents similar to familial relationships; however, residents were not the only people in need of companionship. In this study, relationships were not necessarily dyad based relationships confined to care aide and resident, but resident and family and care aide based relationships.

The care aides in my study were aware of the needs of the residents' relatives often as much as they were aware of the needs of the residents. For example, Jane described how "sharing a little bit" of herself sometimes evolved into becoming an alternative family member for a resident's spouse. Spouses also needed someone to laugh with them, rejoice with them and eat with them. Spouses yearned for companionship – and sometimes found a kindred soul in a care aide, if their joys were like their own:

> *I looked after her (the resident) for so long. Her husband came in every day. And every day, fed her lunch. And every day, fed her supper. And the three of us were… She had Huntington's so she wasn't able to speak any longer. And I think she understood what we were saying sometimes. Minimal. Minimally. So we would always talk and include her. And I would say, "Isn't that right ####?' Even though she didn't speak or anything, I think she recognized me when I came in. We would talk and…he would come in when it was happy hour and he would have his lunch with us. It became kind of a whole family unit within itself hey?….I like them to think I am part of their family. (Jane)*

Sharing a little bit of oneself by becoming an alternative family member became particularly important at the end of life:

> *And sometimes I think even – we can't say that – but we can get closer to them at the end than their families are. You know? That sometimes we are the ones that they want to be with at the end of things. Or we are there. Sometimes families don't come in. Sometimes they do, or sometimes they don't want to. (Susan)*

When a resident died, it could be very difficult for the care aides and the families/spouses to let go. Consider this particularly moving description of "Saying Goodbye":

> *But like I said, I feel it when they go, and we don't even have time to really even say goodbye. And that is another thing too. At (another facility) we were allowed to go to funerals. If we had been the one who was looking after. They would say, 'Oh yeah you can have the time off for an hour or whatever', and a few of us used to go…It would be one or two of us would go and attend. Which was really nice for the family too because it gave them the sense that we really had cared instead…I never get to go because I am always working.*
>
> *Have you asked to go? (Interviewer)*
>
> *I don't have to ask. I know I wouldn't get the time off. They wouldn't let me. But you let the family know when they come in. They always come in with candy and flowers and stuff as a thank you. You always let them know then that you really enjoyed looking after mum or dad or husband or wife or something and try to give them a little support while they are there. This one fellow I looked after…his wife came in the one that had to have him up every morning and made herself quite a pain in the ass for a lot of them (laughs)….But you know they had been married for years and*

> *years and she had his best interests at heart. She lived alone. She came in and said, 'I would really like it if you could come.' I said, 'I would really like it if I could come too but I am working.' I said, 'But you know I will be thinking of you. And you will see me running.'...And I always run by #### field and she lives down that way. And I said, 'You will see me running there huffing and puffing as usual' and she said, "Oh yeah!.' She said, 'If I see you I will wave!' and I said, 'Oh yeah, but don't expect me to wave back because I don't have the breath to raise my hand.' She laughed. (Jane)*

What is important in this story is that Jane perceived that she would not be able to attend the funeral, so she found an alternative way to say good-bye to the resident's spouse.

Received in Return

Even though the participants told me how hard they had to work, and how the organizational culture and structures often impeded their efforts to meet the needs of their residents effectively, many persevered because of the satisfaction they gained. This satisfaction was often derived from the resident's show of support, acknowledgement, and appreciation. Sometimes it was a very simple act of basic recognition:

> *Right now I have several residents with dementia, such that they do not know you one day to the next. And yet other days, they will be right on and say, 'Oh, you are back! Did you have a good holiday? (Susan)*

> *Especially when you go to work and they smile and like, 'Oh!'. Recognize you. And they are happy to see you. 'Oh, you are back!'....That makes my day.... I love it when they smile at you when you come in the door....That makes it worth going to work. (Diane)*

> *Yeah, even after you have a couple days off...Like after my holiday, (a resident) who never talks basically, really. She says, 'Oh! Where you been?'.... It can be very depressing. But those little moments – 'Where have you been? (Jennifer)*

In the next theme, I explore a negative outcome of successful relationships - guilt. A negative outcome occurred due to discrepancies between what the care aides knew was desirable (what would best promote a resident's wellbeing), and their abilities to obtain what was desirable.

Feeling Guilty

"Feeling Guilty" represents an outcome of the care aides' concern for, and knowledge of residents' individual needs and desires. Care aides who had formed caring, benevolent relationships with residents often felt guilty about the care they were able to provide because a) the residents were inappropriately placed, b) they struggled with inadequate resources, or c) they couldn't do anything about a) or b):

> *We have had this lady who was on dialysis. She has now passed…she died at our facility…Anyway, I feel really bad about her death. There were several factors.*
>
> *You feel guilty? (Interviewer)*
>
> *Yes. Absolutely! She was on a special mattress. She was on an air mattress and she was quite slim. The OT took it away. Took it away! Because it had a hole in it. To be repaired. Well, she could not get comfortable. She was distraught. And she kept saying, 'I can't get comfortable'. Well, she did not have enough money to buy her own so they gave her mattress to somebody else. They documented that it had a hole in it.*
>
> *So you don't think there was a hole? (Interviewer)*
>
> *Well, the RN - I was talking about the hole in it and the way she was looking at me, and I said, 'You lied to her?' and she said, 'What are you going to do with a person who is like that?' But it was charted as a hole. And she was so distraught from that. It was probably her last straw. And she did go to the hospital….And we were told to wash her up before the ambulance came. And at that time, she was pretty out of it, but she said to me, 'No, I do not want it! Just so you guys can look good? No!'….She should have been palliative care! (sighs). She should have been placed*

> *properly! Which is the manager's job – to check all that out….And we just let her down! (Cheryl)*

The care aides thought a lot about the residents; they wanted to respond to them but they could not. They felt they knew what was going on, but they could do nothing about it. In the following example, Allison struggled with inappropriate placement and inadequate resources:

> *We were unable to take care of him the way we should have. We did not have the proper equipment for the longest time. We struggled to toilet him because we could not fit the lift into his bathroom. Cause we are not really set up for having all the lifts.*
>
> *So why didn't they move him to the other part of the building where there are lifts? (Interviewer)*
>
> *Well, we are technically not set up in any part of the building….He was going to go downhill really fast. And they said that once he started to go downhill, they would move him out. And they didn't! And he actually got so bad at one point that they actually had to call an ambulance.*
>
> *So he got so bad with his breathing or? (Interviewer)*
>
> *Ummm, he couldn't talk to us anymore…So we just called the ambulance. He was moved to the hospital, and then into hospice care. And then we felt bad because of our struggles. (Allison)*

Some participants clearly expressed frustration because although they had successfully analyzed the resident's situation and determined what the resident needed most, they were constrained by management decisions. In the next story, the care aide prides herself on the care she usually bestows, but when management made a decision to place a cognitively well resident in the same room as a resident with dementia, and would not be swayed to move the cognitively well resident, she ended up feeling guilty because she felt powerless to meet his need for a more suitable room-mate:

> *I am an excellent at what I do and I don't pull any punches in that respect! My focus is to try to get the needs met for the residents that need it the most. Each one is unique; each one has different levels of needs. But when this resident came on it was like at the time this person was a three person (lift). So we didn't have the staffing levels to meet those needs. He was kind of thrown onto our Unit because they had no place to put him. They had no place to put him where he would settle in nicely….He was put into a room with another resident who calls out a lot and this guy is cognitive right. So he is having to put up with this on a daily basis or every night when you put him into bed….So that was brought forward many times and it was stressed by this cognitive resident that he wanted to get into a room where he could actually have a room mate that was cognitive like he was so he could have someone he could chat with expressing his needs on what he would like. But still nothing has been done. So they are looking into it but whether or not they will actually have something done or not, I do not know. I know that management is saying that this is the room that he is going to be in. He does not have a choice. I am thinking well that is really not meeting the needs of the resident….Pretty much she is saying well you have to suck it up. This is the resident, and this is where his home is and these are his needs. That is what you are going to do for him. It is just to meet the needs whatever, but she contradicts herself. It is all about the residents but yet on the other hand well this guy does not really have choice in the matter. This is where he will stay….He is not in place where he wants to be….When he makes those demands (to move)…I feel guilty because I can't give him the required care that he is asking for. (Kathy)*

Cheryl described lack of resources – a predominant theme in my participants' stories:

> *We were intermediate care when I started there. That is why the rooms are, if you ever saw the rooms, they are little kitty-corner things….When somebody (a resident) got to the point where you (staff) couldn't handle them – because we only had manual lifts in the hallway, once they turned to extended care, they went to (another facility). So then they changed the whole system so that we became extended care. But, they would bring all the equipment, all the lifts, and so forth. That is what they said. But we still don't have all the lifts. We still don't have all the lifts. (Cheryl)*

In summary, the care aides who had formed caring, benevolent relationships with residents were often unable to respond to their concerns about inappropriate placement, inadequate resources, and managerial decisions. Because they felt powerless to evoke change, they felt guilty about the care.

Although the participants in this study felt powerless to evoke changes described above, they were still motivated to contribute to the residents' wellbeing by making changes that did not require external resources or managerial authorization.

Theme One Summary and Interpretation

The dominant theme in this section was "Desiring and Creating Ideal Relationships". First, participants shared several ideals or taken-for-granted aspects of a collective consciousness, which supported their beliefs about the attainment of an ideal occupational relational purpose or state. This general ideology involved humanitarian ideals and values, occupational ideals such as altruism and compassion, and explanations of why they chose the job in the first place or why they continued to stay in the job.

After the general ideology was defined, the participants shared the salient aspects of their most successful relationships with residents. They described an initial period of exploratory testing and negotiations with the residents, which could extend to the families of residents. This was often followed by a period spent gathering details about the residents' lives prior to institutionalization. Gathering information was best facilitated by conversations with the residents.

The care aides came to acknowledge and believe in the residents' own appraisals and/or definitions of their situations. Increasing degrees of intimacy often led to discoveries, disclosures or shared privacies. The most successful relationships were marked by duration and consistency of thought or concern -

when care aides indicated that they thought almost constantly about the well being of the residents.

Care aides explained how they knew what would work best for the residents: they knew the routines; they felt that they knew more than casual care aides; they felt that they knew more about the residents than LPNs or RNs. Some care aides were dedicated to residents who were rejected, alienated, neglected or forsaken in some way by others and they provided these vulnerable residents with protection from insults, poor care practices, managerial decisions and some truths.

Participants described how they shared a little bit of themselves by offering small gifts to residents, how they had become alternative family members, and how they provided companionship to residents' spouses. They also described how they received special gifts in return - sparks of recognition from the most reserved, withdrawn or uncommunicative residents.

Coinciding with knowing what would work, were feelings of guilt about the care they were actually able to provide. The sorrow of saying goodbye to residents and families was tangible as was the belief that others should, but often do not understand the significance of the successful relationships.

Theme Two

Workplace Realities

This theme is concerned with workplace factors that my participants perceived to negatively influence their relationship with residents. Many of the participants described relationships with residents that were unsuccessful or constrained in some way because certain workplace issues could not be resolved.

In order to form an in-depth understanding of the personal, situational and environmental factors that determined strained relationships, I asked the participants to describe specific situations or events.

Sub-themes related to the workplace factors that impeded relationships between care aides and residents are outlined in Table 5.

Table 5.

Workplace Realities

Sub-Theme	Categories
The Pressures of Increased Responsibilities	▪ Too many tasks ▪ Too large an assignment Not enough time to feed residents properly ▪ Not enough time for warmth and spontaneity
Organizational Expectations of Unattainable Efficiencies	▪ Incorrect calculations of time required to complete care ▪ Mechanical prescriptions for time management ▪ Dissatisfaction with the universal or versatile worker role
Inability to Obtain Help	▪ Inability to obtain help from RNs and LPNs ▪ Afraid to ask for help ▪ Fixed definitions of roles ▪ Managerial promises to LPNs
Weathering Persistent Stress	▪ Responsible for resident assessments ▪ Responsible to communicate information ▪ Unable to verify quality of information ▪ Mental and physical fatigue ▪ Viewing residents as burdens or loads ▪ Focusing on own health ▪ Emotional breakdowns at work

Many of these sub-themes are congruent with those found in the literature such as: not enough time in the day for care aides to get everything done, high ratio of residents to aides, or high acuity level of the residents (Eaton, 2000;

Kayser-Jones et al., 2003; Kristiansen et al., 2006; Lin et al., 2002; Riggs & Rantz, 2001).

The Pressures of Increased Responsibilities

The first key issue influencing relationships between care aides and residents was work overload. The general work environment/work culture and pressures for performance tended to negatively affect the nature of the relationships. Many of the participants described feeling frustrated because they were so overloaded with responsibilities and work that they no longer had time for thought and reflection. The probability of these care aides forming close relationships with residents was reduced because they were perpetually torn between feelings of compassion for residents and feelings of resentment about the workload. They felt that they had too many tasks and too large an assignment.

However, the most commonly mentioned time concern for the participants in this study was not enough time to feed residents properly. Janice described asking for help by reporting to the RN that her residents needed assistance at mealtimes but that she did not have to time to provide that assistance because she was still busy assisting other residents to get out of bed and get dressed. No one helped. She described her efforts to provide food to her residents by making adjustments: she fed some of the residents in installments, she fed some in bed, and she fed some residents quickly, but in the end, many of her residents did not receive enough food:

> *I say (to the RN), 'This person needs to be fed because I have four more that needs to be getting up', but nobody feeds. So sometimes they go without it.*

> *They go without it? (Interviewer)*
>
> *Yeah. Sometimes what I do is I feed them when I go to the dining room and I take another resident. I feed a little bit and then. But most of the time they do get it but some of the time they fall asleep and then they don't eat it and I am still getting people up. So. Sometimes they don't eat the whole breakfast. Sometimes I say, 'Could you feed this person?' and it doesn't happen. They are busy too. So it is all about staffing. We don't have enough staff members to give the proper care. Sometimes family comes in because some of the families they know…. (Sometimes) I just have to do it quickly. Like some of them, I feed in bed. I do it. You know, I am always like this (demonstates feeding motion). I have more people to get up and I have other people to feed. So we have too much workload and not enough human resources. (Janice)*

Judy also described never having enough time to feed her residents. In the facility where she was employed, a different person was designated to assist with meals, which meant that Judy never spent any time with her residents at mealtimes. She described her residents who needed assistance at mealtimes as "feeds" which implied to me that she was uncomfortable and had detached herself emotionally from this process. I kept reaffirming the situation because it was difficult for me to hear how little attention was paid to this aspect of being human:

> *I don't make it to the dining room now. At all! We have that girl that works 7 to 12. She is basically responsible for doing the dining room. (On) Sundays there is nobody. So that one care aide that does one bath on each side and is 100% responsible to feed all of those people.*
>
> *And how many are you talking about? (Interviewer)*
>
> *Lots! We have lots! I think we have, one time I counted and we had 13 feeds just on my side.*
>
> *So in total? (Interviewer)*
>
> *I don't know how many are on the other side but there is quite a few.*
>
> *So you are still working when it is breakfast time? (Interviewer)*
>
> *Yes! We are still getting people up! You are still working to get them up.*

> *So you really have no time to sit with them and to help them have a meal? (Interviewer)*
>
> *No. I never sit with them at breakfast time! So somebody else does that.*
>
> *So you are pretty much down your side doing your thing and somebody else is down their side doing their thing. (Interviewer)*
>
> *Yeah. (Judy)*

Most of the care aides felt very guilty about the quality of care during mealtimes:

> *So we just - we are in the middle. (Motions sitting between two people). We feed two residents. But it is not good! It is not!*
>
> *No. (Interviewer)*
>
> *I feel sorry for the resident. I feel bad! At least we did it, but we are not comfortable. (Joanne)*

Some provided comments made by families to substantiate their perceptions:

> *And there are certain family members, they say, 'Oh my God …I watch you feeding four people at one time. This is too much!'…And I say, 'You know what, you guys have to advocate for your family members…You got to tell them (the management) this is how it is! What we are doing!'….Certain family members are really nice and they will help with the feeding. (Doris)*

The participants felt that they were no longer meeting comprehensive daily living needs of the residents. Time constraints led to lack of warmth and spontaneity. In sum, the care aides described struggling to provide services to residents within restrictive time limits, but without pleasure or satisfaction for either party:

> *Like in the morning, the pressure is huge! We start at 6:30. The LPN takes her time going through report so you are watching the time…we have 20 people to get up – one has nine and one has eleven, (and) between the two of us, one has to be in the dining room at 0830 to feed. OK. So we have 40 minutes to get up 18 people! To make sure everyone is up. (Cheryl)*

The goal was to finish, so participants also hurried the dressing, cut back on grooming, eliminated oral care or abbreviated the baths in order to save time and this result is similar to the findings described by Bowers et al. (2000) and Kayser-Jones et al. (2003).

> *Some of the girls say that they do not even wash them anymore. They just put them in a gown. They are just trying to get through the shift. They are rushing and just trying to finish the job so they are just cutting corners. And I know it, because you can tell. When you come in, in the morning, and everybody's faces have food dried on. The dentures are filled with dried food. They do not have the time. The care just does not get finished. (Judy)*

Organizational Expectations of Unattainable Efficiencies

Participants explained that they believed that the majority of time crises were often the result of managerial decisions not to replace sick calls. They also perceived that managers failed to consider all the various aspects of care and as a consequence, the managers incorrectly calculated that there was ample time to complete all required care:

> *So we try to get it all done, but corners will be cut if we are working short. Like I said, we can try to rush and get all the baths done, but it has been an ongoing thing. And in the end, we cannot get all the things done.*
>
> *What is let go first? (Interviewer)*
>
> *We drop off the baths first. I mean, they still get washed up and everything, and hopefully, they will get their baths done the next time…. so then the manager came and she wants to talk with us….And she said, 'There should be enough time and I prefer that all the work gets done that you don't miss baths or this and that because you are short. Because there should be ample time to get things done.' She said, 'You know, I have figured it out. If you have 15 minutes to spend with each resident.' And I said, 'You know what? How can you even get someone up in that time? If you have to bath someone?' I said, 'Most baths take half an hour. And there is a couple of residents – their bath is one hour." She*

> *says, 'Why would a bath be an hour?' And I said, 'Well that is the way that it is.' And she says, 'Well, it shouldn't be that way.' (Susan)*

The care aides were very critical of organizational expectations of them. They felt frustrated with what they perceived as the total concentration on efficiencies to the exclusion of important values such as the residents' needs and rights for relaxed and pleasant bathing. As well, they were irritated by the reduction of their difficulties to a mechanical prescription for time management that ignored or excluded their feelings and relationships with residents:

> *I am thinking, Wow. We are so limited for time and she, management has no idea of the time we have for residents….It is like you are just treated as a door mat. (Kathy)*
>
> *Do you think that the managers would ever come down and do a bath with you to see how long it takes? (Interviewer)*
>
> *You know, I said to one of the girls, 'You know what? We do our best job.' And if they come down at some point and say, 'This should not take you that long', say, 'I feel that I personally am working to the best of my abilities.' And if she comes and she says to me, 'It shouldn't be like that, it should be quicker' I will say, 'You know what? I am perfectly willing for you to show me how to do it better…I am a quick learner and if you can show me a better and quicker way I will watch you and I will learn! But you will have to show me how it can be done in that time.' And I will. I will say, 'Show me how it can be done in that time.' (Susan)*

Finally, most of the participants in this study indicated that they did not enjoy being a universal or versatile worker. From the perspectives of the participants, if a job had to be done and no-one seemed willing and ready to do it, the managers were indirectly supported to swiftly assign that job to the care aides:

> *Ever since I have been working as a care aide it has sort of been the attitude well the care aide can do it…like put more on the care aides…Like all of a sudden you would have all your care to do and then on top of it they (management) would decide that they would want you to put all the laundry away and clearing and wiping tables and all kinds of things….You really have to be organized and get your time factor going.*

> *You have lots of trays to bring and lots of people to get up in the morning and stuff. Very challenging! (Linda)*
>
> *You know, by the time you are finished, you are so bagged! It is just like, 'I am tired!' By the time I go home, I am so bagged! And they want us to do all of this extra – they want us to clean all the commodes. They want us to clean the wheelchair cushions. Nothing is getting done! None of it. Nothing! Nothing! It has been three years. Nothing has been done! (The commodes) are not sterilized any more. Not cleaned underneath. Nothing like that is getting done. I get so frustrated. And then they wonder why there are germs everywhere. It just makes you sick. It is unreal.*
>
> *So, the expectations are increasing? (Interviewer)*
>
> *Oh yeah. They want you to do all this extra…for each of my family members, I am the one who has to clean each of their drawers. And cleaning their drawers is not getting done. I go around, do certain things that are getting messy. I will do it when I have time, if I am not too tired I will do it, but generally, it is not getting done. It is a hard job. (Doris)*

Inability to Obtain Help

While numerous reports of care aides' complaints of time constraints exist in the literature, the care aides in this study consistently reported something more alarming - they consistently complained that they did not receive any help from the RNs or LPNs. This is not to say that RNs or LPNs must do the work of care aides, but the aides perceived that the RNs or LPNs were not really interested in helping them provide care even if they were not busy.

In the following paragraphs, I describe how the care aides felt about their inability to obtain help from LPNs and some of the actions they took when they were unable to obtain help. Following this, I describe some of the perceived reasons why LPNs did not provide as much help to the care aides as the care aides wished them to.

The LPNs were perceived by the care aides as not engaging with those other qualities which defined for the care aides the essential nature of caring – that is compassion for colleagues, making efforts to relieve suffering, and providing help willingly when another person needs it (when a care aide is withering, or when a resident needs help):

> *We had an LPN on the floor, she just came down to visit us for a second there, and right in front of her, the resident started to vomit and I said, 'This lady is puking, I need help.' She never came down my side.... She never came down to see the resident. And then I was coming out of the toilet from this lady who was having the emesis – the vomiting and the diarrhea…and there is stuff coming out her back and there is the LPN down the hall. The LPN and the RN by the nurses' station - they are talking about God knows what! And another LPN was there and I'm going, 'Help me! Help me!' I am going, 'Somebody help!' I pushed the emergency button and they just sit there, looking at me. And I said, 'You guys, can you come down and help us?'….And I thought - What the hell? This is just part of nursing. You have got to help us. (Doris)*

Sometimes the care aides were afraid to act on their own discontent. These care aides avoided asking for help from the RN or LPN because they were very much afraid that asking for help might jeopardize their relationships with them. Each care aide was faced with a tension between what he or she wished would happen, and the requirements of the collegial relationships. Therefore, when they needed help, they approached the RN or LPN cautiously:

> *But you have to approach. You have to tell them. But they don't like that. So you are putting your relationship in jeopardy with your co-workers. (Janice)*

Sometimes care aides made personal adjustments. They discovered within themselves, new methods of coping. For example, Janice decided to become very blunt:

> *Sometimes the RNs are not doing anything, they are just sitting there. They are not helping out...it is not their job. The LPNs as well. Some of the RNs are playing video games….I am very blunt. I ask for help from them. (Janice)*

Joanne however, used a different method. She quietly waited out the LPN in order to obtain the help she needed:

> *But what I do is… 'Oh, I am busy.' OK. I can wait! I am going to wait. I am standing up. I can wait. That is what I do. That is what I do. I realize that 'Oh, I have no time!' Oh, what can I do - so no one is going to help me! So I stand up. I meet her and I wait. Standing beside.*
>
> *Oh, OK! So you just stand there! (Interviewer)*
>
> *I cannot do it before. I did not do it! But I am thinking I need the help! So I can wait so that I can get her. I am waiting beside the cart. (Joanne)*

Others just tried to solve problems on their own until they became totally convinced of their own inability to do so:

> *So you have to stay calm…you end up pulling the call bell if it gets too much and someone else hopefully will not be too busy to come down and help you. But anyway, that is just the normal part of the evening and often the evening can go on like that for the good part of the evening. (Linda)*

Overall, the care aides described frustration and anger with the LPNs:

> *The LPN…wanted somebody else's weight. And I said to her, 'If one more person asks me about somebody's weight all day I am going to end up punching somebody in the face!' And that is not me! And that is when you just have to step back and go, wow! (Cheryl)*

One of the perceived reasons why the LPNs did not help the care aides as much as they wanted them to was that the contributions that the care aides, the LPNs, and the RNs made to the welfare of the residents were complementary but highly differentiated. In all five facilities, care aides described how they were responsible for providing basic care to the residents; the LPNs were responsible for the medications and treatments; and the RNs were responsible for overseeing day to day activities, problem solving, data entry, and other managerial tasks:

> *A lot of the new LPNs come on they just do their pills and when they are done they will go on the computer and stuff. A lot of the care aides are very frustrated with that. It is like - why aren't the LPNs coming down and helping out on the floor?....It is really, really bad actually the way they have implemented now and the expectation is more hands off for the LPNs. This is like from my view. (Linda)*

The participants also reported to me that they felt they did not receive the help they needed when they asked for it because they believed that the management had made promises to the LPNs on hiring, that they would not be involved in anything more than their highly differentiated tasks:

> *We have some LPNs on the floor – if you ask for help they go, 'We don't do care'. 'Well, who said that? You guys don't give care, you just do pills? Who?' 'Well, the management told us we don't do care.' Well, you know what?...I am not expecting that you go down and do people, but if I am asking you for help, please come and help!...The LPNs don't come down and help. And they can…but they chose not to. And the management tells them - they tell us that when they are hired, they are told, 'You don't need to do care at all. You just do pills.' Why would management do that? The management should be saying…you do your pills, but, you go down on the floor if you are needed. If you are needed. If you are asked. (Doris)*

The participants in my study perceived that some LPNs were firm in their beliefs in fixed definitions of roles with no overlaps. Therefore, when they had completed their clearly defined activities, they stopped working. On the other hand, the care aides wanted and felt they needed more unifying elements:

> *The LPNs are told that they do not have to work on the floor. They are told that they just have to do meds. So if a light is ringing, they won't get it. And it is like - Oh my God!...Most of the LPNs will not get a light. If somebody says, 'Oh I need to go to the bathroom' they just say to call for us. They are on the computer a lot of the time. Shopping.*
>
> *Really? (Interviewer)*

> *Yes, and they always pretend that they are not. Especially in the morning. They are talking about what they did last night…and we find that really irritating. To me I don't care any more. But it is frustrating to see them shopping for clothes on the Internet. They don't care. They say that they don't have time to give care. 'I was told when I was hired that I would not be doing patient care!' (Judy)*

Weathering Persistent Stress

Besides not being able to obtain help from the LPNs when needed, role isolation and separation also meant that the care aides worked with the residents by themselves and were the eyes and ears for the LPNs and RNs who were busy elsewhere. The participants described how they felt increasingly responsible for assessing and reporting deviations in the resident's physical and emotional health and well-being:

> *You are more on your own down there. You know you can call for help but you know you don't want to constantly be bothering people because they have their pills to give and stuff and the other care aides have their work to do to. So you do the best you can on your own….You are assigned to these people. They are your responsibility. So you have to make it the best you can for them and yourself….You have to be able to communicate with your co-workers and the LPNs and changes or any important things because you are the eyes for everything, everything there. (Linda)*

When the care aides worked with the residents by themselves/without colleagues, they experienced the full responsibility and many of them suffered from emotional strain. The heavy burden of responsibilities was difficult for them to bear consistently, and some were tempted to give it up:

> *And the RNs and the LPNs if they want information, cause they don't tend to have any hands on, they come to you and want to know, and the families come to you and want to know…so there is a lot of pressure. A lot of pressure! And that is part of why I have to leave. Because I am not myself anymore. It is changing who I really am! (Cheryl)*

Additional stress for care aides stemmed from the implication that their role was not only to provide care for dependent residents, but also to gather and communicate important information to LPNs who depended on them to provide it. In many ways, they felt responsible for the LPNs in the same way as they felt responsible for the residents:

> *And I will go like, 'Oh, yeah. OK. Yeah. Someone's blisters have burst on his feet.' Or something like that….You have to tell them! And if you forget, they (the LPNs) are responsible even though they didn't do the care. So it falls to you to make sure that they know what is going on….So the care attendants are really taking on a big role. And sometimes they can feel the burden of if. Because you are so responsible. I feel really responsible for their well-being. Because like I said, it is up to me to report any skin breakdowns or wounds. Anything like that - their emotional well-being, as well as just general, their general health. And for nine people, and sometimes 15, you know, that is a lot. (Jane)*

Because they provided care to residents alone, they had no way of knowing if the information they gathered and communicated to the LPNs was the right information because no other person was available to verify the information. In essence, the feeling of confidence that comes from approval for obtaining correct information was denied to them. This caused them to feel very anxious:

> *Physically you can't really last and mentally I don't know. (Mary)*
>
> *The job just increases and increases and increases. (Cheryl)*
>
> *I really enjoy what I am doing but I am having anxiety. (Joanne)*

Participants could be depended upon to report that they felt overloaded with their assignments and tasks, which added to their feelings of anxiety and caused mental and physical fatigue, which impacted their quality of life outside working hours:

> *I get dehydrated. I have to drink water all the time because I am running around all day and I go home exhausted. When I do day shifts, all I do is go home and sleep. For me, the quality of my life has gone down too. That is no life. I am too tired to go out or too tired to socialize with friends. Too tired to do the dishes. And I am stressed out with my kids. It is like a domino effect.* (Shirley)

The care aides explained that they felt so exhausted that they did not have enough energy to help each other. The fatigue impacted on their ability to develop and sustain relationships with residents because they were only able to see residents as heavy burdens. This was demonstrated by Barbara and Susan who both referred to the residents as "loads":

> *But basically, everybody's whole mentality has gone to…you know what? I am so dog-beat dead tired that we don't want to help. We just do our load. And we just suck it up. Because that is the way it is. Because already our workload is too much for what one person can do. (Barbara)*
>
> *The management, her perspective is we're all here for the residents and I understand that. I totally understand that. I get it. But if you are not going to give us the proper staffing levels to meet those needs of each resident, then where are we at? I am only one person and I'm here to look after eleven residents and I am usually very good. I know how to pull my load. I can pull my load. (Susan)*

Essentially, the workload forced them to concentrate less and less on the wellbeing of the residents and just maintain a focus on their own health:

> *We are constantly running and doing. And I just keep breathing. Just keep breathing. That is all I can do. (Cheryl)*
>
> *We just do the best we can and hopefully we can walk by the end – when we retire. Drugs. That is what my doctor said. Here – take some drugs and go back to work. Take some drugs and go back to work. It can be very depressing. (Barbara)*
>
> *Well us care aides work really hard and speaking for myself, I do everything physically possible and mentally possible to look after them. It is exhausting. You are totally spent. (Linda)*

These complaints are comparable to work overload described by care aides in other studies (Anderson et al., 2005; Jervis, 2002a; Lin et al., 2002; Riggs & Rantz, 2001; Sofie, Belza, & Young, 2003). Complaints of associated health problems were also similar to those in other studies (Chappell & Novak, 1994; Landesman, 2003).

Some care aides felt so overwhelmed, they did not know what to do:

> *To me I go back and forth in my head. I don't know what is right so I will just take care of the resident and hope for the best. (Mary)*

The high levels of anxiety and fatigue could lead to complete emotional breakdown at work:

> *One of the other ladies on another unit, she has so many lifts. And she had a guy who was walking – her only independent resident - which is like a treat right, he had a heart attack and died. And she ends up getting this other heavy lift. She is my age and she said that she was just bawling. They just don't care! They just keep piling them on and piling them on! (Judy)*

It was difficult for many participants to accept that they were not able to meet even the most basic needs of the residents:

> *We have somebody to feed in the room, and then we have somebody to feed in the dining room and then somebody want to go to the washroom. What can you do? Sometime we cannot make it. They can just wet themselves. Because we cannot do it right away. How can you do it right away, especially, you know? So then they get mad at you. And then, oh my! What to do? We just can't say anything. It is getting harder and harder. (Joanne)*

Theme Two Summary and Interpretation

In summary, the workplace realities shaped and directed the boundaries of my participants' possible relationships with residents. Role isolation and separation meant that they worked with the residents by themselves. They were the eyes and ears for the LPNs and RNs who were busy elsewhere. They were responsible for assessing and reporting deviations in the resident's physical and emotional health and well-being to the LPNs who depended on them to provide it. Because they provided care to residents alone, they had no way of knowing if the information they gathered and communicated to the LPNs was the right information because no other person was available to verify the information. This caused them to feel very anxious.

My participants also reported feeling overloaded with their assignments and tasks, which added to their feelings of anxiety and caused mental distress and physical fatigue. They felt so exhausted that they did not have enough energy to help each other and their levels of fatigue impacted their quality of life outside working hours. Because they felt so fatigued, they concentrated less and less on the wellbeing of the residents and more and more on their own health and were only able perceive residents as work. Some were tempted to give up.

Three major dimensions of the working environment were of key importance to my participants:

1. The care aides were very critical of organizational expectations of efficiencies. They perceived that managers failed to consider all the various aspects of care and as a consequence, incorrectly calculated that there was ample time to complete all required care. They were frustrated with mechanical prescriptions for time management that ignored their relationships with residents and important caring components.

2. The care aides consistently complained that they did not receive any help from the RNs or LPNs. One of the perceived reasons why the LPNs did not help the care aides as much as the care aides wanted them to was that the contributions that care aides, LPNs, and RNs made to the welfare of the residents were complementary but highly differentiated. Sometimes the care aides were afraid to ask for help from RNs or LPNs. Other times, they used coping methods such as becoming very blunt or quietly waiting. Some just tried to solve problems on their own until they became totally convinced of their own inability to do so.
3. The care aides perceived that some LPNs were very firm in their beliefs in fixed definitions of roles with no overlaps. On the other hand, the care aides wanted and needed role overlap.

These three dimensions influenced how the care aides felt about their work and thus influenced the nature of their relationships. They felt:

a) Isolated
b) Completely responsible for assessments and reports of deviations to LPNs
c) Anxious because they were unsure of their findings
d) Overloaded with tasks and assignments
e) So distressed and exhausted that they were only able to focus on themselves.

In turn, sometimes they perceived residents as burdens (loads), which strained the relationships. This is the context for the next section, which details more specific descriptions of the kind of situations or events that characterized or determined strained relationships.

Theme Three

The Impact of Strained Relationships

My participants were easily able to identify critical factors that hindered or restricted their abilities to form if not ideal, at least reasonably pleasant and sustainable relationships with residents. While the impact of strained relationships varied from bearable to emotionally catastrophic, very few care aides managed to avoid strained relationships. In order to form a deeper understanding of the personal, situational and environmental factors that determined strained relationships, I asked the participants to describe specific situations or events. For clarity, I have organized the participants' descriptions into three parts.

The first part is devoted to the participants' descriptions of the residents who evoked feelings of stress, distress or discomfort in them. These results are not new and are very similar to the accounts of care aides in other studies (Brodaty et al., 2003; Evers et al., 2002; Gates et al., 2003; Kristiansen et al., 2006; Ramirez et al., 2006). Although the first part is comprehensive, most of the participants in this study seemed less interested in describing residents and more interested in vigorously describing stress and distress triggered by repeated conflicts with *families* of residents. My literature review uncovered some references to conflicts with families, but not nearly to this extreme.

The second part is devoted to the participants' unwavering descriptions of tension, disputes and disagreements with families of residents. The third part is an accounting of managerial strategies that resulted in relational impediments.

Strained Relationships with Residents

A wide range of subjective experiences (somatic, psychological and emotional) were associated with participants' more difficult interactions with some of the residents. All of these factors made it much more likely that the care aides would fall short of the emotional demands placed on them. Overall, a strained or difficult relationship with a resident was a very unpleasant experience:

> *The other thing is the fear factor thing….And when you are under that kind of pressure all of the time it is like, 'Oh my God, is this what I have to deal with on a daily basis?....Oh, this guy is a nightmare, you know, he is my nightmare! (Kathy)*

Unpleasantness was anxiety-inducing because participants realized that they were responsible for residents whom they wished to avoid:

> *He was one of the people that I did not want to look after for sure, or to participate in looking after him because it was all our responsibility. (Paula)*

Sub-themes related to characteristics of residents perceived to negatively influence the quality of relationships are outlined in Table 6.

Table 6.

The Impact of Strained Relationships:
Strained Relationships with Residents

Sub-Theme	Categories
Feeling Uneasy	▪ Sexual behaviour ▪ Sexual talk ▪ Sexual requests
Feeling Persistently Distressed	▪ Embarrassing or humiliating remarks ▪ Culturally insensitive remarks ▪ Use of offensive words ▪ Contamination with body fluids ▪ Worrisome histories ▪ Use of alcohol or marijuana ▪ Failure to comply with safety regulations ▪ Difficult to dress ▪ Perceived as overly particular/demanding
Coping with the Facets of Cognitive Dysfunction	▪ Unpredictable, unintentional outbursts ▪ Screaming

Feeling Uneasy

Some care aides described residents who were overtly sexual towards them or who made requests that appeared to be of a sexual nature. These behaviours made them feel very uncomfortable and sabotaged any possibility of relational success:

> *I had (a resident) who used to drink lots and then get really sexual. Try and grab you, and sexual comments. Try to convince you that you should get into bed with him. He could walk still, which was a little difficult at times if he wanted to get really close to you.*

> *So what did you do about that? (Interviewer)*
>
> *I kept going back to management complaining about him cause I was having lots of troubles…I don't like all that sexual talk…So it finally got to the point where I was allowed to take another staff member in there with me - because he was constantly foul, and he had nasty surprises for us. (Allison)*

Sometimes, some of the residents (male and female) made requests of care aides that suggested they expected the caring role also included privileges of a sexual nature. To compound matters, my participants perceived that the managerial staff seemed, at times, to agree with these residents - whatever the residents asked for, the care aides should comply with. When care aides did not comply, their relationships with these residents were irrevocably strained:

> *Oh God! He drove me crazy!...He wanted us to do rectal massage. Rectal massage! We had to do a rectal massage! I refused. And he complained (to the management). And I was told (by management) 'Why wouldn't I do it?' And I says, 'Because I feel uncomfortable doing it…I won't do it.' And he (the resident) told me…that he pays my wage. That is what we get a lot. (Michelle)*
>
> *We had to put cotton batting in her vagina. Every night! For what purpose? I still don't know to this day. But we had to put it in. They (the management) finally did stop. They finally did stop. But you know how long we did that for? (Brenda)*
>
> *And God help you if you didn't do it. (Michelle)*
>
> *Did you have any meetings where you discussed these things? (Interviewer)*
>
> *Yes. And we were told this is what she wants. And we are to do it. Basically, we have to do anything. We have no recourse. We have no recourse. (Brenda)*

Care aides thought about these situations, and planned in advance to use basic techniques to protect themselves such as making sure that there was an opening to get away from the resident:

> *He can get really sexual. Just watch your back. Because he will grab at you for attention, he will touch you. Just make sure you are never stuck in a corner with him. Make sure you always have an opening to get away. (Allison)*

Feeling Persistently Distressed

Multiple participants described other residents who were also not cognitively impaired but who seemed to readily and repeatedly engaged in conflict with care aides. For example, some participants described feeling embarrassing or humiliated by remarks made by some of the residents. Some participants described how some residents seemed to be able to pick up on their shortcomings and then exploit them at calculated times:

> *He used the f word like you wouldn't believe. I have never heard that word so much in my life…and they will put you down. They will tell you that you are fat. Or, that you look ugly. Anything. (Allison)*

Some residents made remarks about the care aides' cultural backgrounds that seemed offensive or disparaging to the participants. It was very difficult for care aides to form close relationships with people who deeply offended them and/or obstructed their abilities to give care simply because of their ethnicity:

> *The residents also sometimes get really nasty. I have had residents calling me names because I am a minority. I am from South America…. I have lived here a long time. They are saying, 'Speak English', 'Go back to your country', 'I hope they hire Canadians' stuff like that….I had another co-worker who was black and she was told, 'You are so stupid', 'Go back to where you came from', 'You don't know anything' and I told that co-worker to report that, but she didn't. "I had another co-worker. He is East Indian and one of the residents said, 'Don't touch me! I don't want you touching me' and stuff like that because he was dark skinned. So we get it from the residents and the families. And it doesn't happen often, but when it happens, it can really stress you out and make you feel bad. (Shirley)*

Andy observed that some residents had deeply rooted cultural understandings that care aides performed subservient roles, however these residents' understanding of the role bore little resemblance to how the care aides saw their roles, even when the care aides shared the same ethnicity as the residents:

> *In the Chinese culture, they treat…nurses in general as house workers. And what I do as a nurse for them is a right and not a privilege. They are really rude to me…like, 'Change me right now!' But they won't say this to the Caucasian nurses or the Filipino nurses because they don't speak that language. So they are requesting me. I come in. And they will say, 'Change me!'…but then they won't say please or thank you or sorry but they would say those three words to the Caucasian nurses or any other nurses who always speak English. So it is just to me…they will just go completely rude! (Andy)*

Some residents engaged care aides by using words considered in English Canadian society to be extremely offensive and insulting:

> *Let me just help you out of the wheelchair. One hand on the shoulder, that is it. I will be helping him here. And he will go, 'Get your damn hands off of me!' OK, all right! (Andy)*

Most of the care aides felt very uncomfortable with these words as evidenced by Michelle, who was unable to pronounce one of the words out loud:

> *The other morning, he rang and I went in there and I said… 'What would you like?' He says, 'What do you fucking think I want?...Don't you know what I fucking want?' And I said, 'No, I actually don't. What would you like?' He didn't know what he wanted. He wasn't feeling good. He is very abusive. His special word is "c%nt" (participant silently mouths this word). He says we are a bunch of c%nts! That is what he calls us. (Michelle)*

Michelle and Brenda described a resident who contaminated them with his body fluids:

> *He used to take his catheter, as soon as you walk in, he used to take his catheter apart and shake it. Pee! He shakes it all over! Everything! You*

> *have it on your face, you have it on your glasses! Oh God! There were times when I would jump in the shower because it was so gross that I could not handle it…He has poop in his hands and when you walk in, he throws it at you. (Brenda)*
>
> *And he knows what he is doing? (Interviewer)*
>
> *Oh God! He is very cognitive! He is extremely cognitive. (Brenda)*
>
> *And why do you think he is doing that? (Interviewer)*
>
> *He is angry at life….He is doing it for entertainment. He is doing it to entertain himself. Yeah! (Brenda)*
>
> *What was suggested to you? To do? About this? (Interviewer)*
>
> *They (management) don't even want to listen to us. So what do we do? We got to do what we can do. (Michelle)*
>
> *So what did you do? (Interviewer)*
>
> *We had to put a gown on, glasses on, face shield on. We told him a hundred times, 'You know what? This is not appropriate. We are here to take care of you. We are here to help you. We are not here to be abused. Please don't do that!' The next time that you go in, the same thing again. We can't stop him. We cannot stop him. He did that all the time. Throw things at you. Spit at you. (Brenda)*

Some of the residents were living in the long-term care facilities because they had suffered catastrophic spinal injuries during gang violence and they now required 24 hour care. There were other residents living in the facilities who had previously served all of their time for their criminal activities, but were now requiring long-term care due to significant health issues such as debilitating respiratory or musculoskeletal diseases. Some of the care aides described how they were afraid of these residents because of their histories:

> *There was one resident we will call 'Mr. Confidential'. He was very young…not too young, about fifty or so and he was in a gang and he has killed people and this time he got shot and he has done very bad things. He told me he was on cocaine….He was handcuffed to the bed and there*

> *were police officers and stuff when he first came in…. He is not allowed to be on his cell phone. He is not allowed to use a computer ever in his life.*
>
> *Why is that? (Interviewer)*
>
> *Because of what he did - his history….that is the thing. You are in a situation where he is just talking to you and you have that interaction because he is a quadriplegic and he can't do anything for himself…And you are thinking oh my God, you did kill people. (Mary)*

Some care aides reported that they were afraid of some residents who could become aggressive as a result of using alcohol or marijuana:

> *They are allowed to drink… so they got pretty aggressive towards us sometimes…You never know what to expect….They do marijuana too. (Allison)*

Allison described one shift when a resident chased her with a knife. The resident had been drinking all weekend:

> *I got chased by a resident with a knife.*
>
> *Oh? (Interviewer)*
>
> *It started on a Friday….she was drinking whiskey…we had to keep monitoring to make sure that she was safe. She was getting worse and on Sunday we phoned (the manager) four times and honestly, we could not handle her anymore. We had already called the paramedics but they wouldn't take her.*
>
> *Why wouldn't they? (Interviewer)*
>
> *Because she was still refusing to go. At that point, she had drunk three bottles of whiskey. But she wouldn't pass out. We don't know how she was staying awake!...And she couldn't have her pills because she was drinking so much that we weren't allowed to give them to her. So by Sunday, she was… she was threatening suicide. So instead of doing it to herself, she came at me with a knife.*
>
> *How did you protect yourself? (Interviewer)*
>
> *I started backing towards the door. She tried to run after me. She was still able to run – a 75 year old lady in socks, after all that alcohol. So I just happened to run out. For some reason, I closed the door. I don't*

> *know why I closed the door – instinct. That stopped her and she did not follow me out into the hallway….I was freaked out. That gave me something to remember. So we called them (the police). And they had to tie her up to get her out of there because she was not willing to go. But the person who was supposed to work there that day – she is well over 300 pounds and can barely walk. And so I said to my boss, like if it would have been her, who got stuck in the room, I said, she wouldn't have gotten out of the room! You are just lucky that I can run! I don't think she (the other worker) would have made it out of the room without getting stabbed. They put the staff in a situation that was dangerous to us. They told us to wait until she (the resident) passed out and then call the ambulance. That was the plan. But we kept calling to say that she wasn't passing out. What do you want us to do with her? (Allison)*

Other care aides were also afraid because they felt threatened. Although they also had gone to the management and reported the threats, management had done nothing to alleviate their fears:

> *He says he is going to kill us…He (the resident in protective custody) says that he could hire somebody to kill us. Because he knows people in different places. So that is really scary! (Brenda)*
>
> *Yeah, but they (management) don't think nothing of it! They say, 'Don't worry about that.' (Michelle)*
>
> *So this fellow threatens to get his friends? (Interviewer)*
>
> *Yeah, if people don't listen to him for what he wants them to do, he will get his friends. He is in a protective custody, supposed to be, I mean. But the manager doesn't want to hear about any of these things. What are you going to do, you know? (Brenda)*

When the care aides felt embarrassed, humiliated, insulted, or at high risk of being contaminated with body fluids, the care aides were kept in a state of constant uncertainty. Some participants found themselves continually reacting to these types of encounters, and this caused anxiety, stress and fatigue. These participants had to keep tight control over their natural feelings while trying to meet the needs of these residents. Michelle and Andy questioned why management did not offer any supports:

> *A lot of them are angry that they are in there. A lot of them are angry that they are sick. They are just angry. And they take it out on us. And sometimes I refuse. And then what happens? Well, then management will haul us into the office! And they would just say, 'You can't refuse.' Why do I have to tolerate this abuse? 'Because we chose this profession', they said. (Michelle)*
>
> *There is no reason we should have to take abuse like that. Especially verbal abuse…And there is no reason why we just have to stand down and not do anything about it. Because that is just simply not fair. It is like basically we are here for them to take free stabs at. At no consequences….I wonder, do I have to endure this kind of disrespect?….I cannot stand here and take continuous insults. (Andy)*

The nature of the care aide role requires that care aides perform a great deal of physical work. They use transfer and lift techniques and machines that are designed to ensure safety and comfort for the residents and for them. They use the transfer and lift techniques and machines when they help residents to wash, dress, stand, and transfer. In this study, the participants described some cognitively well residents who preferred not to comply with safety recommendations for transfers and lifts. This non-compliance with safety standards strained the relationships between the residents and care aides, especially when residents' decisions increased the likelihood that a care aide would suffer an injury. When a cognitively well resident did not comply with safety regulations simply because he or she wished to remain as independent as possible, the care aides usually tried to meet the resident's needs. The conflict was there, but the strain on the relationship was not significant:

> *He wouldn't let us do mechanical lifts.*

> *So, how did you cope if he didn't let you use the lift? (Interviewer)*
>
> *Most of the times, we did like a pivot. Because he could still hold himself up. He was really strong. He was strong enough to hold himself up so we could wash him and then he would transfer.*
>
> *So did you feel that was safe? (Interviewer)*
>
> *Not really. (Allison)*

In this situation, the care aides were helping the resident with his difficulties, and were willing to let the resident decide to some extent how he would receive assistance, but they did not feel particularly exploited by the resident. However, sometimes a cognitively well resident indicated to the care aides that he or she did not care at all about the care aides' risk for injury. In these cases, the care aides felt that they were being taken advantage of, and the strain on the relationship was quite significant as illustrated in the following story:

> *We had one resident a few weeks ago, he was supposed to be on a ceiling lift (a mechanical lift that lifts the resident's entire body). But he didn't want to. He wants to use the medimaid (a mechanical lift designed to help a resident use his or her own legs to come to a standing position). And we have told the manager that it was an injury risk for us and for him. But the wife was in denial. Three people were injured because of him. And when we told him, 'We are not going to put you on the medimaid because we are going to break our backs', you know what he said? 'Well you can go onto compensation!'*
>
> *So he doesn't care about you at all. (Interviewer)*
>
> *No. And you know what happened? Both of us got injured. My co-worker was away for a week and a half. I was away for three days. (Shirley)*

Difficulties with transfers and lifts were compounded if the residents were heavy or overweight:

> *He was assessed and they said it was OK for him to be on a medimaid (transfer). But when they do the assessments, they usually do it in the*

> *morning when he has the energy to stand up. And he is really heavy. In the evening, he cannot stand and this (staff injury) is what happens. (Shirley)*

To lift is one of the demands of the care aide role, but lifting all day resulted in exhaustion:

> *I have one lady and as I mentioned earlier, over two hundred pounds. Just physically I am getting exhausted because I do look after her every day and the other girls have residents like this too. Physically she is heavy. (Linda).*

In the following situation, a large male resident refused to allow male staff to lift him. The manager agreed to meet the resident's request and only female care aides were designated to lift him. As in the previous situation, the female care aides felt exploited by the resident:

> *He (a resident) would not allow male staff to transfer him.*
>
> *No males? (Interviewer)*
>
> *And we tried to argue that, but our manager said if he chooses certain people, that is what he gets to choose from. That is his choice.*
>
> *So he could pick who would be his caregiver and that person would feel stuck? (Interviewer)*
>
> *Yes. Absolutely! And there would be a lot of pushing and pulling because he was over six feet tall. And I am barely five feet and I have a six foot tall resident that I have to push and pull around. It was just too hard...I had such a back ache! (Allison)*

In a reverse situation, Kathy described how care aides exploited a resident who was overweight – he became a reason for passivity on the part of the care aides who made a decision not to provide care to him until all other residents had received their care:

> *He was three hundred plus pounds and because he was fairly new he was a two person and at that time a three person transfer. So he was the last*

> *person we would have to get up in the morning just because he took a lot of time. (Kathy)*

Another issue related to the physical work environment for care aides were residents who were difficult for the care aides to dress. Residents described as most difficult to dress were those whose muscles were so contracted that it became very difficult to pull non-stretchy items of clothing over bent elbows and knees, and those who resisted the care aides' efforts to dress them:

> *So their muscles just clench up. You are trying dress them and they are pulling against you so you are dealing with a lot of physical-ness of the job. (Carol)*
>
> *They are grabbing you when you are trying to turn them. And that can take a lot of time. (Judy)*

Finally, care aides found it difficult to form caring relationships with cognitively well residents who were perceived to be overly particular or demanding. They found it very stressful to meet these residents' expectations of them.

> *There was a little round thing that the Tylenol had to go in. And it had to be put on the edge. Not in the center of this little dish. So I am telling you… step by step instructions how to help this lady. So you know, where the clothes went, where the socks were to be laid on the edge of the chair. Everything. (Paula)*

They were afraid of disapproval, or exasperated with the tension in the relationship, therefore, the care aides were often reluctant to provide care:

> *There was another little old lady everybody was terrified of. This one was super, super fussy. She had all these pillows on her bed and they had to go right into the right place…if you didn't get it right, she would be so angry that I used to think, 'Oh my goodness. I do not want to go in. I don't want to do her….I thought that I couldn't handle her – going into her room and getting it wrong and everything and being on edge. (Susan)*

The importance accorded by the organization to meet the particular residents' requests for special items (such as food items) limited the abilities of the care aides. This is illustrated in the story below. The care aides often felt thwarted in their attempts to please the particular resident because they could only provide what was made available by the organization:

> *They want things their things their way. Their way or the highway….She will cuss and she will scream and she will phone her daughter and her daughter…started yelling at the staff and we had to call the police. She (the daughter) is just not nice. She says we are not giving her mother what she needs…even though we have given her three different options, 'They didn't feed me!' And in the dining room, she yells, 'I don't like that! I want this! I want that!' Well, we don't have that. What are we supposed to do? (Betty)*

Relationships between care aides and these residents were characterized by high emotional intensity, and feelings of anger and frustration:

> *Everything has to be in order. Like, the cup is supposed to be here, not there. The Kleenex box is supposed to be here, not there. You know? It goes on and on and on and on. And when you go to get her ready for anything, she just…well for example, let's just say you are getting her ready for bed in the evening. She wants certain times. Let's say for example, 6 o'clock. And if it is one minute after 6 she is already agitated. (Brenda)*

Additionally, there were often disagreements between care aides and residents about what constituted enough care. The care aides felt that their time was limited and that the particular residents did not appreciate that others were waiting while they were receiving more than the usual amount of care. The particular residents' expectations of the care aides to provide extra care further intensified negative emotions:

> *And you had to stroke this hair at least 50 times. We had to comb her hair 50 times. OK?*

> *Hm mmm (Interviewer)*
>
> *And we had to brush her teeth six times on each side, on top, and then six times on the bottom. (Brenda)*

Several participants in my study described how they found it difficult to get along with residents who were abrupt as well as demanding, and who appeared dissatisfied because they never expressed thanks for the care provided:

> *And they will say change me! I mean like – Oh really! But then they won't say please or thank you or sorry. 'Nurse!! Come change me!! Hurry up!! Go faster!!' (Andy)*
>
> *You got to be there on time. If you are not on time…even one or two minutes, she (the resident) is already agitated….And then let's say for example, you try to bring the lift. She is already ordering you to do this, this, this, this, this, this, this, this, this. Ten things. You got to do this, you got to do that, you got to do… 'OK, let me do one thing at a time and we will get through this.' No. You leave one thing and go and do the other thing to keep her happy. But you can never keep her happy. There is always something else. (Carol)*

The foregoing descriptions and analysis lead to a conclusion that strained relationships occurred most often when seemingly cognitively well residents repetitively created particular situations for the care aides, bringing about stresses and strains on interpersonal relationships. While some participants reported that they were unable to get along well with certain residents because they could not tolerate feeling humiliated, offended, threatened, frustrated, or exasperated by these residents, other participants reported the same feelings about residents who were suffering from dementia.

Coping with the Facets of Cognitive Dysfunction

Most of the time, the care aides' inability to form close relationships with residents who had cognitive dysfunction were due to the more prominent facets of the dysfunction such as unpredictable, unintentional outbursts. These outbursts radically influenced the quality of relationships as participants described how they spent as little time as possible with residents who were known to strike out:

> *She would be so angry that I used to think, 'Oh my goodness. I do not want to go in. I don't want to do her. (Susan)*

Fear of being hurt by these residents made it very difficult for care aides to engage or become close to the residents. The difficulty engaging is illustrated in the story below where Mary describes the resident as *"a hard one":*

> *And you will see her spitting, hitting you, punching, kicking, biting. She will hit out and kick and spit. She will hate you and you are 'going to hell'. So that one is a hard one….girls have come with their fingers hurt from her. She will bend them backwards. I have had scratches from her…I have seen people punched in the face, kicked. (Mary)*

Some participants found themselves less focused on relational practices and more focused on practical interventions designed to reduce their fears and uncertainty about the resident's behaviours:

> *And I have had one of the other girls say to me, 'Oh, I wouldn't trust him. I am afraid he will strike out at me!' So, you always have to say, 'Bear in mind that you don't stand in front of somebody that is screaming at you. You stand to the side!' And some will refuse to go in. And I have said too, 'If you feel nervous, take another person in with you if possible.' (Jane)*

Fear of becoming physically hurt during interactions with these residents overshadowed all other concerns:

> *I work with quite a few people that lash out at you…dig their nails into you, hit out at you, kick you, bite you. I have been slapped across the face. (Linda)*

> *Certain staff members can't give her a bath at all. Because she will strike out at them. (Doris)*

> *He was very aggressive. And he broke one of the girl's arms….If he got angry, he could grab you. It was nothing for him to grab somebody by the*

> *arm and start taking his anger out by twisting, you know, behind your back. (Paula)*

Other participants found themselves exasperated with residents who displayed particularly disturbing behaviours such as screaming due to cognitive dysfunction:

> *She would just be screaming. Just so much screaming! Just sit and scream! And she wouldn't sleep! She would get up all night. She would sleep in the daytime – maybe in the morning a little bit. But by afternoon, she would literally be screaming….I once went and sat with her all night long and I will never do that again because I worked all evening and then they had nobody so I said, 'I'll do it' and what the heck am I doing? And in the morning, she had just been screaming the whole time. And no matter how much you love her, and I loved her then, but it is not worth the pay, because she is so tough. Now we have some difficult residents but it is not as bad as that. (Doris)*

Many of the participants in my study clearly stated that the cultural norm of consistently assigning the same resident to the same care aide (creating families) was not always a good idea for them:

> *I have one lady… over two hundred pounds. Just physically I am getting exhausted because I do look after her every day and the other girls have residents like this too. Physically she is heavy. It is demanding because often she is incontinent. She often has loose bm which they have not been able to resolve this. I have to bath her today and I am on my day six. I am totally exhausted right now and just the thought of having to push her chair, to turn her and she is heavy. She barely lifts her arms and her legs. It is just really physically demanding. So that part wears me out. (Linda)*

They had to cope with feelings of failure, frustration, anger, or fear day after day. The outcome of the same stressors from the same residents over time resulted in lack of concern, reduced levels of patience, exhaustion, and frustration:

> *You are assigned these people and that is all there is too it. (Judy)*

> *She (a resident) is very repetitive. She won't remember anything from minute to minute. So you are constantly repeating. Why do I have this, why do I have that? Where am I? And it is constant. And you have to be*

> *very patient with her. And when you have to work six days in a row, on the sixth day, you are not very patient anymore. (Betty)*

Mary described how some care aides felt so many waves of frustration and exasperation that they ceased to hold onto standards of the job:

> *It does get draining taking care of her everyday…*
>
> *Do you have her every time you go to work? (Interviewer)*
>
> *No, she is not in my family anymore now that we are doing families.*
>
> *How is the other person coping then? (Interviewer)*
>
> *Not so well.*
>
> *What is going on? (Interviewer)*
>
> *You see a staff member need a break. Need a break….I see staff members really getting exhausted and wanting to give up. Give up in the sense of not wanting to do her care. (Mary)*

In summary, the participants in my study were able to articulate specific resident characteristics that were important contributing factors leading to the likelihood of a strained or difficult relationship developing. A wide range of subjective experiences (somatic, psychological, and emotional) were associated with participants' more difficult interactions with some of the residents. The participants described characteristics of residents who seemed to them to be cognitively well, and characteristics of residents who suffered from cognitive dysfunction.

With regards to residents who seemed to be cognitively well, multiple characteristics or behaviours made the care aides feel very uncomfortable and sabotaged any possibility of relational success. They included:

a) Male and female residents who made requests suggesting they expected that the caring role also included privileges of a sexual nature.

b) Residents who seemed able to readily and repeatedly make remarks that embarrassed or humiliated the care aides, residents who seemed to be able to point out more vulnerable care aides' shortcomings, residents who made remarks about the care aides' cultural backgrounds that appeared offensive or disparaging to the care aides, residents who used words considered in English to be extremely offensive and insulting, and residents whose actions resulted contamination of care aides with body fluids.

c) Residents who had criminal histories (some of the care aides were afraid of the residents who had criminal histories).

d) Residents who became aggressive after using alcohol and/or marijuana.

e) Residents who threatened care aides.

Residents who exhibited characteristics a) to e) kept the care aides in a state of constant uncertainty. Some participants found themselves continually reacting, and this caused anxiety, stress and fatigue. These participants had to keep tight control over their natural feelings while trying to meet the needs of these residents.

In this study, the participants also described some residents who intentionally or unintentionally increased the amount of the physical work for care aides. When characteristics of residents increased the physical work for care aides, it made it much more likely that the care aides would fall short of the emotional demands placed on them. These included:

f) Residents who did not comply with safety recommendations for transfers and lifts because they wished to remain as independent as possible (low level of relational strain).
g) Residents who did not comply with safety recommendations for transfers and lifts and in doing so, made the care aides feel exploited (high level of relational strain).
h) Residents who were heavy or overweight.
i) Residents who were difficult to dress.
j) Residents who were perceived to be overly particular or demanding.

Residents who exhibited characteristics f) to j) increased the physical work for care aides which resulted in higher levels of exhaustion, feelings of exploitation, and high levels of stress due to the care aides' inability to meet the residents' expectations of them. Relationships between care aides and these residents were characterized by high emotional intensity, and feelings of frustration and anger.

With regards to residents who suffered from cognitive dysfunction, strained relationships were due to the more prominent facets of the dysfunction such as unpredictable, unintentional outbursts. These outbursts radically influenced the quality of relationships. Fear of being hurt by these residents made it very difficult for care aides to engage or become close to the residents. Participants found themselves less focused on relational practices and more focused on practical interventions designed to reduce their fears and uncertainty about the resident's behaviours.

Many of the participants in my study clearly stated that the cultural norm of consistently assigning the same resident to the same care aide (creating families) was not always a good idea for them. The outcome of the same stressors from the same residents over time resulted in lack of concern, lowered standards, reduced levels of patience, exhaustion, and frustration. I now turn my attention to families.

Strained Relationships with Families

The care aides in this study were resolute in their convictions of how difficult it was to relate well to some of the families of the residents with whom they worked:

Families for me are the hardest thing in this job. (Mary)

The sub-themes related to strained relationships with families and the impact of those strained relationships on relationships with residents are outlined in Table 7.

Table 7.

The Impact of Strained Relationships: Strained Relationships with Families

Sub-Themes	Categories
Managing Complaints	▪ Fielding complaints ▪ A sense of dread ▪ Time consuming complaints ▪ Care aides as subservient ▪ Complaints to management ▪ Broken promises
Hypervigilant Families	▪ Forever dissatisfied ▪ Attending to micro-details
Never a Compliment	▪ Reduced motivation ▪ Reduced interest in residents ▪ Taking mental health days
Coping with Threats	▪ Go to media, call police, call gang members ▪ Physical confrontations
Contrasting Visions of Care	▪ Family members' visions of care contrast with care aides' visions of care ▪ Strict adherence to pre-arranged routines ▪ Simmering friction ▪ Letting go of the resident
Cultural Conflicts	▪ Reduced quality of understanding ▪ Risking confrontation ▪ Feeling subservient

Nearly every participant indicated to me that he or she had endured multiple unpleasant interactions with families of residents. Some described intensely negative emotions especially when some families made threats. Other participants described families of residents who had critical styles of communicating with them. These families looked for and focused on the slightest oversights or faults. Some participants described families who were habitually and routinely unsupportive of changes, even when the care aides believed changes would be in the best interests of the residents. One participant summed it up by stating:

> *If the families want you to die, you will die. If the families want you to live, you will live." (Brenda)*

Brenda's statement above, and Shirley's statements below suggest that families could be a major factor in determining the success or failure of care aides' relationships with residents:

> *What is it that causes the most stress for you do you think? (Interviewer)*
>
> *I guess being tired all the time. That really increases my stress, and also all the complaints from families…Overall, right now I am really happy with the relationships that I have with all of them (the residents).*
>
> *So you are pretty happy right now. (Interviewer)*
>
> *Yes, except when the families come in and they start to criticize everything….I find that the family sometimes is the ones that make the relationship break. Because some of them come and they start complaining and the resident hears that and their attitude changes. (Shirley)*

Managing Complaints

One of the most significant challenges with families of residents was the perception that families most often targeted care aides to discharge their complaints. Participants described an overwhelming sense of dread when families visited because they fielded many of the complaints:

> *They (the families) complain to us about the food. And I tell them I have no control over that. But they complain to us about the food…And sometimes they come to us about complaints about medication, or questions about medication. And that is the LPNs job and they are still going on and on about it. So they don't understand. They think that we are doing everything. They are asking about medications. Complex questions about the resident's conditions and so on…They expect us to be doctors sometimes. To know everything. (Shirley)*

The reason families targeted care aides most often with their complaints was that the care aides were the most accessible people in the facilities and the families took advantage of this. It was much easier for families to make their complaints to the care aides who were present, then to go searching for LPNs or RNs who were more difficult to find. Care aides also felt that they were unfairly blamed for perceived lapses in care that occurred outside of their control and that responding to families' grievances took a lot of time away from resident care:

> *The thing is, the complaints about the laundry come to us, the complaints about the housekeeping comes to us, the complaints of food comes to us. The complaint of other work coming to us! The complaint of the medication is coming to us. If the medication is not given on time, they go, 'Where is?' Because there is only one LPN, they always see us. We are on the floor right? (Carol)*
>
> *Yes, you are accessible. (Interviewer)*
>
> *We are accessible. And everything comes to us…Not only that we have 11 persons to look after, and we have to answer all these…all the answers, and all the difficult things that we have to take on, you know? (Brenda)*
>
> *You have to be the problem solver in addition to just doing your job? (Interviewer)*
>
> *Yes. Exactly! (Brenda)*

Some participants felt that the families did not fully understand the time constraints, the emphasis on efficiencies, and the workload of the care aides, and did not allow for these factors when they had criticisms. They indicated that many families seemed to view their roles as subservient:

> *What they don't get is the workload that we have. We are not slaves. Some of them think that we are maids and we are supposed to do everything and they don't really respect us. They don't put themselves in our shoes. They don't understand all the stress that we have at work. And with the little time we have, and the number of residents, I do what I can. I am not superwoman. I am not a machine. I am a human being! (Shirley)*
>
> *And she (the daughter) said, 'Well you guys are always losing my mother's laundry.' I said, 'You know, there is something else you can do.' I said, 'If you feel that we are not taking care of your mother's clothing…those ladies take their mothers' clothes home. We have got a basket. You have the option.' She says, 'I can't do that because I am tired. And I am busy! And I have a daughter to look after and I am not doing that. That is what you guys are paid to do!' (Michelle)*

Although most of the care aides in my study were very committed to forming relationships with residents that were full of feeling, and they truly attempted to serve all of their residents' needs as they would their own family member, they resented families who seemed to forget that they were actually working for a living and had days off. These families seemed to think that the care aides were there all the time, or were accountable for things that happened while they were away, or on days off:

> *You are definitely way more accountable. You are absolutely accountable for everything. Even when you are not there, you are accountable.*
>
> *What do you mean? (Interviewer)*
>
> *To the families. We are accountable to the families. You are it. They know you are it. It is a lot of pressure. I mean, when you have your days off and you come back, something is missing. 'What is this, where is that?' I don't know! I have my own family at home, you know? They think that you are there 24/7. You are just magically going to have all the answers for them. And then you have to go and investigate. What happened to the… who was working? (Jennifer)*

Participants consistently reported that they believed if families complained to the management, management would make promises to families that would unreasonably enhance their expectations of the care aides – promises that were not possible for the care aides to keep:

> *I don't know what the families are told when they come into (the facility). I don't know. Are they allowed to abuse us like this? Are they allowed to talk to us like this?....But when you (management) tell a family that 'This is your home, and you can do whatever you want.' Because that is the impression we get. Because if they can swear at us, and tell us…and call us rude names, and tell us that they pay our wages. I mean, this has been told to them by somebody! I don't think families make things up!...Well, that leaves the doors open for a lot for these families. (Michelle)*
>
> *The stuff that they (the management) tell the families sometimes is unbelievable. After a while, it eats away at you….I don't know what they tell these families. I really don't understand what they tell them. Like, when they interview them, do they tell them that there is 6 people working on the floor? There is only two of us. To do 21 heavy people. (Brenda)*

Care aides asserted that they were almost never consulted about the feasibility of families' requests:

> *Sometimes the family wants the resident to be up at a certain time. The manager knows that we have so many residents, yet we are supposed to do it. She doesn't really talk to us and say, 'Is this a possibility?' You know? (Shirley)*

When families believed that promises had been broken, this led to the confrontations between care aides and families:

> *They (management) don't want to be firm with the family members and then we pay the price because we are the front line workers. (Shirley)*

I asked the care aides:

So if you were the managers, what would you do to improve things?

(Interviewer)

> *Well, first of all, I would explain to the families and to the residents…how many care aides and how many LPNs are working there right? And they have got to understand that their family member is not the only one. It is…one out of 10 or 11. So, family member, they have got to understand that….You might be the first today, but you might not be the first tomorrow. So you are not always going to be the first. That this is they way that it is…We don't have just one. They should say to them that there should be no threats to our care aides or anyone that works here! Physical or mental! Threats! We are afraid! And we should work together. (Michelle)*

> *Perhaps you (the management) should tell the families that the baths can't be an hour! Because you are the one that promises when they come in. And the families come and complain to you and you say, 'Oh yes! This can be done and that can be done and this will be done!' And you know, they (the management) do not have a clue about how long it takes to do these things. So I find that management doesn't really know what is going on. (Susan)*

Susan described how hard it was to hear how some family members believed that the care aides were telling lies and not keeping promises:

> *Several people are moving from that position because it is a really heavy group and then you have to cope with the wives club….maybe management will catch on that that position is just not working because you are promising these people (the wives) too much. You know. You are promising the family members too much. They think that it is one on one care and it is not one on one care…We have had things asked for and we have said that we cannot get it done and they (the wives) have gone to the management and then the management says, 'Oh yes, you will have to do this for so and so'. So there are a few things with families that the management have come and told us that it will have to be done.*
>
> *So you just give it the best go that you can? (Interviewer)*
>
> *Yes. And you do hear them (management) say to the family members, 'Oh yes, you will get this and you will get that' but it is just not that way. At times, you hear this and that and you think. 'Oh my God!....So it is hard for us because I think that sometimes the families think that we are lying or we are not doing things for the resident and we are not lying and we are doing things. (Susan)*

As a result of confrontations with families, the participants reflected that the residents who had families who complained were the residents most likely to receive priority care:

> *It is, the one that complains (to the manager) the most gets the help and the one that doesn't have no family, we kind of…we don't neglect, but we don't tend to run to….Because you are so busy trying to keep this family happy so they don't threaten us. And we have said this to the managers. They don't care! Just keep that family happy! (Carol)*

Hypervigilant Families

Multiple participants described family members who seemed to have difficulty disengaging from the complaint mode. These families were hypervigilant and seemed forever dissatisfied with the care. According to my participants, these family members seemed to prefer (even enjoy) looking for and focusing on the slightest oversight or fault, rather than saying thank you for work well done. In the story below, Carol really wanted to please the family but the family failed to acknowledge her efforts. Instead, they looked for, and found another way to be dissatisfied. She felt depleted, frustrated, and angry:

> *You know what happened today? There was everything that was perfect. Everything the way they (the family) want it. The family, they came and they couldn't find anything to complain about. Then, they find that there is a plastic butterfly that was on the wall, and then on the counter. They came to me. They went to the LPN. They went to the RN. They went to everybody. 'Why is the butterfly off the wall?' So, finally. We spent so much time to figure why the butterfly was off the wall. Otherwise they threaten that they will go to the news. They are going to media, they are going to… anyways, we finally found out that the housekeeper cleaned the light thing and took butterfly off to dust it. And she forgot to put it back on. And that was the biggest deal today! (Carol)*

Most of the care aides in my study gained satisfaction at work by doing things well. When the families' comments suggested that they were providing substandard care, some care aides found this very offensive:

> *One time, there was this family member who complains about everything. Little stuff, you know. And when you are in the room with another resident, she is saying to that resident, 'Is she taking good care of you? Is she good to you today? Do you have your water?' And that to me, is completely unacceptable. Instead of being more positive. And that is a form of psychological and emotional abuse. I don't know. It is a psychological thing and those things really affect me. (Shirley)*

Attending to micro-details was very time-consuming and tiring but if they never received any compliments they felt dissatisfied, defeated, and disappointed at the end of the day:

> *It was, like, going on the whole day! Why was the butterfly off? And that is stressful to us because we do the job the best we can and I think we do a pretty good job considering we look after so many people. But it is never good enough! So you never really feel satisfied when you leave…It is something that is petty. Yet, it affects you emotionally and mentally. Never a compliment! (Brenda)*

Never a Compliment

Because the care aides worked with the residents by themselves, they had no colleagues readily available to observe their efforts and to provide approval. Approval was a strong motivating force for many of my participants. Some (like Carol) worked valiantly to gain approval from family members. Feeling that there was no praise or other forms of recognition from families who were most readily available to do so contributed to job stress, negative attitudes towards the work, and diminished job performance. In essence, the participants became de-motivated:

> *With some families, you do have a good relationship and they appreciate you and they do say thank you. But, it is hard to feel good when they are always criticizing and you are put down and they only see your mistakes. So I think that 50% of the stress is family. (Shirley)*

> *The thing is the morale has really gone down. First of all we are not doing the teamwork anymore, we have the larger assignment with people that are sometimes complex care and of course you just don't get any acknowledgement. You kind of feel we are a dime a dozen. (Linda)*

Decreased motivation also fostered reduced interest in the residents themselves:

> *I work on a Sunday and that is her (the resident's) shower day – some of the girls will shower her and get her into her chair. Me – forget it. I don't. It is just too hard. I shower her and then I put her back to bed. Nobody usually comes on Sunday anyway. (Barbara)*

Sometimes the only way to cope with all of the complaints was to call in sick:

> *It is the families that never stop….They (family members) are at you! They are at you! They are at you! And that is where it just drives you sometimes to mad. And that is why people take so much sick time. It is because if you don't take that sick time, you are afraid to go to work! Because they drive you crazy! And they (management) don't get that. They just don't get it! They just don't get it….It is never ending. The demands are never ending….If you didn't put that box of Kleenex where it should be, where she (the resident) thinks it should be, then …she phones her family…And then her family would come down. And tell us that we don't belong there. That we don't know how to do our jobs. That we don't know how to look after her mother. And this is the stress! (Michelle)*

Coping with Threats

Another key factor that negatively influenced relationships between residents and care aides was fear of threats from families. In extreme cases, participants in my study described family members who were angry and frustrated with the care aides because the care aides had not met their expectations of care. Sometimes they threatened to go to the media or call the police:

> *She (the resident's daughter) come in and she said, 'Where is my mum's clothing?' And I said, 'Well it should be in the laundry.' And she says,*

> *'Well I can't find them and they have been gone for a week and I am going to call the police! Because maybe you guys will stop losing my mother's clothing!' (Michelle)*

One participant described how a family member became physically confrontational:

> *She (the resident) was very difficult to get changed…she didn't like any care being done. And her daughter wanted this care done and wanted this and that. And so the nurses said if she refuses, she refuses... So she refused…she wouldn't let me change her tops or bottoms and they weren't dirty…And her daughter came into the room….very stern and looking at me, very kind of aggressive, like a woman looking very aggressive. Not physical yet….and she says, 'Mum is still in the same clothes….And she (the daughter) is just furious. She gets in my face, and she starts yelling, and she is just so rattled that I didn't do my job….and she says, 'You bitch!' She starts yelling at me. And she is like this close to my face, yelling at me. So, as soon as she said 'Bitch' I backed out of the room…It was very scary…Like that was a bad thing. (Mary)*

One participant described how she had been subtly threatened by a family member who suggested that she had some relatives who were Hell's Angels, and that she might have to engage these Hell's Angels in order to make sure that the care aide maintained her focus and gave good care to the resident:

> *The grand-daughter even threatening us that they have angels in their family.*
>
> *Angels in their family? Really? (Interviewer)*
>
> *'Two of my cousins are Hell's Angels! So you had better be good! We have Hell's Angels in the family….We have two Hell's Angels in our family that take care of us.' (Diane)*

Nobody wanted to spend any extra time with residents who had threatening families. Some care aides coped by calling in sick if they anticipated that an angry family member might confront them:

> *Some people call in sick the day that her (the resident's) family comes. Like Fridays. Every Friday her daughter comes. Her daughter comes*

> *once a week and it is Fridays. And thank God I don't work on Fridays! I don't have to deal with it! And a lot of people, they call in sick all the time on Fridays! And then you get called into the office. 'You know what? Something is going on with you. You call in sick on Fridays.' They think every Friday you have some other things booked. But it is not other things. You are scared to come to work! Yes, you are scared! (Carol)*
>
> *Yeah, it is stressful, man. It is really, really stressful! (Brenda)*
>
> *So the way you cope with the stress is by taking some sick time? (Interviewer)*
>
> *Yes, that is how I do it. And I think that is how the majority do it. (Brenda)*

Contrasting Visions of Care

Another form of conflict with family members occurred when the participants' visions of appropriate care for certain residents and/or their concerns for the same residents contrasted with the family members' views. These participants seemed to be in a state of continuous conflict with certain family members because they could not provide care the way they felt best (from their perspectives). For example, Doris wanted to wrap one of the residents assigned to her with a flannelette sheet because this particular resident's backside was exposed and she was concerned that the resident would feel cold. However, the resident's sister would not allow Doris to use the flannelette:

> *I have one family member now…it is impossible to deal with her. Her sister (the resident) is total lift…her clothes are split….the back is open, right? To me that would be cold…So I used to wrap….She (the sister) literally said to me, she said, 'I don't want her to be wrapped. She is not cold.' So I said, 'She is sitting on the chair, and in the chair are holes, so part of her body is totally naked. I am sure she is cold.' And she says, 'No, my sister is not cold'. Her sister can't talk. ….And so it is like, I am thinking…what is wrong for me to wrap her?….But she said 'No.' (Doris)*

In another example, Shirley was tired of struggling to dress one of the residents assigned to her. She wanted the resident's clothing to be split up the back to ease the dressing process. While she reflected that the family probably refused split clothing because it was a sign that the resident's condition was deteriorating, she felt frustrated that the family did not see how much work it was for her to struggle with the resident:

> *There was another family that didn't want their resident to have split clothing cause for them, that means that their family member is going down. You know what I mean?*
>
> *Yes. (Interviewer)*
>
> *But for us, we need the split clothing and we need the correct lift to do the job….She is supposed to be in split clothing because she is a ceiling lift. She doesn't turn. It is hard on my back and it is also hard on her….But when you talk to the family, they are not flexible. They don't think about the work. (Shirley)*

Doris described how she felt very upset and disappointed when the sister of one of the residents assigned to her would not allow her to deviate from pre-arranged routines even though she was convinced that the resident was suffering. The sister, on the other hand, did not believe in Doris' assessments and diagnoses. In the first example, Doris described how she was concerned that the resident was ill. She wanted to put her to bed early but the sister wanted the resident to stay up until her regular bedtime:

> *Last week I felt like she (the resident) was coming down with a cold…after supper she was falling asleep in the chair, and her nose was running….Usually we do not put her in bed until after 8….And (the sister) said, 'She must not go down before 8' and I said, 'Well I think she is coming down with something, I think she has a cold.' And she said, 'Well, she always has that harsh cough.' and I says, 'No she doesn't'. Oh, she let me have it! 'You don't know that! I just don't know what to do with you people! You just can't get this! Don't put her to bed before 8*

> *o'clock!' Well, I do know that! I do know…I said, 'I just thought she would be more comfortable. She was falling asleep in her chair.' And she said, 'I fall asleep in my chair all the time, what is the big deal? (Doris)*

In the second example, Doris explained that she wanted to put the resident in bed for a nap in the afternoon to relieve pressure on her back, but the sister felt that the resident was too young to be napping and insisted that she stay up:

> *We can't lay her down in the afternoon because she is too young….She is only 63.*
>
> *You can't lay her down because she is too young? (Interviewer)*
>
> *No. The sister says you can't lay her down for a nap in the afternoon. She is young. She is not old like everybody else. So she has to sit there from…Eight o'clock till eight o'clock.*
>
> *On her bum, the whole entire day? (Interviewer)*
>
> *Yes. Those are the things I am frustrated about! Oh my God! (Doris)*

When the participants' visions of appropriate care for certain residents and/or their concerns for the same residents contrasted with their perceptions of the family members' views, the result was conflict. The participants became disgruntled and frustrated when they felt their assessments were discounted and when they felt powerless to influence care practices. They described simmering frictions between themselves and the residents' family members. As a result of simmering frictions, some care aides made decisions to *"let go"* of the resident. The process of "letting go" was poignantly described by Joanne, who explained, *"I don't want someone who doesn't want me."*

> *Every time (the daughter) came there, it is not comfortable. It is different. I just ignore that. You know. And then (one) day, she (the daughter) report me.*
>
> *She did? (Interviewer)*

> *And then after that, she doesn't want me to look after her mother. And then the manager said that I have to look after her mother. I must do it! So I keep doing it. And then when she (the daughter) came in, she asks, 'Who looks after my mother?' And the manager mentions my name. 'It is supposed to be not the one to be looking after my mother!' So after that, she report it again to the manager (of the entire facility) and the other manager talk to my unit manager again. And then she (the daughter) said, if they still let me look after her mother, she (the daughter) will go to the highest. So they call me, and they say, 'I don't know. It is up to you. What do you want to do?' 'Well she (the daughter) doesn't want me, so you can give her (the resident) to somebody. I don't want someone who doesn't want me.' (Joanne)*

Cultural Conflicts

Finally, the care aides in this study also described strained relationships between families and care aides that were a result of cultural insensitivities. Some of the families (and residents) had difficulty understanding care aides of varied linguistic and cultural backgrounds, and/or making themselves understood by them. The care aides' abilities to give their best were intimately bound with the quality of understanding. Although this difficulty was not widespread, it was intensely lived by those who experienced or witnessed it. The following stories provided by Joanne and Andy highlight the difficulty of communication where circumstances and feelings kept care aides and families apart.

Joanne described how a family member complained about her accent and subsequently refused to let her feed her mother. Joanne's concerns about the resident's nutritional intake forced her to risk confrontation with the family member as she secretly fed this resident even though she was not supposed to do it:

> *Every time, when I answer the phone…she (a family member) hung up on me. And then she is going to phone back again. And the phone will ring*

> *again, and she is going to talk to the staff who answer it. 'I hate that staff who answer the phone! She doesn't know how to speak English!' And then after that, if she knows I am the one who feeds her mother, she get mad. So I did not feed her. But sometimes I did feed - but I am not the one – you know?*
>
> *Oh, Oh I see! (Interviewer)*
>
> *Because sometimes if we did not do it, her mother would not eat. Her mother has an early tray. So we must do it. Just for the sake of her mother. Just for the sake of her mother. Still, you know, I am hurt….So I have talked to the manager, and I asked, is this person racist? And she said yes, she is. (Joanne)*

Andy described how frustrated he felt when some families made some of the care aides feel subservient. He recalled that some family members, when visiting their relative, treated him as a waiter, and that made him feel "like crap". He struggled between wanting to provide what the resident needed and avoiding validating the families' beliefs of his subservience:

> *His (the resident's) family don't do anything. They just sit there and they call for us. Like they won't even get him food…They call for us. And I say, 'Well there is a kitchen right down the hallway. You can get it.' But then they are like 'No. Can you just get it for us?'*
>
> *Do you think they are tired of looking after him and want you to do it or do you think that is just the way they are? (Interviewer)*
>
> *They want their elders to be treated greatly but they don't want to be the ones to do it. And so they take it out on nurses. Like in the Chinese culture (nurses) are the very low, low status occupation.*
>
> *So really, one of the most difficult things for you is the cultural? (Interviewer)*
>
> *Yeah, because it is just because I don't really know what to do. Because they have been raised to think that way. And I can't really change the way they think. And I don't really want to validate that either. Because it would be like you know agreeing that it is right….Is there something we can do….so we don't get treated like crap? (Andy)*

In summary, the care aides in this study were resolute in their convictions of how difficult it was to relate well to some of the families of the residents with whom they worked. Some participants endured multiple unpleasant interactions with families of residents. Some described intensely negative emotions especially when some families made threats. Other participants described families of residents who had critical, punitive styles. These families looked for and focused on the slightest oversights or faults. Some participants described families who were habitually and routinely unsupportive of changes, even when the care aides believed changes would be in the best interests of the residents.

Multiple participants suggested that families could be a major factor in determining the success or failure of care aides' relationships with residents. Some participants described an overwhelming sense of dread when families visited because they fielded many of their complaints. Care aides felt unfairly blamed for perceived lapses in care that occurred outside their control and were frustrated with the amount of time it took to respond to families' grievances, which left less time to care for residents. Some participants felt that the families did not fully understand the time constraints, the emphasis on efficiencies, and the workload of the care aides, and did not allow for these factors when they had criticisms.

Multiple participants described family members who seemed to have difficulty disengaging from the complaint mode and saying thank you for work well done. Most of the care aides in my study gained satisfaction at work by doing things well and were offended when the families' comments suggested that they were providing substandard care. No praise or other forms of recognition from families who were most readily available to do so contributed to job stress, negative attitudes towards the work, and diminished job performance. Decreased motivation fostered reduced interest in the residents themselves.

Although most of the participants were very committed to forming relationships with residents that were full of feeling, and they truly attempted to serve all of their residents' needs as they would their own family member, they resented families who seemed to forget that they were actually working for a living and had days off. They indicated that many families seemed to view their roles as servile.

In extreme cases, participants in my study described family members who were angry and frustrated with the care aides because the care aides had not met their expectations of care. Sometimes these family members threatened to go to the media or call the police. At other times, they subtly threatened physical violence. When families threatened care aides, they often coped by calling in sick. They reflected that while they gave priority care to residents who had families who complained, they avoided spending any extra time with them.

Another form of conflict with family members occurred when the participants' visions of appropriate care for certain residents and/or their concerns for the same residents contrasted with their perceptions of the family members' views. These participants seemed to be in a state of continuous conflict with certain family members because they could not provide care the way they felt best (from their perspectives). The participants became disgruntled and frustrated when their assessments were discounted and they were powerless to influence care practices. They described simmering frictions between themselves and the residents' family members. As a result of simmering frictions, some care aides made decisions to "let go" of the resident.

Managerial Strategies

My participants perceived that managers and RNs played an extremely important role in whether the complications arising from strained relationships between care aides and residents or between care aides and families endured or improved. Sub-themes related to strategies used by managers and RNs are outlined in Table 8.

Table 8.

The Impact of Strained Relationships:
Managerial Strategies

Sub-Theme	Categories
Nurturance, Protection, and Guidance	▪ Encouraging ▪ Trusting ▪ Setting relational boundaries ▪ Clarifying issues ▪ Suggesting solutions
Feeling neglected	▪ Failure to intervene ▪ Use of repetitive/standard responses ▪ Care aides who are reluctant to obtain help from managers ▪ Relationships with some residents effectively terminated

Relationships between the care aides and the residents were inextricably mixed with many elements provided by the management and the RNs because their responses to care aides influenced the atmosphere in which the residents lived. If the RN created an atmosphere of harmony and good will based on trust, the care aides' relationships with residents were supported:

> *What do (RNs) do to encourage relationships between you and the residents? (Interviewer)*
>
> *They just love us. Like if we ask for something. Say a resident needs some supplies and I say, 'Can I phone the family?' 'Well of course you can! If they need anything, you just phone the family!' They encourage you to do that and you feel good. The family say, 'Thank you for calling!' They don't say 'No you can't do that.' But you get to know which family you can do that with, and which family you can't. I do have some families who are not very nice to me. But when I see the son or daughter, I just say, 'She needs this.'*
>
> *So they are encouraging interaction, I guess, between you and the family? (Interviewer)*
>
> *Yes, yes. Of course, if it is bigger, then you go through the RN. But if it is just little things like toothpaste, or something. So I think that it comes to the people at (this facility) have been there for so long, there comes a responsibility – a trust along with that. We are the nurses and when you talk to a resident, you say, 'I will be your nurse today' because that is what the residents know. When you talk about nurses in particular, we are not nurses. Technically we are not, but we are to the residents. In our eyes, we are nurses. We are taught that in school. So technically, we are" (Betty).*

RNs also had the strength and authority to enable relational boundaries to be set. In some relationships, care aides needed support from the RN to successfully set boundaries. For example, a young and attractive female participant admitted to me that she had been in *"situations where I don't know how to deal with things"*. When speaking about her relationship with "Mr. Confidential" she told me that she had contravened time limits (probably set for her protection) because she enjoyed talking to residents. She soon found herself in a dangerous position - providing too much personal information to the resident:

> *I do get in situations where I don't know how to deal with things. I don't really know how to express my feelings. But I don't think you are going to teach that in six months (in the care aide training program). And especially when they take any age group. I was twentyish when I was taking it but I look very young. I look like a twelve year old sometimes. I am very young right?....You always want to talk about something, make (a resident) laugh…but with this guy I am very…I don't know if I should do that because he is so…he has done super bad things. They (management) do not like you feeding him for a long period of time. So (on one) day, I just sat with him…didn't sit with him…I had something in my hand to make it look like I was helping him but I just let him talk. But he always asks a lot of questions about me personally so then I am like I don't really want to give this information to you. (Mary)*

When rules were set to protect staff members, RNs helped the care aides understand the reasons for them. When there were problems, the RNs helped the care aides clarify the issues and they suggested possible solutions. When the care aides were stressed, the RNs stimulated discussions and/or showed concern for the care aide's well being:

> *The last time that he (the resident) reported me was when I said no to him…he wanted to lie down in bed and wanted cream applied to his groin and I said no. I said 'Once I lie you down I am not going to be getting you back up again.' And that is when he freaked out. So I went to the RN and I told - basically told her I am tired of this guy yelling at me, screaming at me and I said I am trying to the best that I can. He was looking for her. He was in tattletale mode or whatever…he was trying to find her. When he finally did, the RN came back with, 'Well, I'm sorry but I am siding with #### on this one', which was great. It is so nice to have back up….I told her, 'What am I supposed to do? I am just laying down boundaries here.' And she goes, 'That is what you have to do.' And I thought, you know what, that is what I am going to do. 'If you are OK with that I am going to do that.' And she said, 'Yeah.' So it was like OK!....It has to do with having support from other staff to say OK well this acceptable. (Then) you know what you are doing is fine.*
>
> *So when that RN said that to you, was that kind of like a turning point? (Interviewer)*
>
> *Yes. It was like OK, I don't have to feel bad. It was OK to put those boundaries down for him and not feel bad. And I think that is so important because when you are doing that kind of care for someone who*

> *has high demands or whatever it is like you don't know where the stopping point is. Yeah. (Kathy)*

However, many care aides freely expressed that they did not feel as if they were receiving enough managerial support. One of the most troubling issues was that the care aides perceived that some managers allowed the cognitively well residents who were humiliating them to continue without reproach or consequences. Michelle wondered why the managers did not intervene, even if it was only to protect the other residents from hearing or witnessing the insults:

> *So, what is the answer to solving these difficult residents? These people who are really abusive, who throw urine at us, who throw feces at us? That spit in our face? I mean, the language, we can handle. But when they start throwing bodily fluids - that is when I think that the manager…and we get no support from the managers. None!....It is really sad. And what is worse, the managers don't do anything about it. They are allowing this abuse to go on and on. Abuse of us. And not only that. Abuse of the other residents who are listening to this! That is the worst part. I mean, we are old enough to understand. But it is intolerable for them (the other residents). (Michelle)*

According to Michelle, when conflicts with residents occurred, some care aides did not ask for help from the managers because they perceived that some managers relied on repetitive, standard responses to care aides if they complained, and they perceived that the managers would blame them for the conflicts:

> *It is never their (the resident's) fault. It is never their fault! It is always, the way you walked into the room. It is, 'Could have you done something different when you walked into the room?' The managers do not listen to us at all. At all! It is always, 'What could you have done differently? Yeah, so it is always pushed on us. Always. Always, always, always! It is always what you did…And it is always your fault. So you never really go to them for problems. Because they blame it on you. (Michelle)*

Some participants perceived that managers preferred to downplay difficult situations or stay out of difficult situations altogether:

> *She (the daughter of a resident) pushed me on the shoulder….So, she was told not to do, and probably the manager warned her not to do it again, and she kept on not pushing people, but being verbally abusive to care aides.*
>
> *So the manager supported you? (Interviewer)*
>
> *No not really. I was really shaken. I got really nervous. I told her (the manager) that I wanted to go home and she said, 'No, you can't go home. It is not that bad.'* (Shirley)

Some participants felt that their co-workers did not have the energy or fortitude to complain about things to the managers:

> *Nobody wants to bother. They just want to let it go. It is frustrating. I feel like if something happens, my co-workers are going to turn around and say, 'We don't know anything.' You know what I mean, I will be left alone. (Shirley)*

As a consequence, many participants decided that the best way to solve problems with residents and families was on their own:

> *I try to solve some of the problems. That we have with families. Like, myself. (Brenda)*

The following story effectively summarizes nearly all of the most stressful personal, situational, and environmental factors that resulted in strained relationships: the resident was very particular - he had many complaints and demands; he got angry with the participant; he was particularly heavy (a three person transfer) and he was not easy to dress so he was time consuming. The participant felt overloaded and pressured and she was already fatigued. The body fluids (urine and feces) overwhelmed her and contaminated her. She sought the support of the RN. She did not know what to do, so she coped by taking some sick time. She described feeling guilty and in the end, she reported that she felt that she had not received enough managerial support. Her perception that the manager would not support her effectively terminated any efforts towards any sort of relationship with the resident. The evidence for this conclusion is in her summary statement: *"…this man - I do not want to be around him, I don't even want to care for him because I feel I am going to get into trouble again."* To enhance clarity of the complex narrative, it has been broken into paragraphs:

Kathy's Story

> *He has probably been the most challenging resident that I have ever had to deal with. I was under a lot of stress to the point that I did want to come into work… He is to the management like tout de suite for things that I have no control of… He gets upset and frustrated with me and starts yelling and screaming at me to the point that I say, 'Please don't yell at me, don't talk to me like that!' and so I end up having to leave the room and the stress just escalates from there…*
>
> *He is free to go wherever he wants to go and he goes right to the management's office. Or he'll go to the RN. And I feel I am being put on the spot because I am not doing anything wrong.... I kind of have to prioritize what is important and what is not important and a lot of the issues he asks for are not priority at that time so that causes him to get angry and frustrated and he takes it out on staff....*
>
> *What was his diagnosis, what was wrong with him? (Interviewer)*
>
> *Well he has a lot of health issues…too many to name.*
>
> *So give me an example of what he would ask for that would… (Interviewer)*
>
> *That would upset the apple cart?*
>
> *Yes. (Interviewer)*
>
> *When this man when he came onto our unit he was three hundred plus pounds…and at that time a three-person transfer. So he was the last person we would have to get up in the morning just because he took a lot of time. And he would get very upset to the point where he felt he wasn't being treated as a human being because he was the last one left in bed.*
>
> *So when we tried to explain that to him he still did not think it was fair…he felt he was being left out being the last one thought of and he kind*

of went through this thing. So that is how we did it - just to leave him in bed until the last because he was the most time consuming to get up because it takes three people to get him up.

The very first thing that really stuck out for me after he got there was he had a full catheter in dwelling and this guy wanted to have full pants on and the other thing is that when you are assisting him to the commode…he wanted the pad completely done up but the minute you would lift him up he would soil himself because he does not have any control over his bowels. One evening I went into the room and I noticed that whoever had put the bag on or had hooked up the full catheter or the bag onto his chair - it was rubbing against the wheel so the friction actually caused hole in his bag and the whole room was flooded with urine.

And so I go in there and I took just a bunch of stuff to soak up all the fluid or whatever but in the meantime he wanted to go on the commode and I couldn't do anything until everything was cleaned up. So anyways I do not know what it was that he asked and I said, 'No' at that moment and that just set him off like nothing. And with that and with his attitude and everything else for him wanting to go on the commode, by the time I got him on the ceiling lift I had gotten my co-workers to come and help me and as soon as I had lifted him up, everything was just coming out and by that time I was in tears.

I wanted to go home because this guy was not giving me any breaks or anything like that it was like wow….I pretty much said to my LPN I am going home I can not deal with this anymore. Just because of the constant pressure had led up to that point when he had first got there because you could not really do anything right with him.

So the LPN said you better let the RN know that you are going home? (Interviewer)

I had called (the RN) and as soon as I called (the RN) was coming onto the unit and by that time I was flooded in tears. I have never broken down at work like that and so I explained to (the RN) and talked with (the RN) and all that kind of stuff and there were a few other things that happened that night that kind of just piled on top of that.

When I went home I had to phone my family because I couldn't deal with this. I didn't know what to do. I felt dirty. I felt that I was crapped on for no reason at all and it was through no fault of my own and I did not know what to do. So I kept phoning my family and just venting to them and letting them to know what I had gone through. I am usually a very strong person and I can deal with most situations but that one had taken the cake. So I ended up taking a couple of days off. I did not want to come in.

> *It was like you know when you try to do the job really well and you know you are doing your job really well and then you got that hanging over your head. I know I am not perfect but I know that those situations are things that are out of my control but at the same time you are still feeling that guilt that you did not meet that person's needs.*
>
> *I went to management with my co-worker because I was too nervous to go and see her. I did not feel comfortable enough to even tell her that I was feeling like this because I did not feel she had an open door policy. Because I almost feel that her policy is everything was for the residents - for the residents - for the residents, and never mind the staff. I do not care what you do, this is all for the residents. That is her motto. So anyway I went to her and I did not say too much but I definitely could feel the stress was there, really heavy on me. So we went to her, and I explained the situation and it was about him wanting to go on the commode again and him being a three person left and she wouldn't hear my side of it…*
>
> *So I broke down again at work. I told her I do not even want to be here. I said I am doing the best I can but this man - I do not want to be around him, I don't even want to care for him because I feel I am going to get into trouble again.*

Theme Three Summary and Interpretation

My participants' relationships with residents were constrained by multiple personal, situational, and environmental factors. When the participants were asked to describe specific situations or events that they found most stressful, many described their experiences (somatic, psychological, and emotional) that were associated with difficult interactions with some of the more challenging residents and which sabotaged any possibility of relational success.

Experiences with seemingly cognitively well residents included: feeling uncomfortable when residents made requests of a sexual nature or requests that appeared to be of a sexual nature; feeling threatened or afraid of residents who had criminal histories; feeling uncertain/afraid of residents who could became intoxicated with alcohol and/or marijuana; feeling irritated by residents who, they perceived, were overly particular or demanding and intentionally or unintentionally increased the amount of the physical work for them. All of these characteristics resulted in higher levels of exhaustion, feelings of exploitation, and high levels of stress for care aides. Relationships between care aides and these seemingly cognitively well residents were characterized by high emotional intensity, and feelings of frustration and anger.

With regards to residents who suffered from cognitive dysfunction, strained relationships were due to the more prominent facets of the dysfunction such as unpredictable, and unintentional outbursts. These outbursts also radically influenced the quality of relationships. Fear of being hurt by these residents made it very difficult for care aides to engage or become close to the residents. Participants found themselves less focused on relational practices and more focused on practical interventions designed to reduce their fears and uncertainty about the resident's behaviours.

Multiple participants suggested that families could be a major factor in determining the success or failure of care aides' relationships with residents. Some participants described an overwhelming sense of dread when families visited because they fielded many of their complaints. Some were frustrated with the amount of time it took to respond to families' grievances, which left less time to care for residents. In extreme cases, participants in my study described family members who threatened care aides. When this occurred, they often coped by calling in sick. They reflected that while they gave priority care to residents who had families who complained, they avoided spending any extra time with them.

Conflicts with family members also occurred when the participants' visions of appropriate care for certain residents and/or their concerns for the same residents contrasted with their perceptions of the family members' views. They described simmering frictions between themselves and the residents' family members, which contributed to job stress, negative attitudes towards the work, decreased motivation, and diminished job performance.

Participants reported that they believed that most managers permanently sided with residents' or families' requests, no matter how unrealistic those requests were. Participants asserted that they were almost never consulted about requests. Multiple participants found dialogue with managers extremely difficult so they stopped going to them for help when they had relational conflicts with residents or family members. This left them feeling frustrated and powerless. The sense of powerlessness was firmly rooted and was a major factor in much of the anger, frustration, and emotional suffering conveyed to me by many of the participants. Work life for these participants could be filled with bitterness and resentment, which were not good companions for caring relationships. All of these factors reduced interest in the residents themselves and some care aides made decisions to "let go" of certain residents.

Many of the participants in my study clearly stated that the cultural norm of consistently assigning the same resident to the same care aide (creating families) was not always a good idea for them. The outcome of the same stressors from the same residents (and/or their family members) over time resulted in lack of concern, lowered standards, reduced levels of patience, exhaustion, and frustration.

Theme Four

Care Aides' Perceptions of Role Identity and Worth

In this section, I attempt to interpret the processes by which the care aides developed their concepts of self at work. The perception of roles was a thread that ran through all of the other themes and data, and contributed to the care aides' experiences of the work environment and therefore, their experiences of their relationships with residents and the residents' families. When the participants spoke to me about how they perceived their work roles, many participants said something in symbolic form about their experiences of power and prestige. The participants held specific assumptions about what a desirable role for a care aide was, versus an undesirable role; what was rewarding work for a care aide, versus unrewarding work; and what resources should be made available to care aides. Most participants agreed that work role differentials could be summed up as layers differing in power and prestige.

The majority of participants indicated that they felt most bothered by comments or actions that made them feel low in power and low in prestige (subservient). In these respects, there were almost as many reasons for feeling subservient, as there were participants. Because this theme was insidious and contributed to many other themes, I constructed a concept map to compare the desirable roles to the undesirable roles (Figure 1). A summary of theme four is contained in Table 9.

The Desirable Nursing Role Compared to the Undesirable Subservient Role

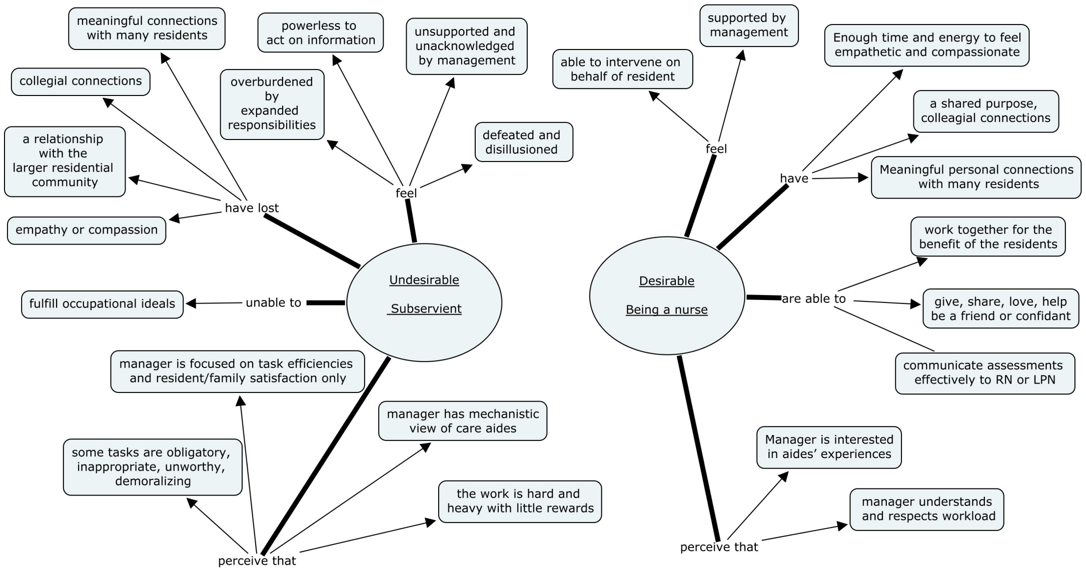

Figure 1. Concept map depicting aspects of the desirable nursing role compared to aspects of the undesirable subservient role.

Table 9.

Care Aides' Perceptions of Role Identity and Worth

Sub-Theme	Categories
Desirable Versus Undesirable Tasks	▪ Tasks worthy of help and being in the ideal state ▪ Tasks not worthy of help and not being in the ideal state
Rewarding Versus Unrewarding Tasks	▪ Feeling acknowledged and/or valued ▪ Not acknowledged or acknowledged inappropriately ▪ Not valued and disillusioned

Desirable versus Undesirable Tasks: The Christmas Party

The most salient reason for feelings of subservience was whether or not the participants recognized certain tasks as worthy of help or unworthy of help. If the managers', residents', and/or family members' requests were perceived to merit the participants' commitment of time and the provision of other resources, the participants did not feel subservient. On the other hand, if tasks requested were obligatory and perceived as inappropriate, unworthy, or demoralizing, the care aides felt subservient. To elaborate this conclusion, I provide two examples of a specific circumstance (the Christmas party) that highlight the processes leading to the judgments of what a desirable for a care aide was and what an undesirable role for a care aide was. In the first example, Betty speaks about desirable tasks and roles. I began by asking Betty: *How did the Christmas party go at your facility?*

Desirable (Betty)

Narrative	Process
Wonderful. Extremely busy.	The ideal state is helping, so being busy is part of that
The RN on our unit had her curling iron out and she had them all lined up like a train. She did all their hair. Wonderful. Yup.	Feeling supported by the RN, no hierarchy of work, RN is committed
And she did all their hair, and we added little personal touches like just making sure they were in red or green or whatever.	The ideal state of caring and sharing, task not obligatory therefore not feeling subservient
Jewelry. We made them all just beautiful. Absolutely stunning.	The ideal state of being a friend
We had 70 extra family guests. Family and friends of the residents. Between the two units.	Altruism, helping/hosting. Receiving recognition for effort
And we got nothing but compliments.	
And when you had this dinner, were you taking part, or were you serving? (Interviewer)	
Serving. We did have to do the serving, and the cleaning up and all that. I mean, that is fine. We are not going to sit down with them and eat dinner because we are serving. We are staff and I am fine with that.	The ideal state of helping. The occupational ideal of altruism
I let them spend the time with their families.	The ideal state of compassion, caring, loving
So what else are we going to do?	Explanation of why they chose this work
We did have extra staff, who came in and took the workload off us though. We got extra staff. We had one extra person come in.	Feeling supported by management, therefore not subservient
He didn't help me, per se. He was an extra care aide who picked up the slack. If I needed him, I could say, 'Can you get her up?' And he would have. Our manager loves us! (Betty)	Feeling worth, supported to do best work. Manager's request merits participants' commitment

In this situation, the manager used discretionary power to provide extra help for the party. There were few rules, and the staff felt supported to use their own initiatives *"little personal touches"*. The care aides had grounds for believing that the manager respected their workload and that they were entitled to extra help during a specific event. Favorable impressions of the manager almost guaranteed the care aides' interest in and support for the Christmas party, ensuring interest in and support for the residents and their families. In comparison, I present another example of undesirable tasks and roles. That is, the Christmas party described to me in detail to by Jennifer and Diane:

Undesirable (Jennifer and Diane)

Narrative	Process
We just had the Christmas party the other day. (Jennifer)	Opening statement by participant means she has something she wants to me to know
I called in sick! (Diane) And by the end of that day, (another care aide) and I both looked at each other and we said that is what we are doing next year - calling in (sick)! (Jennifer)	Task considered not worthy of help, does not merit participant's time
What happened? (Interviewer)	
Well, we were serving the lunch…dressed in black and white - dressed in black and white like a waitress! We had to carry these big trays and serve the families and the residents. (Jennifer)	Task obligatory and perceived as inappropriate, unworthy, or demoralizing, feeling subservient.
All by yourself? No extra staff for that? (Interviewer)	
No. No extra staff. (Jennifer)	Do not feel worthy
They wanted people to start coming at 1100 until 2pm! …Half way through a couple of my	Perceived as inappropriate task

residents couldn't even get through dessert because they had already been up for hours. (Jennifer)	
Their families are already like 'She has to go back to bed! She has to go back to bed!' And I said to (the other care aide), 'Can you cover my section for the dessert because I have to start putting the people back to bed…because they are in so much pain – they have been up for too long already.' (Jennifer)	Feeling frustrated, fatigued, not in the ideal state of helping/compassion, unable to fulfill residents' needs
So here, we didn't get our breaks. And then still on your feet, serving this lunch. (Jennifer)	Not worthy of relief, feeling subservient, perceived inappropriate task
And then they want you to mingle with them – whatever - in between the courses. (Jennifer)	Perceived inappropriate task. Not feeling worthy or supported
It is like, you know we were on our feet straight 8 hours…They didn't care. That was a really hard day!	
I went home and I had a triple rum and egg nog and I popped a sleeping pill and I went to bed. I think I had a hot bath first. Next year, I am going to call in sick on that day…	Task not worthy of commitment next year
The manager, she wasn't even there! She should have been the host…because it is her unit….	Manager not committed, therefore staff not committed
And the other girls took a napkin – I didn't do it because I was just – I had had enough. But they did this fantastic thing. They took a napkin and they stuck it in their belts. Like a fine dining restaurant. And we all had white tops and black pants. You know, like this towel over your pants. And she says, 'We have to be waitresses! So we will act like waitresses! Stick it in their face!' (Jennifer)	Know it is wrong. Reacting in anger, with ill will Conflict between the ideal state and anger due to subservience
And the whole thing became a demeaning experience? (Interviewer)	

Yes. Demeaning for us! (Jennifer)

When I said, "*And the whole thing became a demeaning experience",* I actually meant that the whole party had become a humiliating experience for the residents' and their families (unbeknownst to them) because the party was being lampooned by the care aides. However, the participants interpreted my comment as if it was directed towards them. Undeniably, they were also humiliated and their overall reaction to the event was one of anger and disgust. They were required by management to fulfill a subservient waitressing role. The requirement to dress in black and white was the catalyst ingredient that affected the care aides' decision to satirize the event.

Diane anticipated the extra work and called in sick, but Jennifer reported to work as usual. Hoped for assistance in the form of extra staff did not materialize, so the only possible conclusion was that the management did not care about their needs - *"they did not care"*. The manager's absence from the party was also interpreted as evidence of lack of obligation to staff, residents, and families alike. In relation to these significant problems, the manager's actions did not result in enhancing the staff's initiatives (as it had in the previous narrative) and did nothing to elicit/reinforce care aides' obligations to the residents and family's enjoyment of the party. The whole helping process became ideologically unpalatable.

Many participants shared stories illustrating that problems related to feeling subservient were not unusual. In the next story, Doris described an RN who did not engage in direct patient care. Doris felt subordinate in capacity and function. Her feelings are represented in her words *"almost like we are at the end"* and *"is it (patient care) beneath you?""*

> *It is ridiculous. It is almost like we are at the end. Some of the RNs, like there is one on X unit that sits in front of the computer and one of the residents coughs and I am in the back room and (the RN) comes in and says, 'She has just coughed and she has got mucus all over.' Well, you just walked by her, why couldn't you wipe it?...You can't just walk by her! Is it beneath you to do that? Just because of more education? You are not better than I am just because of your education. Is it beneath you to wipe her? (Doris)*

Rewarding versus Unrewarding Tasks

In this section, it is important to reiterate that the majority of care aides in my study saw themselves as nurses:

> *'I will be your nurse today' because that is what the residents know. In our eyes, we are nurses. (Betty)*

They also viewed themselves as becoming a resident's friend or confidant, being "there" for them (or their families), making a difference in their lives, providing care, and caring about them:

> *You are their (the resident's) friend or confidant. You are there for them. (Susan)*
>
> *You can make a difference. (Linda)*
>
> *We are in this business. We are the carers. The caregivers. (Jane)*

Keeping the aforesaid occupational ideals in mind, it is important to review that even though the participants told me how hard they had to work, and how the organizational culture and structures often impeded their efforts to meet the needs of their residents effectively, many persevered because of the satisfaction they gained. This satisfaction was often derived from the resident's show of support, acknowledgement, and appreciation. The participants' deal goals worked to motivate them and energize them and the reward for all their hard work was a feeling of occupational self worth and contribution:

> *I need to make sure that I can help people. (Mary)*

However, many of the care aides in my study saw some managers' mechanistic views of the care aide role as incompatible with their own views of their roles as nurses or incompatible with their own evaluations or appraisals of occupational self worth. In many cases, participants confirmed that they lacked acknowledgement from managers:

> *If we were thanked. If we were respected. Like, we don't ever get a thank you. (Cheryl)*

Unlike the manager described earlier by Betty - *"Our manager loves us!"* – most of the participants observed that their managers did not care about them (holistically):

> *I have had a friend that wanted to become a care aide and I said, 'Don't. It is not a happy profession. Because of the work overload, all of the injuries, all of the stress.' For me, the management doesn't really care. (Shirley)*

They perceived that the managers were focused solely on task efficiencies, resident/family experiences, and resident/family levels of satisfaction, and were not interested *at all* in *their* experiences at work or *their* levels of satisfaction because *their* roles in the grander scheme were relatively unimportant. These care aides indicated that their main objective was to "survive" at work because they were never going to be acknowledged or rewarded for their efforts by the managers:

> *I think for myself, I have been there for so long that I can survive what the management puts in front of me. (Judy)*

Participants' perceptions of their lack of importance and of the non-caring traits of most managers (relative to them) was best reflected in their assumptions generated in response to several dimensions of practice – the most important of these – the shortage/lack of personnel/human resources. For example, several participants were critical of managers, who they believed valued budget more than any other factor:

> *It is all about the budget. What can we do? For me, the management doesn't really care. They are managers. I think that they are trained to think about money more than care. (Shirley)*

They believed that in most managers' minds, the role of a care aide was unimportant and mechanical, similar to the role of a docile draft horse who continues doing hard heavy tasks for little rewards. These beliefs were represented in Doris' words "they won't know the difference", "they will just work their ass off" and "this is a back breaker":

> *So some asshole up above, decides to cut back because it is all about the budget, it is all about the money, OK. They have done eight people before and we can increase it. They won't even know the difference. They will just work their ass off. They don't care. And they cut back. At times, you get these little messages that somebody wants to become a care aide and wants to know what the job is all about. And there are a few times that I have responded back. Please, let that person call me and this one young girl called me and I said, 'Why do you want to go in this job? At your age, don't do this. This is a back breaker.' Because the management does not treat you good. They don't care. (Doris)*

It is also important to recognize that failure of management to acknowledge what care aides believed, valued, and experienced, was perceived by them as lack of respect and it defeated or de-motivated them. Those care aides who were influenced by service and caring ideologies, described how defeated and disillusioned they had become as a result of indolent efforts to acknowledge them- evidenced by what management did, what they said, and especially their manner of saying it:

> *And our manager had said at the meeting, she didn't want to hear all the excuses of why something cannot be done because of the workload. All she wanted to hear is how we can make it happen. I think that they all go to the same management course. And they all have the same little spiel. This year's spiel is 'We will have to roll that out!' That is this year's quote. One year it was 'Together towards excellence!' Like every year you can tell after they have had their little meeting thing cause they will have some kind of line that they will beat into you. And this year it is about 'How we will roll that out'. I am quite serious…It kills you. It kills you! Slowly it kills you! To the point where I have to get out of it. (Cheryl)*

Cheryl described how her manager had "rewarded" them for their efforts during Nurses' Appreciation Week by giving them Dixie ice-cream cups (small, inexpensive cardboard cups of ice-cream) that were normally served to the residents. This event was perceived as even more humiliating and hurtful because it occurred during Nurses Appreciation Week, and many of the care aides in my study saw themselves as nurses:

> *For nurses' appreciation week – On <u>our</u> appreciation day…at least three people – managers from the other facilities – were waiting for us outside. I guess the other staff had been summoned and they came and did what they were supposed to do. We finished laying our people down. And the manager came down looking for us twice to come out. Like to come out to the appreciation. There were no drinks, no thank yous, nothing spoken. There was a Dixie cup. The residents' Dixie cups. We had a choice. Strawberry, caramel or vanilla. The resident's Dixie cups! They were hounding us to come out and eat those. And we are not allowed to have resident food! But that is all they supplied for us. Resident food. That was our appreciation…Isn't that terrible? We are not appreciated….Like you see people stressed right out and trying to do the best they can, and trying to get help. Trying, trying, trying and working short. And trying to fit the baths in. Trying, trying, trying. Is it worth a Dixie cup? Like, they are just stressed right out. And that is why I say it. 'Is it really worth a Dixie cup?' And it kind of grounds you. (Cheryl)*

Cheryl told me that although she had been certain of the value of her role and her relationships with residents, the Dixie Cup incident had irretrievably changed her opinion. When she was faced with a decision whether to try her best with a resident, or put in a lot of effort on behalf of a resident, or a resident's family, she often decided against it - because all of the effort that she and her colleagues put into caring, sharing, making a difference, helping, and nursing, was only worth a Dixie ice-cream cup. She also encouraged her colleagues to weigh any special efforts they may be tempted to make on behalf of residents with lack of recognition or rewards:

> *This is my sick sense of humour – what I say to people when they get all bent out of shape - 'Is it really worth a Dixie cup? (Cheryl)*

In another dimension of practice, some participants described managers who were perceived to maneuver to place the responsibility for conflicts between care aides and residents (or care aides and family members) firmly on the care aides as if any problem always originated with the care aides:

> *Even though you know you are not doing anything wrong…because he (the resident) is going to management (to complain) you are going to get into trouble anyways right?....I am going to be blamed for this and I am going to be blamed for that even though it is not anything to do with me personally…management is going to come down on me and management is going to see that I am the one that needs to be corrected here, not the resident. (Kathy)*
>
> *So you really felt that they would only look at his side of things. (Interviewer)*
>
> *Yes. (Kathy)*

As a result, these participants found dialogue with managers extremely difficult so they stopped going to them for help when they had relational conflicts with residents. This left them feeling frustrated and powerless:

> *Yeah, so it is always pushed on us. Always. Always, always, always! It is always what you did. And how you walked into the room. And it is always your fault. So you never really go to them (management) for problems. Because they blame it on you. (Michelle)*
>
> *It will be – the dumb care aide. That is how it seems. They have people to blame…and we are so powerless, that is part of why I have to leave! I have to leave. (Cheryl)*

It is relevant to stress that a sense of powerlessness was firmly rooted and was a major factor in much of the anger, frustration, and emotional suffering conveyed to me by many of the participants. For example, Michelle observed that care aides often feel powerless because although they have information about the residents, they cannot act on the information:

> *There is nothing we can do because we are Care Bears. We can only bring the information. (Michelle)*

Considering that the participants saw themselves as nurses and viewed themselves as being "there" for the residents, providing care, and caring about them, it was very unrewarding for them when they could not act on the information and fulfill their occupational ideals. Two poignant narratives below illustrate the distress of being unable to fulfill occupational ideals. The stories are from Cheryl, who agonized over several situations where her assessments of the residents' conditions were discounted (unrewarded) by the LPNs:

> *We have an LPN who doesn't believe in medications. We ask for pain medication for our residents and she says, 'Oh, they are OK. They just need a drink of water.' We had two residents, one psychiatric, diabetic, hallucinating. She is gone now, but her last days – there was no help for*

> *her! I was trying to get help for her. She is in pain. She is screaming about fire. She says she is in a house that is on fire. I went to the LPN. 'Don't you have something that you can give to her?' And she says - she put her hand up in my face and she says 'I don't want to talk about medications! Did you reposition her; did you give her a drink of water?' And she would go in there and I don't know what she would do but this poor woman, she died in pain, in my opinion...She was consistently in pain! And there was nothing I could do about it. (almost crying)*

She felt absolutely powerless to intervene on behalf of her resident because her role was strictly to provide physical care. She confirmed her analysis with a second story:

> *Another time, I had this fellow who had so much pain, he would actually bellow so loud that you could hear him at the desk. And they (the LPNs) would do nothing to help with his pain. Three Tylenols. That is all. And he died shortly after. That bellowing didn't come from no-where. 'Well, did you reposition him? Did you give him a drink? He wasn't in pain when I went down there!' The LPN absolutely refused. No-body wants to phone the doctor. Why would they not give something for pain? There has got to be something! If they won't take their pills, why not a patch? They all go consistently, 'The doctor wants a process followed.' But they don't follow the process. They don't do that. I don't get it. You chase them and you chase them and you chase them. They don't want to do anything about it – to talk to the doctors. And it is killing me. You are powerless. I got myself into hot water because a family member came in, and it was a time when I couldn't take any more. And I said to the family member, 'I think that you need to talk to the LPN or RN about the medication.' Well, she went to the desk and we were told after that we are not to talk to the family – that is not in our job description. Not about anything? Not about medications or concerns. That is not our job. I mean, we don't really know what the medications are, but we try to figure it out. We can go through the chart and try to figure it out…But they really don't want you knowing what they are all doing it seems. It keeps us powerless. (Cheryl)*

Cheryl's exasperation and frustration corresponded with feelings experienced by many of my participants. They described how their roles had expanded in terms of task expectations, but this expansion had not been matched by an equivalent quantity of respect and power to challenge, discuss and/or intervene on behalf of the residents, even though they were most familiar with the residents' usual ways of being, their expressions, and ways of communicating.

Theme Four Summary and Interpretation

The perception of role identity and worth was a theme that ran through all of the data, and contributed to the care aides' experiences of the work environment and therefore, their experiences of their relationships with residents and the residents' families. When the participants spoke to me about how they perceived their work roles, many participants said something in symbolic form about their experiences of power and prestige. They held specific assumptions about what a desirable role for a care aide was, versus an undesirable role; what was rewarding work for a care aide, versus unrewarding work.

A desirable role for a care aide was one where the tasks (even if obligatory and unpleasant) were considered to be worthy or merit the participant's commitment of time and the provision of other resources. A worthy task was one which fulfilled in part or in whole, the care aide's ideal state of altruism or compassion or ideal roles of helping, caring, sharing, being a resident's friend or confidant, being "there" for them (or their families), making a difference in their lives, providing care, and caring about them. A desirable role for a care aide was also one where the care aide felt valued, supported and recognized.

An undesirable role for a care aide was one where the tasks were perceived as inappropriate, unworthy, or demoralizing (for example, dressing up as a waitress and performing as a waitress). These types of tasks did not fulfill any part of their ideal states or roles and resulted in a feeling of subservience.

Care aides who felt unfulfilled in an undesirable role and did not feel as if they had many obligations to the residents and their families had greatly reduced initiative to make extra efforts on behalf of the residents and their families.

It is important to note that in my study, the contributions that the care aides, the LPNs, and the RNs made to the welfare of the residents appeared to be complementary but highly differentiated, and many of the participants felt unrecognized and undervalued. For example, many felt that the LPNs had no compassion for them (their colleagues), because they seemed to be very reluctant to provide help with basic care activities when they needed help. In addition to this, although the participants felt increasingly responsible for assessing and reporting deviations in the resident's physical and emotional health and well-being to both LPNs and RNs, some suggested that their findings and their assessments were unrecognized, overlooked or not taken into account.

Considering that the participants saw themselves as nurses and viewed themselves as being "there" for the residents, providing care, and caring about them, it was very unrewarding for them when they could not act on their information (their assessments) and fulfill their occupational ideals. I provided two poignant narratives to illustrate their powerlessness, frustration and distress related to inability to intervene when residents were perceived to be suffering.

The participants also complained bitterly about work overload (too many tasks, too large an assignment and not enough time). Their biggest time concern was not enough time to feed residents properly. Participants explained that they perceived that managers did not understand how much time was actually needed to give basic care. Participants described feeling very fatigued, frustrated, anxious, and angry as a result of all of these factors. The probability of care aides forming close relationships with residents was reduced because they were perpetually torn between compassion for the residents and feelings of resentment related to feeling stressed, anxious, undervalued, unrecognized, powerless, frustrated, subservient, and overworked.

In this study, associated reductions in numbers of RNs due to the restructured visiting professional role (a component of the Eden Alternative® model) effectively eliminated their constant reassuring presence, their constant relational support, expertise, and problem solving skills that previously contributed much to the overall harmony in many nursing units. As a consequence, participants reported feeling alone at work, with greatly reduced avenues for relational advice and support.

Even though the participants told me how hard they had to work, and how the organizational culture and structures often impeded their efforts to meet the needs of their residents effectively, many persevered because of the satisfaction they gained from nursing. However, many participants perceived that some managers held mechanistic views of their roles, which were incompatible with their own views of their roles as nurses. Failure of management to acknowledge what they believed, valued, and experienced, was perceived by them as lack of respect and it defeated or de-motivated them.

Many of the care aides in my study saw themselves as nurses. Most of the participants observed (correctly or incorrectly) that their managers were focused solely on budgets, task efficiencies, resident/family experiences, and resident/family levels of satisfaction, and did not care about them in a holistic or professional way. These care aides indicated that their main objective was to just to "survive" at work.

Theme Five

Care Aides' Perceptions of the Organizational Philosophy

I turn now to the theme that overshadowed all of the intra and interpersonal factors. This was the care aides' perceptions of a specific culture of care that was organized according to a explicit model: The Eden Alternative®. I have previously described the Eden Alternative® and explained how the Eden Alternative® model of cultural change fits within two well-known models: the model of client centered or resident centered care, and the social model. The following section focuses on my participants' perceptions and experiences of the Eden Alternative® model. It is important to note that theme represents my participants' perceived realities.

The key idea in this theme is that although the theoretical, ideal model of the Eden Alternative® was an attractive way to think about the nature and quality of life for residents in long-term care, my participants perceived that the operation of Eden principles was incomplete, selective, and targeted more towards fiscal goals rather than resident quality of life or care aide levels of satisfaction at work. Their experiences of working in an environment that seemed to espouse Eden ideals that were incompletely implemented or implemented and allowed to erode, had a profound impact on the nature of their work and relationships with residents and families. To recall, the intent of the Eden principles are to enrich the culture of nursing homes and ensure that residents who live in those homes receive not just physical assistance from their caregivers, but spiritual assistance as well. The theme is outlined in Table 10.

Table 10.

Care Aides' Perceptions of the Organizational Philosophy

Sub-Theme	Categories
Faith in Eden	▪ Permanent assignments called families ▪ Participant's understanding and faith in the philosophy ▪ Families who do not subscribe to the philosophy
Erosion of Eden	▪ Family sizes increase from five or six residents to eleven ▪ Number of RNs reduced ▪ Levels of dependency rising ▪ Time constraints lead to difficulties - especially mealtimes ▪ Routines incompatible with philosophy ▪ Residents waiting for care
Alone in Eden	▪ No collegial connections ▪ No ability to obtain help ▪ No avenues for support or fellowship ▪ Lost relationships with residents not in assignment ▪ Feeling inadequate ▪ Feeling sad ▪ Residents isolated from the larger community

Faith in Eden

The Eden Alternative® requires shifts in perspectives, organization and culture of care. A transition towards the Eden Alternative® model involves significant changes in job duties and routines for all staff members. In this study, all participants referred to their permanent assignments as families. In all cases, each family existed as a distinct unit clearly separated from the other families:

> *Before that (implementation of the Eden Alternative®) they had three care aides at one end (of the facility). So we did everyone. We kind of mixed it up. Now I have a specific family. (Mary)*
>
> *They gave us all a family. I have eight residents now and you are responsible for your family. (Susan)*
>
> *You are responsible for 9 people. And then at certain times of the day…you are responsible for more families. (Cheryl)*

In the initial stages of implementation, the shift to permanent assignment was seen as a welcome development - a primary source of stability for both residents and care aides:

> *So when they gave you your family, when they brought this in, were you happy about it? (Interviewer)*
>
> *Quite frankly I was quite happy because before that…we shared the workload….I had a couple of really good LPNs I worked with and we worked together. (But) the LPNs…left and they were filling it with casuals (who) didn't want to do any care. They wouldn't help. Then I was doing basically fourteen residents…And I was at the breaking point to be honest. I am a good worker, but I just can't anymore. So then they announced we were going to Eden! So it was good for me, I liked it! (Susan)*
>
> *So it sounds like at the beginning, when they told you about the Eden philosophy, you were kind of looking forward to it? (Interviewer)*
>
> *Yeah! Like it was kind of great! (Judy)*

Although some of the care aides saw cultural change as a welcome development, some of the families (of residents) did not. There is an underlying assumption in the model that all of the residents' families desire this type of care for their family members, and have faith in and understand the philosophy. The care aides in this study suggested that this is misleading.

Some participants had great faith in the model and followed the principles very conscientiously. However, they described how they found themselves in conflict with some family members who did not support all components of the model. For example, two important components of the model are: a) to encourage residents to do what they can for themselves without having to work within time constraints, and b) to eliminate rigid schedules for meals, bathing, medications, bowel care, sleeping/waking etc.

Some families (of residents) described by the participants were not fully committed to this perspective. Subsequently, these families had conflicts with participants who had faith in the philosophy. For example, Jane described one family who wanted their relative up for breakfast everyday, no matter how he felt. Jane felt frustrated because although she wished to follow the model, the family did not:

> *And if he (the resident) was really, really miserable – leave him! Back out and give him some time to figure out. There was also the family. Wanted him up for breakfast no matter! (Jane)*

In another example, Paula described how she conscientiously followed the principle of eliminating rigid schedules. When one of the residents aggressively resisted his bath, she backed off and postponed his bath. However, the family was very unhappy that his bath had been postponed:

> *There was this one gentleman in our unit…a very well known man in the community too. So that was one thing, because he was well known in the community, the family made it very well known in the nursing home that if he didn't look…let's say, they would come in and notice his finger nails*

> *not cut. And they would say, 'His fingernails haven't been cut and he had his bath yesterday.' And we would go, 'Well he didn't have his bath yesterday.' 'Well, why not?' (Paula)*

Paula described how she was placed in an uncomfortable position. She didn't know what to do. She had faith in the philosophy but the families' requests were not congruent with the philosophy. Because she was afraid that the family would complain and go to the management, she altered her plans for care and then felt guilty about it. In the following story, Paula describes how she and two other care aides coerced a resident to get changed, (which was going against the philosophy of care) because they were afraid of the family:

> *He was incontinent and he wouldn't allow us to change him….But for us, the threat of the family walking in the door at any minute and he being incontinent. You know? What are you going to do? So you know, the three of us generally would go in…I would distract him and the other two girls were – unfortunately – taking down his pants and trying to wash him up and get him changed - whatever. So we did that a lot. If he got angry, he could grab you. It was nothing for him to grab somebody by the arm and start taking his anger out by twisting, you know, behind your back. (Paula)*
>
> *Maybe if the family were different, then maybe you might not have felt the pressure to tackle him? (Interviewer)*
>
> *Yes, we would have left him a little longer till he calmed down. (Paula)*

Erosion of Eden

As the participants reflected on what the Eden Alternative® should mean in their facilities, they shared their disappointments and frustrations with several other key components of the philosophy. According to the participants, key components had eroded substantially over time in all five facilities. For example, participants stated that the families were smaller when the Eden Alternative® was initially implemented, but gradually, the family sizes had increased:

> *When Eden was first introduced to us – true Eden is one care aide for five people. Well that never did happen for us. It was seven, and now it is eleven.*
>
> *How did this (the change in assignment) come about – how did things change from seven to eleven? (Interviewer)*
>
> *They deleted positions…They got rid of a few beds. But we still had to pick up the load. So now we have 21 people instead of 25 on each side, but between two care aides, not three. (Judy)*
>
> *So what happened when that decision was made? Did anyone say, 'We can't manage'? (Interviewer)*
>
> *We said that. They don't care. They really don't care. What they (management) say is, 'Oh there are statistics out there and you actually have less than everybody else.' In all the other facilities. That is what they are telling us. And they are actually saying this. And some family members complained to them and they said, 'No, they have the same.' But we don't! We have a lot more! (Judy)*
>
> *Whoever is doing this Eden…Eden philosophy you are only supposed to have six patients. Not eleven! Right now, I have eleven. And it is very, very tough! (Doris)*
>
> *When they first started the Eden, we had seven. I had seven. And that was nice. You had time to look after these people and now they have got rid of staff and now I have got 11. (Barbara)*

Because the family sizes had increased, other key components of the philosophy became unattainable. For example, as a result of the large number of residents in each "family" and the high levels of dependency, the care aides felt that they were no longer able to fulfill the relational goals of the philosophy. Care aides knew that according to the Eden Alternative®, they should be spending some time sitting and talking with residents:

> *But they are trying to tell everybody that this is Eden where it is actually an assembly line in the morning. You can't take the time to sit and talk with them or anything else. Like in the morning, you just can't! No not at all. You are rushing, especially in the mornings. The problem is, we*

> *really don't have time to have any relationships at all. You do what you can. And that is basically it. (Judy)*

Jane knew that she should be allowing residents to do as much as they could for themselves without time constraints to help them feel as if they were reciprocating in the relationship. Jane could not meet this goal because she found that she had too many residents to track what everyone was doing:

> *The idea of Eden too is they should do as much for themselves as possible. But they don't give you the time….if someone is brushing their teeth in that bathroom and somebody is doing this in that room you lose track of them. So you end up doing a lot for them and that defeats Eden right there. Because some people can do their blouse up if you give them an hour and they have nothing else to do so they might as well do it. Except you have to remember to get them - to take them somewhere else. You just can't leave them forever. (Jane)*

Doris and Shirley knew that a goal of the philosophy was relaxed, pleasant mealtimes that would enable care aides to sit and talk with the residents and build connections with them. They could not meet this goal because they had too many dependent residents and the residents ate very slowly:

> *We have to do everything on our own – some of them have a really hard time swallowing so you have to be there for half an hour. And that is not realistic because I have more people to get up and I have other people to feed. So we have too much workload and not enough human resources. (Shirley)*

Kathy and Jane reflected that the care aides used to have time to drink coffee while the residents were eating and drinking, and this was in keeping with the goals of the philosophy because the residents would be more likely to sense that they were sitting at a family table, rather than being fed mechanically by a person who is not eating:

> *To be able to have a cup of coffee with your residents would be part of the Eden philosophy but it is not there. The only relationship you have with*

> *your residents is when you are doing a personal care and that is it. (Kathy)*
>
> *When I first started in the business, when we fed people, we would sit with them and half the time we would eat something with them. Like at (bedtime) snack, we would have something too. A little sandwich or a cookie and coffee with them. And we would all sit in the dining room and we would talk and it was family. (Jane)*

Doris described how the managers had given them one hour from 1200 to 1300 to feed the residents. However, the dilemma was that she had four residents who needed to be fed. So she had to split that hour between all four:

> *For me, I always try to feed my residents. I put two on each side of me and feed them at the same time, and they want us to feed for an hour long. They (the managers) want us to take from 1200 until 1300 to try the Eden atmosphere. They want us to feed one at a time, but it is impossible. If I feed four feeds one at a time, I will never get done. You can run around – you can have a bite (demonstrates feeding four people at one time) and that is when I am thinking this is Eden? I am feeding four people at one time and this is Eden? It is not Eden. You feed four people at the same time. Bite bite bite bite (demonstrates) That is not Eden!*
>
> *What was Eden supposed to be? (Interviewer)*
>
> *Do not rush. Give them choices. It should be as it is in their home. Eden is a homey atmosphere. That is what they want. They want animals and all that. Let people if they want to have dogs. Eden is a homey atmosphere. (Doris)*

Doris implied that the managers did not realize how many people could not feed themselves:

> *See, the management, when they first cut back and they started to give us ten people or eleven people, they wanted us to bring the residents out. 'You should go and get breakfast for them.' And this is what my boss said. There is no way I can bring them all out and give them breakfast. I will never get done…I tell management that I can get them up and bring them out to the floor…And they say, 'Give them juice, give them toast, give them porridge – that is maybe five minutes of your time.' (Doris)*

Doris also implied that the managers did not realize that one resident could take one hour to complete a meal. It was not possible to feed according to the goals of the philosophy, given the number of residents who were dependent on Doris to feed them. So I asked Doris:

> *Do the managers ever come around and say, 'You are not supposed to feed two people at the same time.' (Interviewer)*
>
> *I have never seen the managers come around at mealtime. (Doris)*

Doris went on to describe what actually happened each morning. She knew that morning routines were completely incompatible with the relational and spiritual values of the philosophy:

> *Don't drag them out of bed...If you don't want to get up, you get up when you are ready. If you don't want to get up, you don't have to get dragged out of bed. (Doris)*

She had to use her own practical judgment to decide who had a right to choose when to get up, because of time constraints:

> *We have a girl that starts at six o'clock in the morning. Well, who gets up at six o'clock?...When they first started this shift I said, 'Why would you want them to start at six o'clock? It is so early.' They are getting people up! At six o'clock. They have no choice. Me I start at seven. Well, I go down the hall and sometimes there is one person awake. If so, I will get them done. Lots of times there is nobody. And you think, OK, who is the best person to get up? Because you have to get started. That is my challenge. Cause I have got to get started! So I usually leave my lifts in bed. And I do the walkers. You got to get them started. (Doris)*

Judy described how it was possible for residents who were assigned to a permanent care aide to suffer because they wait for their own care aides to provide care:

> *When you go on a coffee break, who looks after your family? (Interviewer)*

> *My partner on the other side. She has to pick up my load. And that is another thing. Some people don't know that. And they will say, 'That is not my resident.' So that also happens.*
>
> *So you go for a coffee break and it is possible that your residents, because they belong to you, will have to wait for you to get back? (Interviewer)*
>
> *Yes. And a lot of times, we have to carry our phones and I will know that that resident is ringing to go to the bathroom and my whole break that is on my mind. And I will know that the other care aide has not answered that bell. And that would be for half an hour. (Judy)*
>
> *Wow! (Interviewer)*

Most of the participants had two primary concerns: first, they did not feel adequately staffed in any of the facilities to fulfill the relaxed, homey, resident-centred ideals of the philosophy and second, the Eden Alternative® methods did not seem to take into account the high levels of dependency of residents in nursing homes:

> *It is supposed to be a home environment. Where we are supposed to have time with the residents, talk, provide recreation, stuff like that. More of a home environment. But right now, it is unrealistic.*
>
> *So do you feel that you are fulfilling any parts of the Eden philosophy right now? (Interviewer)*
>
> *Probably one percent. (Shirley).*

There were other perceived problems as well. Too large a "family" meant that they were falling short of the goal of fulfilling the residents' spiritual needs:

> *I don't have the time to sit down and talk to somebody – one of my residents, because I am running around all morning. And I cannot be there for them when they need me right away, so they get angry. They think we are not answering because we don't want to. So that breaks the relationship. (Shirley)*

Susan described how she had only a few minutes once in a while to chat, and that she did not have adequate time to ease the suffering of boredom and loneliness:

> *You (need) time emotionally tend to them and help with their boredom and we don't have a lot of that….You really don't have time to spend…they make it seem like you have time to sit and reach them emotionally but you really don't have much time… you can spend a little bit of time chatting but in general you are so rushing around just doing. There is still a lot of boredom and loneliness for all of them. (Susan)*

Judy described how some of the residents were very mindful of the time constraints and made deliberate efforts not to bother the care aides with anything more than absolutely necessary:

> *They (the residents) know you and they know you are busy. Like most of them know you are busy. So you are rushing just as much. In fact, we are rushing more because we have more than we ever did before like 10 years ago. (Judy)*

As a consequence, participants adamantly complained that they worked in a façade:

> *They are trying to promote this Eden philosophy but really it is not. Because you still have to do 11 residents yourself. You don't have time. You just work. So really instead of taking the time with these residents, you are working as fast as you can just to try to get by. (Judy)*
>
> *They have tried to promote this Eden philosophy thing and it is such a sham of what the Eden philosophy should be. I mean it is great - on paper but it is not a reality at (our facility). Not at all! Not one iota! I get very upset because if this is the Eden philosophy then you guys really need to get with the program here because it is not the Eden philosophy, yet you try go get us to tell you what it is. I mean we can tell you exactly what it is but you know if we try to tell them this is not the Eden philosophy, they don't want to hear it! We want to hear something positive now! (Kathy).*

Participants understood that in theory, permanent assignments should foster closer, more intimate relationships between care aides and residents and facilitate familiarity between care aides and families of residents. They were frustrated and disappointed because the principles seemed to have been applied indiscriminately in their facilities. They perceived that the managers promoted the benefits of the model to families of residents, but "cherry picked" the actual reforms and/or reduced staffing levels after implementation of the philosophy, so that other reforms eroded over time. The birds and the animals were there, and the daycares were in place. The care aides had been permanently assigned to residents, and the numbers of RNs had been reduced. However, the care aides' workloads were perceived to have increased dramatically. It was evident that they did not feel that they had enough energy or time to be compassionate, empathetic partners to the residents.

Participants described how the organizations kept all of the restructuring consistent with the Eden Alternative® model such as permanent assignments, new roles for care aides (versatile worker/universal worker) and reduced numbers of RNs (visiting professionals), but then reduced the numbers of care aides so that they were no longer able to fulfill the philosophical goals of the model. They felt sure that the cultural changes and subsequent erosion of staff resulted in significantly more work for them and an increase in their general fatigue. Participants also noted that the associated reductions in numbers of RNs had effectively eliminated important and influential personnel whose constant presence, relational support, expertise, and problem solving skills had contributed much to the overall harmony in many nursing units:

> *One thing I did notice is that you are pretty much on your own as a care aide. It was quite a long ways back I think, they had a LPN and a care*

> *aide working together doing the eleven people….we worked together doing the lifts and stuff. There was more teamwork. It was much more manageable. Now they have kind of separated everybody. The RN is up at the desk…the LPN is doing the pills….But it separates everybody more. (Linda)*

As a consequence, participants reported feeling alone, with greatly reduced avenues for relational advice and support:

> *Mostly you work by yourself.*
>
> *It is kind of lonely isn't it? (Interviewer)*
>
> *It is. It is. (Judy)*

Alone in Eden

This section is a portrayal of care aides' thoughts and feelings about the permanent assignment component of the Eden Alternative® philosophy/model irrespective of the subsequent erosion of numbers of staff. In very general terms participants described how they would prefer to work in groups with the residents rather than separately with the residents. They stressed the importance of shared tasks, interchangeable tasks, and joint decisions, and they described a strong need for collegial fellowship and friendship that is the missing component of the Eden Alternative® philosophy.

Many of the participants reminisced fondly about this type of team work (care aides working with other care aides to complete care for residents and care aides, LPNs, and RNs spending time together, sharing tasks, helping each other, making decisions together). This was a strategy that many of them remembered prior to implementation of the Eden Alternative® philosophy of care:

> *Everybody was so good. The staff were so good. That was when we all worked together. Like RNs, LPNs, we all worked together as a team. It*

> *was a great place. Like even our manager. She used to be right there. Sometimes help. (Doris)*

> *We knew each other. How we worked. We worked as a great team. There was never 'Oh that is your resident' or 'that is your person'…We were never sick. We were the most conscientious people that never phoned in sick. We were always there. We had each other. We worked well together. (Paula)*

Participants indicated that they needed to work together again in order to find fulfillment and purpose together. Betty compared working by herself with residents in a facility that subscribed to the Eden Alternative® philosophy to working as a team member in a facility that had not embraced the Eden Alternative®. She much preferred working at the second facility because the team work helped her to form close connections with her colleagues that she described as "family":

> *We are one big family at (the other facility). We work together. I have worked at (the Eden facility) and personally, I don't like it there. Because it is not a family. They don't have team work there. Whereas at (the other facility), we are a team…I didn't know what team work was until I came to (the other facility). Like you can ask for help at (the Eden facility) but because I am new, it seems like no-one wants to help me. It is like, 'Well, you are in the work force now so you have to learn how to do things on your own.' But at (the other facility) it doesn't matter if you are new or if you are old, you all work together… A perfect example was last night. We had a girl there that was on the next family over from me. Never been there before. Didn't know the people. Of course we are going to pitch in and help her. That* would not *happen at (the Eden facility). I love (the other facility). (Betty)*

Where there was teamwork, there was friendship and confidence (especially for new care aides) because the load was shared:

> *We are treated well (at the other facility). I know we are appreciated. Cause even our RN understands what we go through. But she is the kind of RN who pitches in. She will come and help me. She is right there. And she is awesome. So we have a really good family.*

> *So when you are talking about family, you are talking about your colleagues? (Interviewer)*
>
> *Yes. Absolutely. We treat everyone the same. Even new-comers. The ones that have been there 12 years will jump right in and tell them about the residents. This care aide on this side will know what somebody needs on the other side.*
>
> *And why is that? (Interviewer)*
>
> *Because we have all done everybody. (Betty)*

The care aides' overwhelming preference for teamwork did not align well with the permanent family assignment component of the Eden Alternative®. The permanent assignment component requires that care aides work by themselves with residents, and for my participants, permanent assignments also meant that there were no options if things weren't going well. Instead of feeling supported and reassured by fellowship, most of the care aides did their work without reference to each other, therefore they emphasized what separated them, rather than what united them. Some participants reported an overwhelming awareness that there was not any support, anywhere:

> *Well, you do your own people, and that is pretty much it. We don't help each other. I mean, we don't do each other's people. (Jennifer)*
>
> *We know who each other's people are, but we really don't answer each other's bells unless we absolutely have to. We don't have time. (Diane)*
>
> *We are by ourselves. We don't even see each other. (Jennifer)*
>
> *Yeah, we don't even see each other!...We don't help each other. We don't have time. (Diane)*

Participants also described how they felt that managers had introduced new policies and procedures so that care aides could work with even the heaviest of the residents by themselves. For example, new turning sheets were introduced and policies pertaining to mechanical lifts were changed or overlooked so care aides could work by themselves:

> *And you are doing all of these lifts yourself. What about the rule that two people have to be present during a mechanical lift? (Interviewer)*
>
> *Well, now that we have the ceiling lifts, we are allowed to do them by ourselves. And we have these green turning sheets now. That we use to roll people. So. (Judy)*

The implication of these changes was that care aides should/could provide care to the residents in their permanent assignment without having to seek assistance from other care aides. The result of these changes was that the care aides had no shared purpose and no collegial connections:

> *I came to (this facility) because we always used to work together. That is my thing. And I used to always say, 'You guys, we have got to help each other. If you are done, help each other all the time.' I have stopped saying that because nobody does it…. So I just work, do my job and that is it. Yup….There is not much use to going down together anymore. We used to laugh, and work together. That doesn't happen anymore. We are so isolated. You have got your own people. And the other girl does her thing, and you just go. (Doris)*

Some were desperate; many were frustrated; most were stressed. All of these factors hindered empathetic, compassionate relationships with residents assigned to them. This conclusion is represented by the words "if you have happy caregivers you have happy residents" combined with "there is a lot of unhappy people right now":

> *"I think to be in the ideal Eden philosophy they have so tried to promote, it would be where they care about the care givers as well. Not just the residents. I mean we can do what we can for the residents but that also involves if you have happy caregivers you have happy residents. There is a lot of unhappy people in (this facility) right now because there is so much stress because of the workload that has been added to… It is about us getting the grunt work done. But there is no caring for the caregivers. We can come together as staff and vent to each other but it does not*

> *change the situation of the Eden philosophy syndrome that they call the Eden philosophy. (Kathy)*

The care aides also described a paradoxical relationship between the Eden Alternative® and their abilities to develop and maintain meaningful relationships with the larger residential community (residents <u>not</u> assigned to them/not part of their permanent assignment). They described to me that permanent assignments meant that they began to know less and less about the other residents who were <u>not</u> assigned to them:

> *I don't know nothing about the other people on the other side. That is a bad thing….I don't know what they do on the other end. I don't even know. I see those residents but I don't know what they do for them because really, when the family members come in, they ask for certain people. And he is not on my side. And I will go, 'Just a minute. I don't work with him so I don't know.' So sometimes I wish we wouldn't be just the same family. Maybe go for two months or something? (Doris)*

> *Before…we did everyone. We kind of mixed it up. Now I have a specific family. But before with the residents, it was easy to know everyone. You could still remember their care. Naturally you would just know it rather than looking at the care plan. (Now) you don't know…they need to go to the bathroom and they have specific things, creams or whatever, this and that, if they go on the commode and not the toilet and there is different transfer and stuff you don't know. You lose that. After a while…you don't actually know the other people anymore." (Mary)*

Some participants suggested that losing contact with other residents and not knowing other residents made them feel unsure, incompetent or inadequate.

> *It is like, if I have to go to a different family, I am not really too sure what I am doing…I know them from just seeing them in the dining room. But for the actual care, I have to read it. So I know what their transfer is. Their different transfer. What they use for their benefit (incontinence pad). That sort of thing. Usually, you have to sort of wing it. That is how we do it." (Jane)*

Other participants felt that sad because they had lost contact and had lost meaningful personal connections with the residents no longer assigned to them:

> *So you don't know those people down the other side? (Interviewer)*
>
> *Yes…Somebody will come in and they will say, 'Oh what room is that person in?' And I will say, 'I don't know.' I don't! Even though I have been there for 25 years!...Sometimes you feel really down when somebody comes in and you don't know the person.*
>
> *So you have been there for 25 years, and you do not know those people because you only know your people, basically. (Interviewer)*
>
> *Yes" (Judy)*

Participants also reflected that the Eden Alternative® meant caring for each other in addition to caring for residents.

> *I think to be in the ideal Eden philosophy they have so tried to promote, it would be where they care about the care givers as well. Not just the residents. (Kathy)*

Yet, save for brief interactions, care aides spent very little time together and almost no time with the RN. It was not the lack of human contact, but the lack of certain kinds of supportive, understanding human contact:

> *Just knowing that I can go to somebody and say, "You know what? I am not having a good day here! (Kathy)*

The permanent assignments (meaning working alone with residents) combined with the loss of continuous presence of the RNs reduced participants' feelings of success, their general happiness, and their satisfaction at work:

> *I think when they cut back on the RNs. That is what changed. (Doris)*

Finally, participants described how the residents in the permanent assignments had *themselves* become isolated from the larger community because the assignments were now regarded as one care aide's responsibility. Prior to culture change, no one had any particular assignments, so the residents interacted more with everyone. As Jane reminisced about work prior to implementation of the model and expressed a desire to work together (in teams) rather than separately, she reflected that working together was more "family" oriented for residents than working separately because the residents were not tied to one particular person:

> *I think that there was more of a family unit. (prior to culture change) (Jane)*
>
> *Oh? (Interviewer)*
>
> *Amongst everyone. The kitchen staff, laundry workers, we all worked pretty much hand in hand. Like for instance if someone was at the table, you know. One of the girls from the kitchen – 'Oh, do you want to go to your room now?' And she would drive him home. Or we would sit and talk a lot more. You don't get a lot of that anymore. Virtually, I work independently now. (Jane)*
>
> *It was probably more Eden when we all worked together. My saying is always, you know, they wanted to make it a home and make it a family. When I started there 15 years ago we were way more of a home and a family. (Judy)*

Theme Five Summary and Interpretation

The Eden Alternative® is an American organization that is heavily promoted in the United States as a solution when troubled long-term care institutions are required to reform their practices. The model is aimed at restructuring the delivery of care via cultural changes and operates according to ten principles designed to increase the quality of life for institutionalized persons. A transition towards the Eden Alternative® model involves significant changes in job duties and routines.

Changes in the workplace consistent with the Eden Alternative® start with the introduction of animals, birds, plants and gardens, and permanent assignments of groups of residents to care aides called families. In theory, permanent assignments assist care aides to form closer, more intimate relationships with residents. Each family exists as a distinct unit clearly separate from the other families. In some organizations, care aides also become cross-trained to dispense medications, do laundry, prepare food, organize social activities and care for the animals, plants, and gardens. Cross-trained care aides are called universal or versatile workers.

In this section I explored my participants' experiences and perceptions of working in an environment that espoused Eden ideals even though those ideals were incompletely implemented or implemented and then allowed to erode. At first glance, the shift to permanent assignment was seen as a welcome development - a primary source of stability for both residents and care aides. However, the care aides soon found themselves in several dilemmas.

The first dilemma concerned the underlying assumption that all of the residents' families understood the philosophy, desired this type of care for their family members, and had faith in and understand the model. My participants suggested that this assumption was misleading. Some conscientious aides found themselves in conflict with family members who did not support all components of the model.

The second dilemma occurred when the principles of the model/philosophy were seemingly applied indiscriminately and incompletely in the facilities. The participants perceived that the managers promoted the benefits of the model to families of residents, but "cherry picked" the actual reforms and/or reduced staffing levels after implementation of the philosophy, so that other reforms eroded over time. According to several participants, the families were smaller when the Eden Alternative® was initially implemented but gradually, the family sizes had increased. As a result, the care aides' workloads increased dramatically. Participants did not feel adequately staffed in any of the facilities to fulfill the ideals of the model. They had neither the energy nor the time to be compassionate, empathetic partners to the residents. Some participants reminisced about lost opportunities for eating with residents. These participants reported that eating together was important for successful relationships between care aides and residents, but opportunities for eating together had been cut back due to work overload and time constraints.

Participants also reflected that the Eden Alternative® meant caring for each other in addition to caring for residents. Yet, save for brief interactions, care aides spent very little time together. The permanent assignments (working with residents alone) combined with the loss of continuous presence of the RNs reduced participants' feelings of success, their general happiness, and their satisfaction at work. The care aides perceived that they had began to know less and less about other residents, which made them feel unsure, incompetent or inadequate. They attributed this loss to the permanent assignment component of the model. Many described how they had lost meaningful personal connections with the residents no longer assigned to them. New turning sheets and changes in policies pertaining to mechanical lifts implied to the care aides that they should/could provide care to their families without ever having to seek assistance from other care aides.

Many participants reminisced about work prior to implementation of culture change and expressed a desire to return to teamwork in order to find fulfillment and purpose together. Some reflected that working together was more actually more family oriented than working separately. Participants described how the residents in the individual "family" assignments had themselves become isolated from the larger community because the other staff members (such as dietary) regarded them as "belonging" to one care aide, therefore, they refrained from interacting with them.

Theme Six

Integrative Thoughts

In this theme, I explore my participants' lay theories and strategies. Lay theories are non-empirically based thoughts and beliefs that can influence workers' assumptions, observations and caring behaviours and become tacit and automatic through frequent use (Bower, 1998; Jervis, 2002b). Bower (1998) hypothesized that idiosyncratic or lay theories help care aides reduce the complexity of observed behaviours, rationalize residents' actions and predict future behaviours. In this study, the language of the participants was examined carefully for indirect statements, assumptions, explanations or illustrative stories that impressed emerging lay theories. Although idiosyncratic or lay theories have received very scant empirical investigation, they can form important catalysts between care aides' relational practices and quality of life for residents who have complex, challenging or difficult personalities.

The theme “Integrative Thoughts” consists of seven lay theories that reflect how my participants accounted for the residents’, families’, and managers’ actions. I provide exemplar quotes. The lay theories include: residents are cognitively unwell and unable to control their actions; residents are cognitively well but unable to change; families are just trying to make sure that their residents’ needs were being met; families have underlying mental health issues; families or residents have no other avenues or outlets to express their misery; residents are inappropriately placed; and managers are afraid of the media.

It was evident that many of my participants also spent time reflecting on the central aspects of their difficult relationships with residents and families. The language of my participants was carefully examined again for indirect statements, assumptions, explanations or illustrative stories that suggested use of specific techniques and methods. I was able to extract thirteen different strategies that my participants used to ease the difficulties and cope with discomfort, stress and distress caused by strained relationships. These strategies were: try something new even if you don’t think it will work; back off when necessary; bargain; bribe; scheme; become more assertive; use a script; provoke an incident; call the police, security or ambulance; accept what cannot be changed; compromise; and take a mental health day or go home. Finally, the care aides in this study spoke of the importance of communication. Communication was the thirteenth and overarching strategy found in the language of my participants. In their illustrative stories, and explanations, my participants described how communication could ameliorate many aspects of difficult or strained relationships with residents and families.

Seven Lay Theories

The first lay theory identified by careful examination of the language of the participants was: residents who made offensive, demeaning or disparaging remarks aimed at care aides (including racial slurs) were cognitively impaired so they were unable to change:

> *I think that everyone there has some sort of dementia. Maybe not Alzheimer's, not severe, but definitely some, you know. (Paula)*
>
> *Her reason for being mad is not rational… So I am thinking that she is a little confused. (Andy)*

Alternatively, as the second lay theory suggests, some cognitively well residents who were offensive or rude could be operating from an old set of social norms, values, and interactional skills that were familiar and unique to them but objectionable to the care aides:

> *Like, I know where they are coming from. I am dealing with people who have lived a long time ago – prejudiced. And they didn't accept minorities as much as they do now…. Some of them are kind of stubborn, but you have to understand the age... (Shirley)*

These residents were unable to perceive the inappropriateness of their behaviours and were unable to change to a more socially acceptable approach. The evidence for the lay theory of an established set of interactional behaviours was seen in the aide's assertion that the current behaviours were no different from the past. Aides used terms such as "stubborn", "immature", or "pampered":

> *(He thinks) he should be able to do exactly what he wants all the time. (Andy)*

> *He is very cognitive and with it but very immature in a lot of respects as far as not getting his own way. He is like a little child in that way in that respect. (Kathy)*
>
> *Stubborn old lady. (Andy)*
>
> *He has been pampered his entire life. He said, 'Jump' and they said, 'Is this high enough?' He doesn't understand why we can't jump. (Shirley)*

In response to stress and distress triggered by repeated conflicts with families of residents, a third explanatory belief contained in the language of the participants was: families who had repeated disputes or disagreements with care aides were just trying to advocate for their residents - just trying to "protect them" and "make sure" that their residents' needs were being met:

> *But I know that I really, I have to pick out the good information….It is a way for them (families) to protect them (residents) and make sure that they are getting the care that they need. (Shirley)*

However, when the requests from families were seen as unattainable or impractical, yet persistently demanded, the care aides made statements suggesting that they believed that family members had underlying mental health issues which attributed to their inabilities to understand the reality as described by the care aides:

> *She (the resident) can't walk and she hasn't walked and she (the daughter) thinks she is going to walk. She thinks her mum is going to walk. And we had to put a floor mat down and that the bed is in the very lowest position because mum is going to walk. Mum can't even talk. She can't move. She is very contracted.*
>
> *Why do you think she thinks this? (Interviewer)*
>
> *She is crazy. I think she is mentally…she is sick. (Mary)*

The fifth explanatory lay theory is represented in Doris' language as an explanatory account. Doris suggested that difficult or strained relationships with family members occurred when these particular family members had no other avenues or outlets to express their misery. Doris used terms such as "she has so much stress", "she is overwhelmed", and "she wants to be miserable". This lay theory is linked to the earlier theme: assuming a surrogate family role. If care aides are perceived by some family members to be de facto family members, then greater intimacy and allowance for emotional displays are assumed:

> *And I think with this lady, she has so much stress. Her dad is in a home, her mum is in a home, her sister is in a home and she has a mentally challenged son. I think she is so overwhelmed with her personal life that she so when she comes in it is almost like she wants to be miserable. She used to be the same on the other side. The same on the other side. And you can't make her happy. You can't even, like put a soaker on her sister's bed because she doesn't want her sister to know that she (the sister) is incontinent. Very particular. And so I just do what they want you to do. If you don't she gets mad. 'How many times do I have to tell you?' (Doris)*

A variation on this lay theory is that residents may also have no other outlets to express their misery (other than to the care aides who may take the place of a family member), particularly if residents have no family support nearby. This lay theory is represented in the words "he feels sorry for himself", "he doesn't really have a support system" and "we are kind of there":

> *I think he (the resident) feels sorry for himself and he probably feels that everyone else is to blame for where he is at. Even though he may not even be aware that he is like that. I don't know… he is awfully young. He is in his sixties. I think there is a lot of emotional issues because he doesn't have his health… and he probably takes it out on us because he doesn't really have a support system in place. He has got family but not really a close family I guess, I don't know. I think he gets very frustrated because of where he is at. We are kind of there and we get the brunt of it all. (Kathy)*

> *He was the same demanding type: this had to be done at this time and that time. I really got to like him. I think he was just really lonely. He had had a lonely life and everything else. (Susan)*

Several care aides made statements that suggested they felt strongly that strained relationships were directly related to resident distress and misery as a result of placement difficulties (lay theory six). For example, Kathy described a resident who was not happy because he was not placed in a facility with young people:

> *I think for the most part he (the resident) is not in place where he wants to be. He wanted to be on this other unit where this unit all has young people. He is kind of in a place where all the residents he is with are older and I don't think he feels like he fits in. (Kathy)*

A variation of this lay theory is that some residents will attempt to manipulate a situation through interactional strategies for some ulterior motive. For example, multiple participants described a resident who had been diagnosed with narcissistic personality disorder and also charged with malingering. These participants made statements suggesting that they believed that this resident felt entitled to long-term care. When threatened with discharge planning, they described how the resident reacted in anger:

> *She is more normal than most people think. (Jennifer)*
>
> *And when she is being threatened by management that she will be discharged, she will act crazier. (Diane)*
>
> *To keep her secured place. She (the resident) is so familiar with all of the activities at (the facility) that she totally dominates. She knows all the people at the top that we as staff members have never met. Administration listens and does the best that can be done to appease (her). Only then does (she) let up on management when it is agreed to give her what she is asking for. All previous attempts to have (her) discharged have been stymied at the administration level.*
> *(Jennifer)*

In the language of Michelle and Brenda, were statements suggesting that a resident (described earlier) who used foul language and contaminated care aides with urine and feces was an angry young man, who was inappropriately placed. Michelle and Brenda felt strongly that the resident knew what he was doing, but he did these things because he was angry and had no other outlets to express his anger or sexuality. I was able to extract a similar lay theory by examining an illustrative story provided by Allison. The lay theory is represented in her words "It was not easy for him", "he was bitter", "he was depressed", and "he didn't have a partner":

> *He was actually a really nice guy but he couldn't deal with his disease. It was not easy for him.*
>
> *So what was wrong with him? (Interviewer)*
>
> *MS. The thing is, he is young, and he was really upset. He told me one night that no female would ever be interested in him being in a wheelchair….He was not willing to accept his illness and he was bitter. He was depressed. He didn't have a partner. (Allison)*

Critical points in lay theory six are that the care aides believed that the residents felt trapped and they believed they had no alternative modes of expression. Kathy was also able to reflect on her resident's main source of anger and frustration (he was so heavy that he had to wait for three people to transfer him – causing his anger and complaints to the manager) and how the loss of extra body weight freed him and reduced his complaints to the manager (because one care aide could now do his transfer):

> *Well you know as time has gone by, the stress is gone. He has lost incredible amounts of weight and a lot of it had to do with body fluids he was carrying. He went to the hospital and had it all drained or whatever they do there to make him lose all that body fluid…so now he is two hundred and forty-seven pounds. So now he is rolling and everything and*

> *he is probably easier out of that room to get up. Now I've changed…we get him up in the morning first before the other resident who is probably heavier and harder to do…He is much happier and it gets him off our backs….not having him go to management all of the time. (Kathy)*

Finally, participants made statements suggesting that they believed that the managers who did not respond to care aides' concerns or complaints, silenced care aides' concerns or complaints, or responded very slowly, were afraid of the media:

> *I think that they are afraid of the media. Issues. That is what they are afraid of. (Michelle)*

Thirteen Extracted Strategies

It was evident that many of the participants had spent time thoughtfully examining the central aspects of their difficult relationships with residents, families, and managers. After carefully analyzing the participants' language and stories, I was able to extract thirteen different strategies that the participants used to ease the difficulties, cope with discomfort, stress and distress caused by strained relationships, and possibly even enhance the quality of their relationships. Each extracted strategy is listed below, followed by quotation(s).

Innovative Action: Sometimes the participants described that they had to take a new course of action that would for the moment ease the situation or avert conflict, even if they didn't think it would work. This strategy demonstrated to the resident or the resident's family that the participant was concerned enough about the resident to listen to alternatives, but it also involved accepting risk that the outcome might be entirely different from what was planned:

> *Everybody has to be open a little bit. And sometimes some things really do work even if we think that they won't in the beginning. So I find that it is good to try new ideas... (Jane)*

Waiting or Backing Off: Providing the right kind of help to residents was, at times, very difficult. Sometimes participants chose not to do anything. Backing off was a dominant strategy described by many participants. Choosing not to take any action (backing off) should not be considered to be a non-strategy. Instead, backing off was a dynamic strategy as it almost always involved making a decision based on concern for the safety of the resident. For example, Paula and Joanne described choosing not to use physical force, but instead choosing to wait for residents to become calm before providing personal care:

> *I would say wait. Wait until he is happy. I will check on him and we will go in and see what he is like. If he is not really happy, or if he is agitated, we are just going to walk away. We will wait. And in 20 minutes, we will go back. You know, it may take us a while, but let's just see before we get forceful with his care. Absolutely, absolutely. (Paula)*

> *If he is not ready to be cleaned up, you have to have the patience. I just bide my time. (Joanne)*

In a similar manner, Jane described how waiting or backing off would provide opportunities for some residents to express negative feelings in a safe environment. In the story below, Jane described how she waited to allow an angry, frustrated resident to regain his composure:

> *And he sat at the table with his eyes down. And he sat there! And I left him for close to an hour and I went over to him and I said, 'Would you like to go to your room now or would you like a piece of toast or something? Can I get you some cheese or whatever?' Well, I could take a hike, thank you very much! He was fine! So I said, 'OK. You let me know when you are ready. If you look up, I will be around on the floor.' And I left him. (Jane)*

In other situations, the care aides backed off to maintain their own composure, and in this way, maintain the relationship as is, rather than allow it to deteriorate further. Care aides often left antagonistic situations with little verbal explanation:

> *There would be times where you would bring him the wrong food or the right food or stuff like that and he would yell and scream and you would have to walk out of the room because it would just hit you sideways. What I have said in the past is that this person can be very difficult so he makes up a big stink or whatever just leave the room. Just excuse yourself from the room. Just say, 'Excuse me, I will be right back' or whatever and just leave the room. (Kathy)*

Participants also waited or backed off to maintain mutuality in their relationships with residents. For example, Jane described how the success or failure of an offer of help often depended as much on the resident's choice as it did on the care aides. In this way, mutual decision-making was maintained:

> *I went into his room to call him for supper and the door was closed. I knocked on the door and opened it and he said, 'Get out of here! I don't want to talk to you! I want nothing to do with you! If you don't get out I am calling the police!' And I went, 'I came to ask you if you wanted to come for dinner. That was all.' And he said, 'I am not talking to you!' And I said, 'OK, that is fine! Fair enough!' And I went out and shut the door. (Jane)*

Andy described how he felt uncomfortable with the risk element, but still backed off from an agitated, frustrated, and unsteady resident who wished to walk without support because he also wanted to maintain a mutual relationship:

> *I said to the guy 'Apparently you can do whatever you want!' And he said 'Good, I will!'…So we left him to his own little devices, but we still…keeping an eye on him, making sure he doesn't fall. (Andy)*

On occasion backing off was also used when there was concern for the safety of the care aides:

> *What happens if a resident is drinking? (Interviewer)*

> *There, we just have to make sure that they are safe. We are allowed to leave if they are getting really aggressive or verbal towards us. And he did drugs on top of that. They do marijuana too…If he is too aggressive, we are allowed to leave. (Allison)*

> *She has moments when you can't even approach her. And I tell new staff not even to pass by her or try to approach her because you just can't. You just can't. She just screams and yells and you are best to just leave her. You can't negotiate. She is somewhere else. (Susan)*

Bargaining: The third extracted strategy was bargaining with the residents. Concern for the resident was always present in the language of the participants because bargaining was a way to work with the residents – to negotiate or to meet the residents half way:

> *So then I just try – you know, 'Well I am working hard for you, so how about I will let you do what you want and you will let me do what I want and then we will both compromise. Because what I want to do, you don't want me to do and what you want to do, I don't want you to do. So how about we meet each other half way? (Andy)*

Bribing: Bribing a resident was also a prominent extracted strategy. Although bribing could be considered to be an inappropriate strategy, it had a single and well-defined purpose: to provide residents with something to look forward to in order to help the residents cope with non-negotiable situations that were very stressful or even unbearable for them:

> *He didn't like his bath. So I tried to figure out what I could do - to get him to take a bath. And he loved happy hour. So I went to him one day and I said, 'You know, look! You come for your bath – with me, I will bath you. If you come with me for your bath, I will give you a beer afterwards.' And he said, 'A beer?' and I said, 'Yes.' And he said, 'OK.' So every Friday, I bathed this gentleman and we ended up having a great relationship with him! We could look after him. We could do his morning care, get his clothes changed, do his bath, because of that. For the price of a beer. A beer. (Paula)*

In this situation and in others where bribing was discussed or described, care aides who used bribes used them to preserve the dignity of the residents rather than as controlling mechanisms.

Scheming: Scheming with residents was another strategy found in the illustrative stories provided by participants. Scheming enabled care aides to enhance levels of emotional intimacy with residents rather than engage in conflict with residents about non-negotiable situations (usually bathing). The purpose of scheming was to find something that the resident enjoyed that was slightly contrary, and build on that in a fun way. Bribing and scheming may be seen as double loyalties - on one hand, the care aides who use these methods were agents of manipulation, but on the other hand, they were also helping the residents to receive care without force, and they were giving them something that they enjoyed. In the following illustrative story, Paula found out that her resident had really enjoyed surreptitiously irritating her husband by spending his money. Scheming together to "spend" his money increased the level of emotional intimacy between the care aide and the resident and they shared in some fun:

> *One of the approaches that I used was, so I would say 'OK! Well, you know, we are at the spa, let's just get our bath done because you know, your husband is paying for it. You know, he is paying for this! So let's just spend his money! You are mad at him anyway! Let him just pay for all this stuff! We will get our nails done and we will go to the hairdresser, and we will get our hair done! Let's get an appointment with the hairdresser!'....And instead of her ripping her rollers out, we would say, 'Oh this is so great! He is going to be so mad!' And she would say, 'Oh, yes he is!' And then we would go for tea afterwards. 'Oh, let's get a cup of tea too!' And it was great! It was fabulous. It worked out. It was fun. That is the kind of stuff that I love! (Paula)*

In the end, the resident was motivated to bathe; the resident was happy and cooperative; and the care aide felt satisfied and cheerful.

Becoming Assertive: Some care aides tried to become more assertive when relationships were strained. Becoming assertive did not mean becoming indifferent or not caring about the residents. Rather, becoming assertive meant making statements to avoid becoming overly passionate or emotional in charged situations and/or helping the residents come to terms with the reality of what was socially expected of them. Many care aides became more assertive with residents who used foul language directed at them. For example, Allison described how she felt very disturbed by foul language and used her assertiveness to protect her private self and draw professional boundaries:

> *I stayed my ground, and just stayed completely polite with him, but stayed my ground, and he couldn't figure out how to hurt me. (Allison)*

Andy described how he became more assertive as he became fatigued by foul language:

> *I told him…we are professional health providers. There is no reason why you need to be talking to us that way. Or, you know, ordering us around…and I said, 'If you want to be changed, you can ask us and we will try to make the best for you as we can. But we are not here for you to abuse. So do not talk to me that way…So, either way, I am going to be here and I am going to be looking after you. So you can tell me what you need, and I will see what I can do about it. But other than that, don't raise your voice to me.' So you know, I try to be more assertive, more firm about it. (Andy)*

Cut and Paste: The seventh extracted strategy was to use a "cut and paste" method of communicating with residents when relationships were strained. In other words, the care aides resorted to using a pre-arranged script. The success of this strategy was mixed. For example, when Carol answered the call bell for a resident known to consistently use foul language, she explained how she always said, “You rang, what would you like?” Carol was deliberately obtuse to highlight the inappropriateness of his communication techniques. However, her method was not successful in ameliorating the conflict:

> *The other morning, he rang and I went in there and I said, ‘What would you like?’ He says, ‘What do you fucking think I want?’…I said, ‘You rang, what would you like?’ And I said, you know, ‘You rang. And I am here to help you so what would you like?’ He said, ‘Don’t you know what I fucking want?’ and I said, ‘No, I actually don’t. What would you like? (Carol)*

However, other care aides used “cut and paste” very successfully to calm agitated residents. For example, Jane explained how she used a consistent statement as an element in her routine (described earlier) to calm her resident who became agitated in the mornings:

> *I would say virtually the same thing every morning. With very little variance in it. (Jane)*

Andy also described how he helped an agitated resident who was unable to calm herself, and in his language/illustrative story, the “cut and paste” method can clearly be extracted:

> *In school, we did some role playing, some skits in class to show us what kinds of things we can do. Kind of techniques we can use – validation, empathizing, not sympathy. Just you know.*
>
> *Hmm mmmm. (Interviewer)*
>
> *So I start off, and I would be like, I just basically play that in my head. Like copy and paste the script… ‘Do you mind, there is a chair over there. Do you mind if I have a seat?’ And she was like, ‘Oh, go ahead’. So I go, ‘I am going to sit right here, OK? Is this distance OK?’ Cause I don’t want to be too close to her. And she would be like ‘Yeah, that is fine.’ So I remember in the class you know, like to try to switch to something she is more happy about. So I said, ‘So OK, where are you from?’ And so she says, ‘I am from (name of town)’ and so I am like, ‘Oh, really! I have*

> *heard a lot of good things. Like, what are your favorite memories of that place, of home?' And she goes, 'Oh I just love driving down the long roads by myself. I love tumbleweeds. Tumbleweeds mean a lot to me.' And I go like 'Oh, Oh wow! You are like a traveler. You like traveling.' And she is like 'Yeah, I love traveling. I haven't been to too many places.' So I am like, 'Why don't you tell me about some places you have been to?' So then that goes into another conversation. 'Do you have any family?' Oh yeah, family, children, husband or ex husband, she was split up. So all of these things. So I say, 'That must have been really hard for you. I can't even imagine being in your position.' You know, like validation. And that worked really well. So everything I used, I learned in class and it was like working perfectly. Like text book! (Andy)*

Andy was the only care aide who discussed using techniques that he learned during his training.

Deliberate Provocation: One care aide described how she resorted to deliberately provoking a resident to kick her out of his room. Allison was the only care aide to mention this method, but she indicated that it was a known method, used by other care aides: *"I tried like everybody else did – their method"*. She described how she had become very overwhelmed and exhausted providing care to this resident on a daily basis, but felt that she could not ask to be re-assigned. Therefore, she felt trapped in her assignment. In order to free herself from the resident, she tried provoking the resident to ask her to leave because she knew that this method had worked for other care aides:

> *If he (the resident) could figure out a way to get you to be upset, he used it against you every time….If you got upset and left the room, then it would be fun for him. I figured that out because he was my resident for the first whole year. And I was trying to figure out a way to deal with him because he was stressing me out. And I hated going in there, and he wouldn't take anyone else. If he didn't think you were competent, he wouldn't let you in the room. If you grumbled about anything, you got kicked out. And like, I tried all those near the end….So I tried. I tried like everybody else did. Their method. Like arguing with him. But he would not kick me out!*
>
> *So you actually tried to be a non-caring person? (Interviewer)*

> *I did! I tried to get kicked out!...I wanted to get kicked out for just one day. Just exhausted right? I was just so tired! (Allison)*

Call for Help: Multiple care aides explained to me that after a certain period of time passed, and multiple options were ineffective or deemed inappropriate (depending on the situation), some care aides had no other option but to call the police, security or ambulance:

> *And actually, I mean, that particular gentleman (the resident), it was after her (the care aide) arm got broken that there were several police calls because the police have to come and help us sometimes. (Paula)*

Acceptance: The tenth strategy found in the language of the participants was to accept what cannot be changed:

> *I try to do my job and try to do it with the best ability I have been given and I think sometimes I get very frustrated if I know that I have done my job and it is not met with satisfaction...I end up feeling really bad about myself because I wasn't able to meet someone's needs for them…So I try to come to a happy medium where I am not going to beat myself up because something didn't get done. (Kathy)*

To accept what cannot be changed meant that these care aides yielded to an approach that dispelled with some of their taken-for-granted values and assumptions about what an ideal relationship with residents ought to resemble:

> *We just try our best. (Jennifer)*
>
> *We just try our best. (Diane)*
>
> *That is all we can do. (Jennifer)*
>
> *Exactly. (Diane)*

Compromise: Rather than trying to problem solve for many issues at once (the whole), some care aides described how they had chosen to give up one part of the whole. The rationale for this extracted strategy may have been to conserve energy:

> *I just do what they (the families) want you to do. (Doris)*
>
> *I just let her (the resident's daughter) do it because I know it is not going to harm the resident. If crazy people are going to be crazy than you have to let them be crazy. (Mary)*

Take a Mental Health Day: If giving up one part did not work, some care aides chose to take a mental health day/go home. This was the method chosen by some care aides who felt helpless or unable to cope with the whole. Taking a day off may have allowed them to gain courage to tackle a little more after returning to work:

> *I pretty much said to my LPN I am going home I can not deal with this anymore. (Kathy)*

However, the strategy was used more often by care aides who wanted to avoid something predictable. For example, Carol and Brenda described how they, and other care aides, avoided working on certain days of the week when they knew they would be confronted by a family member:

> *If you don't take that sick time, you are afraid to go to work! (Carol)*
>
> *So the way you cope with the stress is by taking some sick time? (Interviewer)*
>
> *Yes, that is how I do it. And I think that is how the majority do it. Some people, they call in sick when they see that it is Mrs. X's bath day, for example. (Carol)*
>
> *Yeah. So not to deal with it, some people call in sick. (Brenda)*
>
> *Some people call in sick the day that her family comes. Like Fridays. Every Friday her daughter comes. Her daughter comes once a week and it is Fridays. (Carol)*

> *And a lot of people, they call in sick all the time on Fridays! You are scared to come to work! (Brenda)*

> *Yes, you are scared! And you don't tell them (the managers) the truth because they won't pay you. They don't pay you for mental days. They only pay you for sick. (Carol)*

The Importance of Communication: The majority of the participants in this study indicated to me that due to workloads and time constraints, they did not go to care conferences and they did not spend any time at the beginning of each shifts together in formal report:

> *So you don't talk much together and plan? (Interviewer)*

> *We don't have the communication because there is no time. (Kathy)*

> *Oh. (Interviewer)*

> *And we come into our shifts, I am leaving and they are coming on so there is very few minutes to talk. (Kathy)*

There were very few opportunities to share experiences and seek support:

> *We have like a mini report: 'Everything is the same. OK, see yah!' Cause you can't wait to get out of there. (Betty)*

As previously described in Section Two, the care aides worked with the residents by themselves. They described feeling increasingly responsible for assessing and reporting deviations in the resident's physical and emotional health and well-being. They described experiencing emotional strain related to working by themselves. The heavy burden of responsibilities was difficult for them to bear consistently, and some were tempted to give it up. They also described how they gathered and communicated important information to LPNs who depended on them to provide it, but very few described communicating with each other. The care aides explained that they felt so exhausted that they did not have enough energy to help each other.

Those participants who did meet together indicated that this was an important forum for sharing difficult experiences and for validating individual experiences as common themes among the staff. For example, Kathy revealed that their unit had recently gone back to having a formal report with the RN, LPN, and care aides attending:

> *What is happening now is that we are having report together…The RN sits in on the report. The LPN, all the care aides…which is great! We actually have an RN, we know who it is, and all this kind of stuff! (Kathy)*

Kathy described the mutual give and take that is a feature of a formal report as very beneficial for her and for other care aides who were having trouble acknowledging their difficulties. Formal report also reinforced joint aims and objectives:

> *Sometimes I would just bury (my concerns) and not try to say anything or try to look conspicuous or out of sort or whatever. But this time I thought no, I am going to express to them - these are my concerns, this is what I am doing whatever. And as soon as I shared it….they (the other care aides) were expressing the same issues…they were kind of validating what I had said and that they were just saying that other staff were going through the same thing as I was so. So it was like ahh, relief! Ok, now I have support. OK this is wonderful! OK I don't have to do this alone or I don't have to go through all this on my own. I am not the only one going through it with these things. So it was like awesome!...I made a comment or she made a comment about this resident and expressed what had happened to her in terms of, 'Oh you have actually gone through this too' and we had kind found some common ground, 'Oh, you are getting this kind of friction too!' kind of thing. But I think for me it was like I always wanted to know what the other staff were experiencing. 'What are you guys doing? Are you guys having the same difficulties I am?' But these are questions I don't usually get to ask because you don't get the opportunity to. You don't want to come across as I am the only one that is having this problem…..You probably think that if I say I am having this problem somehow it illustrates some sort of weakness that you might have*

> *right? But if you could just be open and say, 'I am having this problem, does anybody else?' And everybody else can say, 'Yeah, I am having it too!' (Kathy)*

To summarize, seven idiosyncratic or lay theories were represented in the language and illustrative stories of my participants. These lay theories helped them reduce the complexity of observed behaviours. For example, they concluded that the residents who were cognitively unwell were unable to control their actions. They predicted future behaviours by stating that the residents who were cognitively well had firmly established sets of interactional behaviours and were unlikely or unable to change. They rationalized family members' actions by stating that families who made many complaints either had a) underlying mental health issues, b) were just trying to make sure that their residents' needs were being met, or c) had no other avenues to express their sadness/misery. They rationalized some residents' actions by stating that they also had no appropriate outlets to express themselves. Finally they rationalized that managers did not help them/support them through their dilemmas with some residents and some families because the managers were afraid of being reported by these residents and/or families to the media.

Thirteen strategies were also extracted from my participants' language and stories. They described the different methods that they used to ease the difficulties and cope with discomfort, stress and distress caused by strained relationships. They tried new ideas; they backed off when necessary (which was a dynamic strategy based on concerns for their own or the residents' safety and/or dignity); they bargained, bribed, and schemed; they tried to be more assertive;

they used scripts with mixed success; they provoked incidents to escape; and sometimes they called the police, security, or ambulance. Finally, some decided to accept what could not be changed; some gave up pieces of the whole; and others took mental health days. The majority of care aides in this study spoke of the importance of communication as the overarching strategy that they felt could ameliorate many aspects of difficult or strained relationships with residents and families.

Theme Six Summary and Interpretation

It was very difficult for the care aides in my study to form close relationships with residents and/or their family members who deeply offended them or frightened them. However, even though they may have felt afraid or offended, they still had to persevere in order to meet those residents' basic needs. Several participants described how they believed that residents who made offensive, demeaning or disparaging remarks (including racial slurs) were either cognitively unwell or had grown up at a time when people were not as culturally sensitive as they are now, and they were unable to change.

Participants also suggested that some families who had repeated disputes or disagreements with care aides were a) just trying to make sure that their residents' needs were being met, and/or b) suffering from underlying mental health issues of their own and/or c) without any other avenues or outlets to express their feelings of general misery. Similar to the lay theories about family members, some participants also believed that some residents had no other avenues or outlets to express their misery.

A considerable number of participants stated that many of the relational difficulties between care aides and residents occurred because the residents were inappropriate placed. Care aides described multiple situations where they felt challenged by residents who were much younger than the general population in the facilities. Participants suggested that these residents (who were usually male) were without appropriate outlets to express their anger, or their sexuality. These young residents were also without avenues for entertainment other than alcohol or drugs, and some care aides speculated that they often entertained themselves by engaging in humiliating confrontations with them.

When the language and illustrative stories of my participants were carefully examined, thirteen different strategies became apparent. The participants used these strategies to ease difficulties and enhance the quality of their relationships with residents and their families. These strategies were techniques used by participants to approach and manage the relationships with residents and families. Because the care aides worked with the residents alone, there were very few opportunities for them to share experiences and seek support. The majority of care aides in this study spoke of the importance of formal gatherings for communication such as a shift report, as the overarching strategy they felt could ameliorate many aspects of difficult or strained relationships with residents and families.

Chapter Five

Discussion

The goals of this study were to explore care aides' perceptions and experiences of their roles and relationships with residents in long-term care institutions, and how the context, including the organizational philosophy, influenced those perceptions and experiences. The key finding from this study is: some cultural change models, though attractive to organizations working within current fiscal restraints, address what is important to residents and families, but fail to address what is important for the largest, female dominated sector of the workforce: the care aides who carry out the majority of the care services for residents. This key finding can be summed up by the words of one care aide: *"If you have happy caregivers you have happy residents…there is a lot of unhappy people right now."* This study contributes new information to the field of inquiry on long-term care facilities as it focuses on the perceptions of a specific occupational care giving group, and attends to the interrelationships between aspects of cultural change and occupational experience.

In this chapter, I will discuss my results in terms of extant literature. Six key components of the discussion are: a) the ideal state, b) work overload, c) alone at work, d) the diverse population of residents, e) conflict with families, and f) the influence of cultural change. In the next chapter, I will discuss specific implications for practice, education and policy arising from this study.

The provision of long-term care services to residents has changed dramatically in recent years. While residents and their families may hope for close and caring relationships with care aides who believe in them, act as an advocate for them, and provide the help that they need on a daily basis, we are still unsure how to best shape and sustain these types of relationships. With widespread concern about the quality of care provided to residents, we need to know more about the processes that foster successful relationships between care aides and residents, and the processes that could hinder the development of successful relationships. The results of this study (which is limited by a delineation of the perceptions of care aides only) may help in the identification of core elements that distinguish between successful, well-functioning relationships between care aides and residents and unsuccessful, strained, mal-functioning relationships. In this study, the belief systems of the care aides were key to understanding how they coped with adversity, viewed various problems and options, made meaning of their experiences, and how they linked their experiences to the model of cultural change that had been implemented in their facilities.

The Ideal State

My analysis of the data revealed that my participants shared several ideals or taken-for-granted aspects of a collective consciousness, which supported their beliefs about the attainment of an ideal occupational relational purpose or state. The ideal state involved humanitarian ideals and values of inclusion, occupational ideals such as altruism and compassion, and explanations of why they chose the work in the first place or why they continued to stay in the role. The components of the ideal state included: sharing, becoming a friend or confidant for residents and their family members, helping people who needed help, protecting people who needed protection, being a nurse, providing good care, and having *"nothing but good days"* with residents (Kathy). These perceptions and attitudes of the care aides are in keeping with Swanson's theory of caring (Swanson, 1991; 1993; 1998). According to this theory, all care aides are capable of being in the ideal state if they are given the necessary resources. Swanson (1991) referred to this as *maintaining belief*. The ideal state also meant that the care aides believed in the importance of establishing respectful and authentic relationships with residents and their families and were interested in safeguarding the dignity of the residents. An important result from this study is that most care aides in the study also *believed* that they were nurses, and that the residents (and perhaps some family members) perceived them as nurses. This fundamental belief has not been clearly revealed or explored in any other empirical research about care aides but it affected all of the participants' perceptions. Previous researchers have linked care aides' perceptions of feeling valued and respected, and care aides' abilities to make changes or improvements to resident care, with improved levels of job satisfaction but they have not specifically stated that care aides see themselves as nurses (Anderson et al., 2005; Bowers et al., 2000; Jervis, 2002a; Moyle et al., 2003; Parson et al., 2003). Barry, Brannon and Mor (2005) suggest that care aides are unrecognized members of the health care team, but if they were recognized as members of the health care team, and provided with more authority and autonomy, satisfaction levels could rise, turnover rates could decline, and residents might benefit.

The term “nurse” is a professional title that is protected by law. In British Columbia, this title can only be used by registered nurses, licensed practical nurses, nurse practitioners, and registered psychiatric nurses (CRNBC Practice Standards, 2012). Yet, my participants believed they were nurses. These beliefs were expressed in their narratives and stories and guided their personal expectations and actions. Although the participants’ definition of *nurse* seemed more fluid and diverse than a professional title, it was based on similar humanistic foundations of caring, helping, giving, sharing, and friendship with residents.

Several factors experienced by my participants affected their formulation of self as nurse. First, many appeared to enjoy the helping and caring role and many were quite successful in their attempts at helping and caring. In the more successful, well-functioning relationships, my participants perceived the residents as people who merited their continuous concern and support. Care aides who felt that their role was a desirable one perceived tasks (even if obligatory and unpleasant) as worthy tasks that merited the commitment of time and the provision of other resources. The most successful relationships between residents and participants were marked by duration and consistency of thought or concern.

Second, many described how important they felt their role was, because they were the residents’ most central and accessible service providers. Some participants acted as surrogate family members and truly attempted to serve all of their residents’ needs as they would their own family members. This is consistent with the fourth component of Swanson’s theory of caring: *doing for*. Doing for means to do for the other what they would do for themselves if possible

(Swanson, 1993). Some participants protected or shielded more vulnerable residents from factors that they perceived decreased the residents' quality of life. Many described how they were willing to go to some lengths to find the resources needed by their residents. These results are similar to Anderson et al. (2005) who described how care aides often responded to residents as "they would want someone to do for them" (p. 1006).

The results of my study suggest that care aides can be very determined and many are very motivated to help, share, and give of themselves. My participants described searching for techniques that would work when they were assigned to challenging residents. Many of my participants made specific contributions and used specific methods to manage the interpersonal dynamics affecting their relationships with residents and families and for them, the process was as important as the outcome.

Third, my participants' relationships with residents were not necessarily restricted to dyad based relationships. Many of the care aides in my study described how they expanded their relational capacity to become an alternative or surrogate family member for residents who had no close relatives and some described providing companionship to some of the residents' spouses. This is consistent with the third component of Swanson's theory of caring: *being with*. Being with means to be emotionally present for the other (Swanson, 1993). In a fairly recent study, Anderson et al. (2005) found that care aides sometimes refer to themselves as mothers, and treat residents as if they were their children. Anderson et al. described the care aides in their study as using "Mother Wit" defined as “acting from wisdom gained through the experience as a mother” (p. 1006, 1012). In this respect, my results were different. Although some of the care aides in my study did describe residents who seemed to enjoy affectionately referring to them as their “mothers”, they never indicated to me that they perceived the same residents as their children. My participants were motivated to fill perceived relational gaps in their residents’ lives but were not motivated to treat any resident as an infant/child. What dictated success or failure of relationships between my participants and the residents was not so much motherly attentiveness, but how successfully they were able to guide the residents and/or their family members through the challenges associated with living in a long-term care facility.

Fourth, my participants valued and were very proud of their experiential knowledge of the residents and they described how the family members often viewed them as legitimate sources of medical knowledge and other information. This commitment to knowledge about the residents is in keeping with the second component of Swanson’s theory of caring: *knowing*. Within the caring theory, knowing means to strive to understand events as they have meaning in the life of the other (Swanson, 1993). Whether or not the family members thought that the care aides were nurses is uncertain. However, my participants needed to know, wanted to know, and took pride in knowing as much as possible about the residents. They would remark, *“I know what will work.”* Knowing about the residents meant that over time, my participants had tried and refined various methods to overcome obstacles. Thus, knowing what would work allowed them to have more pleasant, less confrontational interactions with more challenging residents. This result is also consistent with McGilton and Boscart (2007) who found that care providers perceive that they have a close relationship with a resident if they *know* how the residents act and what the residents like (p. 2152).

Researchers who have studied relationships between nursing home staff and residents have found that care aides often struggle with challenging residents because they *do not know* what to do. As a result of using ineffective strategies, the care aides in their studies often stopped trying and shut down emotionally. For example, Jervis (2002b) described care aides who resorted to strategies that were insensitive/not helpful such as evading or ignoring challenging residents. Similarly, Evers et al. (2002) described care aides who had became cold or calloused.

My participants' overarching formulation of selves as nurses encompassed their values, convictions, responses to residents and families, decisions, and actions. While this ideal state helped to facilitate their relationships with residents and families, it also had an opposite effect: leading to many feelings of depletion, guilt, and resentment. I turn now to the second key component of the discussion: work overload.

Work Overload

My participants all described feeling frustrated and angry because of the number of tasks they were required to complete, the type of tasks they were assigned, and the number of residents assigned to them. Their complaints were very similar to the frustrations described by many care aides in other studies such as: not enough time in the day for care aides to get everything done, high ratio of residents to aides, high acuity level of the residents, and not enough time to interact/converse with residents (Eaton, 2000; Kristiansen et al., 2006; Lin et al., 2002; McGilton & Boscart, 2007; Riggs & Rantz, 2001). The most commonly mentioned time concern for the participants in this study was not enough time to feed residents properly. Some participants reported that they no longer routinely sat at a table with residents to feed them because they are too busy with other tasks and that another person was assigned specifically to help residents eat their meals, especially on weekends. These participants indicated that one person might have to feed 13 or more residents. Some participants described never having enough time to feed residents. Some described efforts to provide food to the residents by making adjustments: they fed some of the residents in installments, they fed some in bed, and they fed some residents quickly, but in the end, the care aides in my study indicated that some residents did not receive enough food. These grim observations have been previously confirmed by the well-known ethnographic researcher Jeanie Kayser-Jones who made multiple observations of palliative patients and dysphagic patients residing in nursing homes, and confirmed that care aides are often unable to, or do not provide adequate nourishment and fluids to these residents, and are often unable to, or do not provide adequate assistance with meals (Kayser-Jones, 2000; 2002; Kayser-Jones & Pengilly, 1999; Kayser-Jones & Schell, 1997; Kayser-Jones et al., 2003).

My participants were also very critical of organizational expectations of efficiencies. Most participants perceived that their managers failed to consider all the various aspects of care and as a consequence, incorrectly calculated that there was ample time for them to complete all required care. They were frustrated with mechanical prescriptions for time management that they perceived ignored their relationships with residents and ignored important caring components, which were functions of their ideal state. In an ideal state (being a nurse), they perceived that their primary purpose was to fulfill the residents' physical *and* emotional needs. This is consistent with Swanson's overall definition of caring: "caring is a nurturing way of relating to a valued other person, towards whom one feels a personal sense of commitment and responsibility (Swanson, 1991, p. 165). What hampered them, they felt, from obtaining their ideal state were external circumstances not under their individual control, and created most often by managers. They also perceived that managers' interests with regards to 'nursing' processes were primarily fiscal in nature and therefore in conflict with their ideals. Some participants suggested that their managers needed to be more forthright with them and with families of residents regarding the nature of their fiscal motives and to acknowledge that they were clearly acting on behalf of the larger organization and not necessarily in the residents' interests.

Several of my participants described health problems that they associated with excessive workloads, expectations of efficiencies and increasing responsibilities. For example, they described high levels of fatigue such as *"dog-beat dead tired"* (Barbara). They described how their families suffered because they were too tired to participate in family activities after work and some participants indicated that they consumed alcohol and sleeping pills after work, and/or relied on prescription medication from their physicians to ease back pains. This result corresponds to reports of significant levels emotional exhaustion and emotional strain among care aides in Canada and in the US (Morgan, Semchuck, Stewart, & D'Arcy. 2002; Muntaner et al., 2006). Morgan et al. (2002) assessed the levels of job strain among RNs, care aides, and activity aides in seven Canadian rural nursing homes, by using the Job Content Questionnaire (JCQ), a 49 item self-report scale assessing the psychological and social structure of the work environment (Cronbach alpha .61-.81). These researchers found that the care aides reported significantly higher psychological job demands and job strain than the RNs and activity aides. Muntaner et al. (2006) examined the effects of workplace and individual variables on depression symptoms among 868 care aides employed in 55 US nursing homes. These authors found that many care aides experience significant amounts of "emotional strain" when they provide direct care to elderly and disabled residents, and that the "emotional strain" has a "statistically significant association with symptoms of depression" among care aides (p. 1461).

Work factors that are associated with care aides' complaints of musculoskeletal health problems have also been investigated with increasing frequency. Trinkoff, Johantgen, Muntaner, and Le (2005) examined the association between injuries and organizational characteristics of nursing homes in three states in the US. These authors found that for each additional hour of nursing care per resident per day (average was 3.3 to 3.5 hours - more than the average hours in the facilities in my study), the musculoskeletal injuries suffered by care aides decreased by 16 percent (p=0.0004). In a recent study, the rates of musculoskeletal injuries in care aides were still found to be substantially higher than the rates of musculoskeletal injuries in registered nurses - shoulders, arms, wrists, and back injuries most common (Boden et al., 2012). However, the psycho-geriatric workload stress first described by Leatt and Schneck (1985) was the more salient concern described by my participants and a contributing factor to their alcohol and sedative consumption. My results fit with Eriksen, Bjorvatn, Bruusgaard, and Knardahl (2007) who found that any factor at work that produced sustained arousal such as exposure to conflict and/or aggression with families and residents, or role conflict (described in detail by my participants), is likely to produce sleep difficulties for care aides. It was also interesting to note that threats at work (such as the threats from family members or residents experienced by my participants) has been found to be contributing factor to smoking relapse in care aides (Eriksen, 2005) and several of my participants smoked cigarettes. In a related study, Geiger-Brown, Muntaner, McPhaul, Lipscomb, & Trinkoff (2007) interviewed 1,643 home care workers by telephone to determine the prevalence of abuse and violence they experienced, and its relationship to depressive episodes. These researchers found that the most common abuse type experienced by home care workers was “criticism” (12%) followed by “verbal abuse” (18%) with some “prejudicial remarks” (4%) (p. 67, 68). The experiences of verbal abuse were positively associated with depressive episodes measured by a 20 item Revised Center for Epidemiologic Studies Depression Scale (RCES-D). Geiger-Brown et al. (2007) conclude that exposure to abuse or violence should not be considered to be “part of the job” for care aides (p. 73) and that care aides should be encouraged to report all incidents.

The care aides in this study worked with the residents by themselves and were the eyes and ears for the LPNs and RNs who were busy elsewhere. The participants described how they felt increasingly responsible for assessing and reporting deviations in the resident’s physical and emotional health and well-being. Because they provided care to residents alone, they had no way of knowing if the information they gathered and communicated to the LPNs was the right information because no other person was available to verify the information. In essence, the feeling of confidence that comes from approval for obtaining correct information was denied to them. This caused them to feel very anxious. This is congruent with an inability to *know* or understand which is one of the components of caring theory (Swanson, 1991). The anxiety, isolation, physical stress, and related fatigue due to work overload and increasing responsibilities impacted on their ability to develop and sustain relationships with residents because many were reduced to a state where they were not able to care, and were only able to see the residents as burdens (described as loads). Essentially, the workload forced them to concentrate less and less on the wellbeing of the residents because they were just trying to maintain a focus on their own health.

The application of Swanson’s theory of caring also encompasses professional nurses’ understanding of the care aides’ experiences: validating their feelings, communicating respect, assuring their dignity, fostering partnerships with them, supporting their inner resources, and creating positive and safe practice environments (Swanson, 1993). Based on Swanson's theory, *being with* means that the relationships between professional nurses and care aides should be as important as any other relationships. Although the perception of selves as part of a nursing group could have increased the care aides' abilities to overcome challenges at work and weather crises with residents and their families, the participants in my study often described feeling very distanced and separated from the professional nurses. Much of their frustration and anger probably resulted from these feelings of lack of cultural affiliation. They indicated to me that they did not feel accepted, respected or connected to the professionals because they didn't work together. This is not to say that RNs or LPNs must do the work of care aides, but my participants felt that the RNs or LPNs were not really interested in helping them provide care even if they were not busy. This result is in keeping with Anderson, Bailey, Corazzini and Piven (2005) who described RNs who had minimal interaction with care aides and LPNs who were "tied up with medication and treatment carts" (p. 105). In this study the LPNs especially were perceived by my participants as not engaging with those other qualities which defined for the care aides the essential nature of caring and nursing – that is compassion for colleagues, making efforts to relieve suffering, providing help willingly when another person needs it (when a care aide is withering, or when a resident needs help).

In all five facilities, the contributions that the care aides, the LPNs, and the RNs made to the welfare of the residents were complementary but highly differentiated. The care aides described how they were responsible for providing basic care to the residents; the LPNs were responsible for the medications and treatments; and the RNs were responsible for overseeing day-to-day activities, problem solving, data entry, and other managerial tasks. My participants reported to me that they felt they did not receive the help they needed when they asked for it because they believed that the management had made promises to the LPNs on hiring, that they would not be involved in anything more than their highly differentiated tasks. Some of the participants stated they were told by the LPNs that this was the case. They described how some LPNs and RNs were “hands off” and would not respond to call bells. It should be understood that this characterization represents my participants’ perceptions, and is like a composite cultural photograph. It does not represent all RNs and all LPNs in the facilities, but in this study complaints of this kind were quite pronounced.

Like other social hierarchies, the distanced status of the LPN or RN gave rise to some antagonism between the levels of the hierarchy in the five facilities. My participants provided evidence of deep-seated inferiority feelings to which they reacted with anger and frustration. For example, multiple participants described how privileges such as ready access care plans, care conferences, and the computer/internet were role-typed. These results are not new. In multiple qualitative and quantitative investigations aimed at exploring management practices, the quality of relationships between care aides and their supervisors, turnover rates, and levels of work satisfaction for care aides, the authors have concluded that facilities with high turnover rates and low levels of satisfaction are more likely to have hierarchical organizational structures (Anderson, Bailey et al., 2005; Anderson et al., 2003; Jervis, 2002a; Noelker, Ejaz, Menne, & Jones, 2006; Riggs & Rantz, 2001). In my study, the care aides described an undesirable fragmented culture that was marked by a lack of unit cohesiveness. This lead to feelings of isolation and the next key component of the discussion: “alone at work”. Based on Swanson’s theory, k*nowing* means that professional nurses and managers make attempts to *know* what is going on though assessment of care aides’ strengths and abilities, current strains and stressors, quality of work life, and manageability of workload.

Alone at Work

My participants described how they worked alone with the residents, had few opportunities to communicate with the professionals and even fewer opportunities to communicate with each other in order to share their experiences. Although they believed they were nurses, they did not experience the emotional climate of belonging, or the mutual support that often exists between professional nurses.

Considering that a) the most successful relationships were marked by duration and consistency of thought or concern; b) that the care aides explained how they knew what would work best for the residents because they knew the routines; c) the care aides felt that they knew more about the residents than the LPNs or RNs; and d) they were the main care providers - it was surprising that many of the care aides in this study told me that they did not go to care conferences; they did not bother to access the care plans at all; and that they did not have time to communicate with each other at shift changes. Instead they quietly gleaned extensive information about the residents as they tried to create conditions that fit with the residents' attitudes and preferences and they only participated in *"passing conversations"* (Kathy). Most indicated that they were not given an opportunity to listen to a formal report at shift changes. Some of the participants described how they felt that they were the only ones having difficulties.

This result is very similar to Kontos, Miller, and Mitchell (2009) who examined the decision-making and core care practices of care aides in two Canadian nursing homes within the context of the Resident Assessment Instrument-Minimum Data Set (RAI/MDS): a standardized process that informs care plan development in nursing homes. Twenty-six care aides and nine supervisors participated in focus groups and semi-structured interviews. These researchers also found that the care aides "drew heavily on their own personal experiences…imagination and empathy" because they had poor access to computerized records, were not involved in any of the care planning, and were "prevented from making occupation-specific experience-driven contributions to the broader interdisciplinary team either in written form or through interprofessional meetings" (p. 355, 356). The care aides in this study also consistently reported that the "nurses often failed to solicit information (about the residents) and did not respond positively when (care aides) initiated exchange of clinical information" (p. 358). This finding is consistent with the stories provided by many of my participants.

In order to help all care aides reach their ideal state of helping people who need help, providing good care and having *"nothing but good days"* with residents, my participants indicated that they would like to *know* what the other staff members are experiencing, and whether their own experiences resonate with others. This is in keeping with Eaton (2000) who found that care aides rarely share their experiences and receive little or no feedback on effects of their work, and Heliker (2007) who found that care aides were more focused on engaging residents in conversations after they (the care aides) were provided with formal opportunities to share stories with each other. My participants described few opportunities to share their successes and weaknesses. If they had been given an opportunity to join a formal report they may have felt less alone. They need to be provided with opportunities to share their problems. Based on Swanson's theory, the components of *enabling* and *empowering* would include keeping the care aides fully informed, evaluating the care aides' level of understanding of events and changes, providing necessary explanations, following up on stressful events, and evaluating the need for additional resources.

Swanson's theory of caring emphasizes confidence in the abilities of care aides but at the same time emphasizes an appreciation of their current difficulties (Swanson, 1991). According to this theory, their experiences and perceptions of the strains and stressors encompassed in their roles and work should improve if professional nurses and managers who work alongside them are sensitive to and guided by this caring theory.

Role identity theory is another theory that could also help to provide insight into some of the results of this study, especially to understand more about the origins of my participants' deep-seated feelings inferiority, their feelings of anxiety, discontent, anger, depletion, guilt and resentment. Role identity theory is a middle range theory (as is Swanson's theory of caring), rooted in the discipline of social psychology (Burke & Reitzes, 1981; Burke & Tully, 1977). According to this theory, the care aides' identities (in this case, their work identities) develop as they interact socially with others and respond to the expectations of others. Gradually, they will choose actions that support their roles in order to behave consistently within their identities (Siebert & Siebert, 2007).

My participants' perceptions of themselves as nurses was a thread that ran through all of the themes and contributed to their experiences of the working environment and therefore, their experiences of their relationships with residents and the residents' families. The participants who felt recognized, valued, rewarded, and supported by managers who respected their workloads and allowed them to follow their own initiatives almost guaranteed their interest in and enthusiasm or residents and for any activities that the residents and their families might enjoy.

Another component of role identity theory is *self-categorization* (Burke & Reitzes, 1981). Self-categorization means that people continue to develop their identities by categorizing themselves into in-groups (the care aide group) and out-groups (the professional nurses or managers). In addition, when one role identity becomes all-consuming, a person's ability to give prominence to another role is greatly diminished. In keeping with this theory, the participants who perceived some tasks as inappropriate, unworthy, or demoralizing because those tasks did not fulfill any part of their ideal state or role often described feeling very subservient. The participants who felt unfulfilled in an undesirable role did not feel as if they had many obligations to the residents and their families, therefore they had greatly reduced initiative to make extra efforts on behalf of the residents and their families (the caring role was reduced). These participants described managers who failed to acknowledge/reward them and/or managers who held mechanistic views of their roles, which were incompatible with their own views of their roles as nurses. Their main objective was to just to "survive" at work.

My results also build on those of Secrest et al. (2005) who found that most care aides are very conscientious and want to be able to attend to all of their residents' needs. If they cannot, they experience reduced attachment to the facility, the residents and their families. These authors suggest that if care aides had more control about the meaningful and important "little things" that make life better for residents, they would be less likely to leave the job (p.93). Multiple other researchers have confirmed that care aides are deeply affected by the stigma of their work. If they do not feel respected and rewarded, they are less likely to feel committed to the work (Anderson, Corazzini, & McDaniel, 2004; Bowers, Esmond, and Jacobson, 2003; Jervis, 2002a).

Although my participants' ideal occupational purpose or state (nursing/being a nurse) often contrasted greatly with the many of their actual evaluations or appraisals of their occupational self worth and their descriptions of what they were really required to do, it did work to motivate them and energize them when they doubted their occupational self worth and contributions. These results are congruent with previous researchers who found that care aides often conceptualize the work that they do as of low value or insignificant, but stay in their jobs because of their rewarding relationships with residents (McGillis-Hall & O'Brien-Pallas, 2000; Parsons et al., 2003; Secrest et al., 2005; Sung, Chang, & Tsai, 2005).

Role identity theory explains that as care aides become depleted, defeated, and disillusioned over time because they are overburdened by their expanded responsibilities and workloads, they may make unconscious efforts to maintain the undesirable role subservient role which could keep them from attending to their own needs, as well as the needs of the residents and families. The choices that care aides make are a reflection of the external social forces within the working community such as the affirmation, support, and caring shown to them by the professional nurses and managers.

The Diverse Population of Residents

In all five facilities, participants described caring for an extremely diverse population of residents. Older residents who had chronic mental and physical impairments co-existed with older residents who were acutely ill, and young male residents with severe behaviour disorders. Complex problems occurred when residents with a multiplicity of physical and mental health problems and different levels of functioning co-existed. Some of the young male residents' behaviours described by the participants must have been disruptive and distressing to the other residents who could see and hear what was going on. Participants indicated that the placements of young male residents, in particular, were not based on careful examination and evaluation of behaviours, functioning, and degree of potential disturbance to others.

Young people are most often admitted to nursing homes following strokes, brain injuries related to substance abuse, neurological trauma, and traumatic injuries resulting in hemiplegia or quadriplegia (Persson & Ostwald, 2009). My participants described young residents with similar injuries. These young people have been, and will continue to be placed with older people in long-term care facilities in British Columbia due to the ‘first available bed’ policy. Since 2002, people who require residential care in British Columbia must accept the first vacancy that is offered to them. After they have accepted the first bed, they must request to be placed on a waiting list for a more desirable/appropriate facility (Residential Care Access Policy, British Columbia Ministry of Health, 2002). The local health authorities manage all of the waitlists, access and transfers to residential facilities.

Multiple researchers have examined the challenges faced by care aides when young residents are required to adapt to living in nursing homes. These authors describe young residents who have limited family and community involvement, high physical, social, and emotional needs, low potentials for recovery and discharge and considerable difficulties managing their sexuality, their privacy, boredom, and depression (O’Reilly & Pryor, 2002; Persson & Ostwald, 2009; Smith, 2004). In a reverse situation, Parke and Chappell (2010) studied older people who are required to adapt for long periods of time to acute care. These authors found that some older patients who stay for long lengths of time in acute care also have considerable difficulties because they are “inappropriate for the hospital’s cultural space” (p. 115), have difficulties adapting, suffer from “lack of fit” with the acute care environment, and have “difficulties expressing their needs, wants, and desires in ways that hospital employees understand” (p. 120).

My participants also described some residents who were overtly sexual towards them or who made requests that appeared to be of a sexual nature. These behaviours/requests made them feel very uncomfortable and sabotaged any possibility of relational success. They described some managers who failed to support them and protect them by responding to their complaints related to sexual behaviours of some residents. Despite the widely promoted zero-tolerance policy for employee abuse, some participants described how their managers had told them that they must comply with some of the requests even though they felt very uncomfortable. It was also difficult for the care aides to form close relationships with people who deeply offended them. Some participants described some residents who explored more vulnerable care aides’ shortcomings and then exploited them at calculated times, some residents and/or family members who resorted to offensive or disparaging remarks about the care aides’ cultural backgrounds, some residents who purposely contaminated them repeatedly with body fluids, and some residents who habitually used extremely foul language directed towards them. My participants described feeling very demoralized, and distressed by offensive remarks, name calling, intimidation and inappropriate sexual remarks. Other researchers have shown that similar remarks result in feelings of reduced personal accomplishment, feelings of isolation, and feelings of emotional exhaustion in care aides (Brodaty et al., 2003; Evers et al., 2002; Gates et al., 2003; Kristiansen et al., 2006; Ramirez et al., 2006). Some of the care aides perceived that some managers allowed the seemingly cognitively well residents and/or their family members to continue without reproach or consequences.

Some of my participants reported that they were afraid of certain residents who had unpredictable violent outbursts. Sometimes the outbursts were due to symptoms of dementia but at other times the violence was the result of alcohol or marijuana use by the resident. With regards to residents who suffered from cognitive dysfunction, most of the time, the care aides were less likely to form close relationships with them due to the more prominent facets of the dysfunction such as unpredictable, unintentional outbursts. Fear of being hurt by these residents made it very difficult for care aides to engage with or become close to the residents. These results are similar to the findings of multiple other investigators who have reported that care aides find it very difficult to cope with residents who are unpredictable and violent (Brodaty et al., 2003; Gates et al., 2003; Kristiansen et al., 2006; Ramirez et al., 2006; Shaw, 2004).

Some of my participants described managers who did not seem to consistently reinforce policies and procedures that were established for the safety of the residents and the staff. Some participants described some very heavy and unstable residents who did not comply with safety recommendations for transfers.

They also described some managers who allowed the residents and/or their family members to make unsafe decisions about transfers. Other participants described how difficult it was for them to dress certain residents in clothing that was too tight for them or not stretchy/loose enough to ease over the residents' contractures. Some managers allowed families to make unrealistic decisions about clothing that resulted in many difficulties for care aides such as having to pull and push on residents' elbows, wrists, and knees. These problems that could have easily be rectified had the clothing been stretchy, looser, or split. These kinds of situations resulted in tension and conflict between the residents and the care aides and the families, especially when the residents' or the family's decisions increased the likelihood that a care aide would suffer an injury. Families often want and expect care aides to cooperate with their priorities, therefore, if their priorities are not the same as or similar to the care aides' priorities, the result is conflict (Abrahamson, Suitor, & Pillemer, 2009; Friedemann, Montgomery, Maiberger, & Smith, 1997; Guruge, McGilton, Yetman, & Campbell, 2005). Families who engage in conflict with care aides or "report problematic relationships with staff" have been reported to be less likely to visit their family members (Port, 2004, p. 775).

The care aides in my study also found it very difficult to form successful relationships with residents who seemed to be cognitively well, but who were perceived to be overly particular or demanding. They described how stressful it was to meet these residents' expectations of them. They described feeling afraid of disapproval, or feeling exasperated with the tension in the relationships;

therefore they were often reluctant to provide care. Additionally, there were often disagreements between the participants and the residents about what constituted enough care. The participants felt that their time was limited and that the particular residents did not appreciate that others were waiting while they were receiving more than the usual amount of care. The particular residents' expectations of the participants to provide extra care further intensified negative emotions. The importance accorded by the organization to meet the particular residents' requests for special items (such as food items) limited the abilities of the care aides in my study. The care aides were often thwarted in their attempts to please particular residents because they could only provide what was made available by the organization. Relationships between these care aides and these residents were characterized by high emotional intensity, and feelings of anger and frustration.

The participants who described coping with feelings of failure, frustration, anger, or fear day after day, found themselves suffering from lack of concern for the residents, reduced levels of patience, exhaustion, and frustration. These symptoms are not new and have been previously documented as burnout (Evers et al., 2002; Harrison et al., 2002). According to Kristiansen et al. (2006), care aides who experience collegial fellowship are better able to resist the feelings that occur during burnout. Many of the participants in my study clearly stated that the cultural norm of consistently assigning the same residents to the same care aides (creating families) was not always a good idea for them.

Conflict with Families

My participants spent a great deal of time describing stress and distress triggered by repeated conflicts with some of the families of residents. Nearly every participant indicated to me that he or she had endured multiple unpleasant interactions with family members. Multiple participants suggested that families could be a major factor in determining the success or failure of their relationships with residents.

Some participants described an overwhelming sense of dread when some families visited because they fielded many of their complaints. They described some families of residents who had critical, punitive styles and other families who looked for and focused on the slightest oversights or faults. Some care aides struggled because their visions of appropriate care for certain residents and/or their concerns for the same residents contrasted with the family members' views. These participants seemed to be in a state of continuous conflict with certain family members because they could not provide care the way they felt best (from their perspectives). They became disgruntled and frustrated when their assessments were discounted and they were powerless to influence care practices. They described simmering frictions between themselves and the residents' family members. As a result of simmering frictions, some care aides made decisions to *"let go"* of the resident.

My participants also described feeling unfairly blamed by family members for perceived lapses in care that occurred outside their control and they were frustrated with the amount of time it took to respond to families' grievances, which left less time to care for residents. Some participants felt that the families did not fully understand the time constraints, the emphasis on efficiencies, the workload, and the diverse population of residents, and did not allow for these factors when they had criticisms. My results are congruent with a recent study of care aides' perceptions of their relationships with family members (McGilton, Guruge, Librado, Bloch, & Boscart, 2008) and a study of managers' perceptions of their relationships with family members (Guruge et al., 2005). McGilton et al. (2008) also noted that care aides ran out of time to provide care if they spent too much time trying to solve family members' complaints about perceived lapses in care. In the same study, the investigators also acknowledged that lack of resources contributed to strained relationships between care aides and family members. Guruge et al. (2005) noted that while some managers did acknowledge that time constraints, equipment shortages, and lack of resources had a negative impact on the relationships between the care aides and the families, those managers explained that it was very difficult for them to tell the families the real reasons why they could not meet all of their expectations. One of the managers in this study concluded, "we are setting staff up for failure" (p. 133).

Previous studies of relationships between care aides and families of residents confirm that complaints and conflicts between families and care aides are pervasive and time consuming (Abrahamson et al., 2009; Friedemann et al., 1997; Nelson & Cox, 2004; Port, 2004; Ryan & Scullion, 2000).

In my study, some of my participants described intensely negative emotions especially when some families made threats. Nobody wanted to spend any extra time with residents who had threatening families. Participants consistently reported that they believed if families complained to management, management would make promises to families – promises that were not possible for them to keep. My participants also believed that most managers permanently sided with residents' or families' requests, no matter how unrealistic those requests were. My participants asserted that they were almost never consulted about requests. These results are similar to those reported by Majerovitz, Mollott, and Rudder (2009) who stated that care aides were not only *not* involved in the decision-making processes between families and managers, but often not informed of decisions after the fact. However, Guruge et al. (2005) would suggest that most managers would have a very different perspective on this situation. The managers in their study perceived that they did make every attempt to negotiate and preserve agreeable or cordial relationships between long-term care staff members and families. They indicated that they met with staff, they "listen(ed) to their interpretations", and that their role was to "negotiate win-win situations" (p. 133).

I believe that my participants were more focused on conflict with families than on residents because of the nature of their beliefs about their ideal state (giving, sharing, loving, helping, being a friend or confidant, caring, and being a nurse) and the nature of their beliefs about ideal relationships. The care aides in my study indicated early on that a certain amount of time was needed before they and residents grew accustomed to each other's particular ways of doing things. The care aides probably do not spend as much time with families, therefore, they have less time to grow accustomed to the families' ways of doing things. My participants also indicated that new residents conveyed their preferences, habits, and patterns to them in an ideal relationship, but there were always negotiations and adjustments because of the constraints of what they and the institution as a whole were able to provide. In contrast, the families of residents may not fully understand the need for adjustment and negotiation, or they may feel as if it is not reasonable to have to make these adjustments. Finally, as previously discussed, in the most successful relationships with residents, the residents were perceived by the participants as people who merited continuous concern and support – consistent with their ideal state of giving, helping, being a nurse etc. These relationships were further enhanced when the residents' responses implied that they accepted that they merited continuous concern and support from the participants. In this study, the families who seemed to allow, even encourage, the participants to be in their ideal state were the families who had the best relationships with the participants.

The Influence of Cultural Change

Perhaps the most frequent criticism of long-term care facilities is the impersonal atmosphere in many of these facilities, and lack of consideration for the residents who live there, as individual human beings. Much attention has been devoted to organizational and operational arrangements in long-term care facilities. Most, if not all policy and decision-makers hope to gain a more comprehensive and deeper understanding of the reasons why the care provided to residents in long-term care facilities is considered painfully inadequate by many persons experiencing it (Canadian Healthcare Association, 2009; Jansen & Murphy, 2009; Silversides, 2011).

Since care aides constitute the largest group of care providers in long-term care facilities, and since they are indispensible to the running of the facilities and providing resident care, much attention has been paid to recruitment and retention of care aides (Hsieh & Su, 2007; Kristiansen et al., 2006; Lin et al., 2002; Riggs & Rantz, 2001). Rapid turnover of care aides means that recruitment is a continuous process for most facilities. Many decision-makers have come to a conclusion that the organizational and operational arrangements as well as the overarching philosophy within the organization are important determinants of how employees feel about the work that they do for the residents and how they think about the residents. Therefore, the formal organization and the overarching philosophies are considered to be principle factors that will not only enhance recruitment and retention but also enhance quality of care for residents.

Several models of cultural change have been introduced to long-term care policy and decision-makers. These include: the Wellspring model focused on respect and egalitarian relationships between staff members (Barry et al., 2005); the Sisters of Providence/Mount St. Vincent model that is a model of neighbourhoods similar to the Eden Greenhouses (Eaton, 2000); the Client Centred/Resident Centered/Person Centered models that focus on the unique needs of the individuals living within the organizations (Gould, 2001); the Social model which focuses on improvements to the physical features and the aesthetics of nursing homes to help the residents to feel more at home (Caspar et al., 2009;

Cooney & McClintock, 2006); and the GentleCare model which focuses on permanent assignments and staff training (Caspar et al., 2009). The developers of the models suggest that most of the personal care in long-term care facilities has been inappropriately segmented into discrete blocks of care (medication administration, bathing teams, people who feed etc.) and that most of the operational arrangements have been inappropriately departmentalized. The developers conclude that segmented care results in inadequate care for the residents. Therefore, most models are designed to utilize human resources in a manner that will enhance care by ensuring a continuous flow of events in relation to the residents.

The participants in my study were recruited from five facilities that had all implemented a cultural change model that combines aspects of the client-centered and social models – The Eden Alternative®. The Eden Alternative® prioritizes a home-like atmosphere that is intended to improve the quality of life for residents in long-term care facilities. Most articles about the Eden Alternative® philosophy/model focus exclusively on what the philosophy claims to attain: higher levels of resident and family satisfaction, enhanced quality of care and quality of life for residents (Schmidt & Beatty, 2005). A large component of my study was aimed at exploring the perceptions and experiences of care aides about the Eden Alternative® model/philosophy because that topic was very important to them. All of the participants expressed a strong desire to speak about the Eden model that had been implemented in their facilities. The experiences and perceptions of the care aides (the versatile or universal workers) who are integral to the functioning of the Eden model have never before been adequately or thoroughly explored.

To incorporate the Eden Alternative®, the care aides in all five facilities were permanently assigned to "families" of residents. “Families” were formal, organized, clearly defined work assignments. In descriptions of the Eden Alternative®, the positive attainments and functions of “families” are emphasized while the internal stresses and strains in the “families” are almost never discussed (Mackenzie, 2003; Monkhouse, 2003; Schmidt & Beatty, 2005). In this study, many of the participants clearly stated that the cultural norm of consistently assigning the same resident to the same care aide (creating families) was not always a good idea for them. The outcome of the same stressors from the same residents over time resulted in lack of concern, lowered standards, reduced levels of patience, exhaustion, and frustration. Multiple participants complained about inadequate flexibility in their assignment and described how they struggled day after day after day with a defined set of very challenging residents who spat on them, made threats, sprayed them with urine or feces, or used extremely foul and degrading language.

Since the Eden Alternative® model/philosophy was implemented in all five facilities (accessed for this study) the population of residents in those facilities continues to be very diverse. The diverse population of residents is a direct result of the “First Available Bed Policy” that has been implemented in the province of British Columbia. People with differing physical and mental health problems and differing levels of functioning must co-exist for long periods of time in long-term care facilities as they wait for their preferred beds. Residents who are happy with their placements are often forced to live with residents who are unhappy and/or angry with their placements and/or inappropriately placed temporarily. Some of the residents currently living in long-term care institutions have social principles, personal values, cultural values, and codes of conduct that others may find intolerable and threatening. Some, for example, have very serious criminal histories (drug and weapon offences, pedophilia, prostitution, other violent offences and affiliations with criminal organizations). These residents have served jail time for these offenses, but now require long-care due to significant health issues. For example, during gang activity/violence, some gang members do suffer head or spinal cord injuries from gunshots and these gang members sometimes become residents in long-term care facilities because they require 24 hour per day care for the rest of their lives. Other people who live in long-term care facilities are there because they have suffered from permanent brain injuries as a result of drug overdoses. It is reasonable to believe that my participants who provided care to residents with criminal histories did feel afraid of these residents and their visitors and were not exaggerating. Keeping this in mind, it is also reasonable to believe that the residents who were cognitively well and had no such histories were probably not comfortable being in a "family" with residents whose social principles, personal values, cultural values, and codes of conduct are not comparable with their own.

The Eden Alternative® model of "families" of residents has the potential to compound the difficulties created by policies such as the "First Available Bed

Policy" because the model does not make any allowances for such policies when the positive attainments and functions of permanent assignments and "families" of residents are emphasized to organizations. This is not a problem with the Eden Alternative® model. The problem occurs when the "family" component of the Eden Alternative® model does not fit with an existing policy such as the "First Available Bed Policy". This is a new result. It is very possible that in other facilites that have implemented the Eden Alternative® model (in other provinces and countries), the "families" of residents are chosen very carefully so that their social principles, personal values, cultural values, and codes of conduct are similar.

The Eden Alternative® literature does address potential conflict in "families" by suggesting that each neighbourhood choose "a council of elders, caregivers and family members" who oversee the social environment and intervene if and when relational conflict in the neighbourhood occurs (Thomas, 2003, p. 150). Ideally, according to the Eden Alternative® philosophy, these councils are led by residents who "possesses the life experiences and skills needed to help this group of people identify and resolve interpersonal conflicts as well the dilemmas of daily life in a communal setting" (p. 150). However, given the high levels of frailty and dependency of residents who currently live in nursing homes (Statistics Canada Residential Care Facilities Survey, 2011), it is difficult to imagine residents who are able to facilitate during conflict.

Although some participants had great faith in the model and followed the principles and philosophy very conscientiously, they described how they found themselves in conflict with some family members who did not support all components of the model. For example, two important components of the model are: a) to encourage residents to do what they can for themselves without having to work within time constraints, and b) to eliminate rigid schedules for meals, bathing, medications, bowel care, sleeping/waking etc. Some families (of residents) described by my participants did not seem fully committed to this perspective. Subsequently, these families had conflicts with participants who had faith in the philosophy. This problem most likely originates when families of new residents are not properly informed about the philosophy and culture of care when they are first introduced to a facility that has embraced the philosophy.

Many of my participants described significant problems with the permanent assignment component of the Eden Alternative® model. While some of these problems may have been due to the permanent assignment component, many of these problems were rooted in perceived erosion of the Eden Alternative® model after it had been implemented. For example, my participants described a paradoxical relationship between the Eden Alternative® as they knew it, and their abilities to develop and maintain meaningful relationships with the larger residential community (residents not assigned to them/not part of their permanent assignment). They felt that as a result of permanent assignments, they began to know less and less about the other residents who were not assigned to them. While this problem has never been addressed in any studies of the Eden model, it originates in the large workload for care aides in all five facilities, and not with Eden model itself. My participants described being assigned to up to eleven residents, therefore, they had no time to converse or socialize with any residents other than those directly assigned to them.

My participants also reported that because they worked alone with the residents who were permanently assigned to them, this component of cultural change resulted in feelings of helplessness and isolation. They described a very strong need for collegial fellowship. Although they still belonged to a network of care aides, the network was no longer close and cohesive. The experienced care aides recalled that prior teams (collegial support systems) had helped them to moderate or buffer the effects of stressful events or work environments. Participants indicated that teamwork and rotating assignments would help them feel more confident and professional. This result is in alignment with previous researchers who suggest that care aides who work in teams feel more empowered at work, are better able to persist during stressful conditions, better able to maintain their composure, and better able to coordinate resident care (Janes, Sidani, Cott, & Rappolt, 2008; Yeatts, Cready, Ray, DeWitt, & Queen, 2004). Many of my participants expressed a desire to return to teamwork for collegial companionship and support. Some participants indicated that they were already in the process of giving up on the permanent assignment component of the Eden Alternative® and reverting to teamwork.

To compare my results with extant literature, I found one study where researchers (Burgio, Fisher, Fairchild, Scilley, & Hardin, 2004) examined the isolated effects of the permanent and rotating assignments (also referred to in the literature as primary care and team nursing) on quality of care, specifically the quantity and some quality aspects of care aide / resident interaction, resident behavioral disturbances, affect states, and personal appearance and hygiene. Permanent assignment was defined as consistently assigning individual care aides to specific residents and rotating assignment was defined as a team of care aides assigned to a group of residents with the team rotating by use of a predetermined schedule. The study was conducted in four nursing homes in Birmingham Alabama. The homes were similar in size and staffing levels. Two of the facilities used permanent assignment and two used rotating assignment. The authors used a between-groups quasi-experimental comparison design. Resident ratios were comparable to the resident ratios in the facilities I accessed: On average, 1:8 and 1:12 for the morning and evening shifts, respectively. The authors analyzed the data independently by shifts because prior research suggests that turnover is higher for evening shifts and found that residents who were permanently assigned to care aides were prescribed significantly more medications ($p < 0.0001$) and more psychotropic medications ($p=0.04$) than residents who were not permanently assigned to care aides. There were no differences found on any of the resident/care aide interactions or resident disruptive behaviours. The authors reflect that neither permanent assignment nor the rotating assignment showed clear superiority in the quality of care measures but that it was possible that the greater number of overall medication prescriptions and greater number of psychotropic prescriptions was an outcome of permanent staffing “greater exposure to the same resident results in better knowledge of and attention to changes in resident conditions, translating into greater attention to medication management" (p. 375). When comparing these conclusions to the results from my study, it is also possible that greater exposure to the same residents might have resulted in decreasing tolerance of aberrant behaviours and increasing requests for psychotropic drugs. From a safety perspective (safety of residents and staff), considering that multiple participants described lifting very heavy residents by themselves as they worked alone with residents, teamwork would be a definite improvement.

Teams do form a large component of the Eden Alternative®, however, the Eden Alternative® interpretation of teamwork is not in alignment with my participants' interpretations of teamwork (care aides working with other care aides to complete care for residents; care aides, LPNs, and RNs spending time together, sharing tasks, helping each other, making decisions together). The Eden Alternative® interpretation of teams is specific and distinctively different. Each Eden team consists of five to eight individuals who represent each department of the organization - managers, RNs, LPNs, care aides, families of residents and residents. These Eden teams meet approximately once per month in work groups dedicated to quality improvements for residents (Eden Alternative® Associate Training Manual, 2006). It is unclear as to whether or not these teams existed in the facilities that I accessed for my study. Certainly, my participants never mentioned them, so it is possible that they did not exist. My results suggest that the care aides who work in facilities that embrace only parts of the Eden Alternative® are at risk of losing feelings of affirmation and solidarity derived from good fellowship with their colleagues.

My participants also described how other staff members (such as dietary or housekeeping staff) were unlikely to become involved in benign helping activities (such as giving a resident juice or pushing a resident in a wheelchair to his or her room) because they knew that the residents "belonged" to particular care aides. It was also very disconcerting to hear multiple participants describe how residents would wait to be toileted or fed because the care aide permanently assigned to them was having a coffee or a meal break. These problems were a result of significant lapses in caring practices and a culture that prescribed to such strict definitions of "family" that the individual members of the "families" suffered. These lapses in caring practices are not in keeping with the overarching goals of the philosophy which are to reduce loneliness and ease helplessness for residents.

Permanent assignment also assumes that the relationships between care aides and the residents are pleasing or agreeable to the residents and that the care is always of high quality. It should be considered that when the workloads are as high as those described by my participants, the care aides who are permanently assigned to residents might become permanently apathetic, sloppy, or fatigued and give permanently inadequate care. The high potential for this problem is also a result of reduced numbers of registered nurses in long-term care who provide direct supervision and leadership. Residents should not be restricted to receiving care only from one defined set of care aides if heavy workloads for care aides are compounded by a lack of supervisory personnel. The care provided day after day could be less than ideal and/or have missing components. It is very concerning to think that some residents in this situation may receive consistently poor care from some care aides who are permanently assigned to them (for example, care aides who are not very observant or who consistently take short cuts). Again, this problem originates in the heavy workload and not in the Eden model, but in situations where there are very high ratios of residents to care aides and low numbers of supervisory personnel, care aides who rotate from resident to resident may be a better solution. Care aides who rotate may also be better able to observe something about a resident's condition that another care aide (who sees the resident every day) may have missed.

While the versatile worker role in the Eden Alternative® philosophy does contain expanded duties, all of these duties are expanded horizontally (dishes, laundry, food service, cleaning) and not vertically (decision-making, leadership, discussions, assessments and related judgments). The care aides in this study consistently reported that they did not have any decision-making ability and often felt powerless to fulfill their ideal state. Even if they had information, they often could not act on it. Two of the most poignant situations revolved around residents who were perceived by my participants to be experiencing pain. In these situations, my participants believed that although they had provided important, relevant information about the pain to the LPNs, the LPNs did not act appropriately. With no RN as a backup, they were helpless. Considering that a large component of my participants' ideal occupational purpose or state was to help people who need help, to protect people who need protection, and to provide good care, in these situations, my participants agonized because they felt absolutely powerless to intervene. This result is similar to Kayser-Jones (2002) who observed that dying residents in nursing homes did not consistently receive adequate medication, and Anderson et al. (2005) who found that care aides were isolated from clinical professionals and although the care aides often made sound observations about residents and “possessed raw data” that could be used for the residents’ benefit, the clinical professionals did not listen to them (p. 1019). Again, this problem is a result of the cultures of the workplaces that emphasized role hierarchies/role isolation and separation. These types of cultures are not in keeping with the Eden model.

In summary, the Eden Alternative® model and philosophy was perceived by my participants as having been negated in the study facilities by inadequate numbers of personnel. Because the family sizes had increased from five or six residents to ten or eleven residents, key components of the philosophy became unattainable for the care aides. As a result of the large number of residents in each “family” and the high levels of dependency, the care aides were no longer able to fulfill the relational/spiritual goals of the philosophy and they knew it. They found that they were unable to track residents who were trying to do as much as they could for themselves (for example, trying to groom or dress themselves). They did not sit and talk with the residents and build connections with them during meals because they had too many dependent residents and the residents ate very slowly. The morning routines were completely incompatible with the relational and spiritual values of the philosophy because there were too many dependent residents. Because of the high levels of frailty and dependency of residents who currently live in nursing homes in Canada (Statistics Canada Residential Care Facilities Survey, 2011), many other facilities may also be inadequately staffed to fulfill the relaxed, homey, resident-centred ideals of the Eden Alternative® philosophy/model.

General Trends in Long-Term Care

While my participants described feeling very frustrated, angry, disappointed, and disillusioned with their roles and their workloads, and attributed much of their misery to the way the model of cultural change had been implemented and eroded in their facilities, many of their experiences and perceptions may actually reflect broader, systematic changes in long-term care contexts (irrespective of the impact of cultural change models). Publicly funded long-term care facilities cannot provide more individualized attention for residents because of the growing complexity and diversity of residents combined with financial stringencies. Thirty-eight percent of Canadian nursing homes are now populated with 100% of the residents requiring type three care (Statistics Canada Residential Care Facilities Survey, 2011). Financial stringencies result in numerical limitations in staff, and reduced ability to recruit professionally trained nurses. RNs who work in long-term care are declining in numbers (Canadian Nurses Association Nursing Workforce Data, 2009). The increased workloads and responsibilities for care aides most likely represent the method implemented to alleviate some of the immediate and crucial difficulties.

Quality Work Life Environment

Multiple authors agree that although the Canadian government is attempting to implement standardized resident assessment instruments in order to ensure high quality care for residents in long-term care facilities, and the facilities are attempting to implement new models designed to enhance person-centered care, these changes fail to address what is most important for the largest, woman centered sector of the workforce: the care aides who carry out the majority of the care services for residents. For example, Daly and Szebehely refer to these Canadian workers' "unheard voices" (p. 139), while DeForge, van Wyk, Hall, and Salmoni (2011) refer to the "mortification" of Canadian frontline staff (p. 425).

Daly and Szebehely (2012) note that many Canadian care homes are marked by strict divisions of labour (when compared to care homes in other countries) and that the Canadian care aides are assigned to too many residents. These authors suggest that the work of Canadian care aides has become very "task oriented" with little time for relational work (p. 146). "More equal sharing of responsibilities…could moderate some of the negative consequences of (the) heavy workload" (p. 146). These authors conclude that the high demands of the job combined with the lack of control over the required work is a very unhealthy combination for most of the care aides and results in mental and physical exhaustion.

DeForge et al. (2011) suggest that many Canadian care aides work in an unbearable "atmosphere of surveillance and culture of compliance" because they are unable and afraid to provide the kind of care they intuitively know is necessary (p. 424). According to these authors, the “atmosphere of surveillance” in Canadian nursing homes is a direct result of the RAI (resident assessment instrument) while the “culture of compliance” is most often a result of rules, regulations, and tensions between the care aides and the management team. DeForge et al. suggest that a “blame culture” exists in many Canadian care homes (management consistently attributing incidents with residents to the care aides’ approaches) and this leads to low morale, high levels of stress, and care aides who feel “afraid to care” (p. 421), all contributing to their “mortification” (p. 425). The care aides in my study perceived also that some managers relied on repetitive, standard responses if they complained, and they also perceived that the managers would blame them for the conflicts:

> *It is never their (the resident’s) fault. It is never their fault! It is always, the way you walked into the room. It is, ‘Could have you done something different when you walked into the room?’ The managers do not listen to us at all. At all! It is always, ‘What could you have done differently? Yeah, so it is always pushed on us. Always. Always, always, always! It is always what you did…And it is always your fault. So you never really go to them for problems. Because they blame it on you. (Michelle)*

In conclusion, the results of my study, and of others suggest that Canadian care aides do not currently have enough resources, flexibility or support to alleviate the stress and strains associated with their often-unmanageable workloads.

Conclusion

Most cultural change models aim to increase the quality of life for institutionalized persons by restructuring the delivery of care and transforming the institutional environments into more habitable places to live. Some cultural change models provide opportunities for organizations to save money by expanding the duties of the care aides and reducing the numbers of RNs and LPNs. According to Widdes (1996), this approach is not only more "efficient", it is also more "holistic" because a worker whose responsibilities have expanded "attends to all the daily living needs of their residents" and "the result is care that is more personal, customized and consistent" (p. 24).

Although there are many components of cultural change models that have implications for care aides such as expanded roles for care aides, permanent assignments, and reduced presence of RNs, for the most part, the reactions of care aides to organizational changes consistent with a cultural change model have been presented positively (Mackenzie, 2003; Monkhouse, 2003; Yale, 2003). In this study, however, the participants indicated that although they were attempting to give ideal care (attend to all the needs of the residents), they often felt overwhelmed by their responsibilities and workloads. Some were desperate; many were frustrated; most were stressed. All of these factors hindered empathetic, compassionate relationships with residents assigned to them. This conclusion is best represented by the words of one participant: *"If you have happy caregivers you have happy residents…there is a lot of unhappy people right now."* In this last chapter, I will explore the implications and recommendations arising from my explorations and discoveries.

Chapter Six

Implications

This chapter is the culmination of my dissertation work and contains implications and recommendations for practice, education, and research. Although my research is contextually limited by the number of participants and the type of facilities they worked in, and the results may not be easily transferable beyond their context, there are some recommendations arising from this research that could positively impact practice. Given the major shifts in staffing patterns towards residential care given primarily by care aides and the philosophical shift towards resident-centered care, I offer a number of recommendations for practice, education, and policy.

Recommendations for Practice

In my study, care aides played a major role in guiding new residents and/or their family members through the challenges associated with living in a long-term care facility. It was clear, that for my participants, building caring and compassionate relationships with residents was a priority. A number of specific events throughout the day and care routine are particularly important and could be better utilized to foster good relationships. For example, mealtimes should be specifically targeted as a priority of care. Adequate nutrition is fundamental to the residents’ health, and it was disturbing to find in my study, as in so many other studies of long-term care practices, that mealtimes continue to be disregarded as a priority (Kayser-Jones, 2000; Kayser-Jones & Pengilly, 1999; Kayser-Jones & Schell, 1997; Porter et al., 1999). Care aides need to be provided with help so that they are able to sit with residents during mealtimes, focus on them, feed them in a professional and courteous manner, and even share food with them in some small way (to eat something at the same time that the residents are eating, even if it is just coffee or tea and toast). This fulfills three goals: meeting the residents' nutritional needs, respecting the residents' dignity, and providing opportunities to enjoy each other's company. This recommendation is in alignment with Wadensten (2005) who found that care aides tend to talk most about the resident's health status or state of sickness when they provide basic care to residents and that care aides need opportunities to shift the topic of conversation away from the resident's health status and onto other topics in order to see "the older person as a separate individual" (p. 87). My results suggest that care aides who have time to participate in the residents' meals are better able to reach their ideal occupational goals.

The next recommendation is specific to the practice of not openly advertising or calling for volunteers specifically to help during mealtimes in long-term care facilities. My participants indicated that dependent, dysphagic residents required significant time to consume their meals and were not provided with enough time to eat. This result is consistent with studies of dysphagia, and malnutrition in nursing homes (Kayser-Jones, 2000; Kayser-Jones & Pengilly, 1999; Kayser-Jones & Schell, 1997; Porter et al.,1999) and it appears that the situation has not improved markedly over the past few decades. Inadequate nutritional intake is of such importance that I believe more volunteers would give their time if they knew that the residents were in such dire need. Currently, I believe that the public is generally unaware of the situation because care homes do not openly advertise/call for volunteers specifically for meals. The constraints in funding long-term care are such that this practice should be reviewed. Understandably, agencies may not want to advertise their lack of staffing or indicate problems with standards of care, but warning flags are being raised by families who write letters to the newspapers highlighting deficiencies in current levels of care. A campaign for volunteer mealtime companions for residents could be a community project for nursing students who are currently doing a community practicum.

Care aides are a valuable human resource in long-term care settings. Although health care professionals should treat everyone respectfully, my participants described often feeling devalued, subservient, and demoralized. There are specific events in the year in which it may be particularly important to recognize the staff. Expanding on the previous recommendations, managers should consider carefully, the differences between providing a celebratory Christmas meal to residents and families with care aides acting as servers, and providing a celebratory meal that recognizes residents, families and care aides as equal celebrants. Additional staff for very special events like Christmas parties is important, so that eating together can occur. In my study, one manager was able to obtain extra support. If there is no budget for extra staff, managers could seek support from volunteers who may be more than willing to participate in a special event. In Canadian culture, Christmas and Thanksgiving celebrations tend to honour rituals and values based on family. It is at these times, that care aides need to be acknowledged as an important component of the resident's family rather than as a service provider. This would help the organizational culture to move closer towards the Eden Alternative® ideals. Other ways to support relationships between care aides and residents may include barbeques in the summer, social teas, and other seasonal activities where food is shared and everyone eats together.

The next recommendations are concerned with acknowledging and maintaining the temporal dimension of successful relationships between care aides and residents. Organizational changes have the potential to disrupt the relationships, for example, when staff and residents are transferred from unit to unit. My participants indicated that the importance of their relationships with residents was not acknowledged when decisions were made to divide a wing in a facility, or transfer or reassign a resident. In addition, when a resident was admitted to hospital, some care aides in this study became very distressed and very worried about the resident. Some care aides indicated that they continued to think/worry about the residents at home after working hours. Therefore, managers, RNs, or LPNs should make every attempt to maintain the relationships by finding out about a resident admitted to acute care and providing the care aides with current information as to the resident's progress in acute care. Given that care aides often form long-term relationships with residents, care aides who have formed a close relationship with the resident should be acknowledged and offered paid time off to attend the funeral, which in Canadian society is an important ritual and rite of passage. Some family members have a very difficult time saying goodbye/closing their relationships with the staff members of the facility, so this is as important for the family members as it is for the care aides.

There are also implications arising from my study for inter-professional and inter-nursing communication related to shift reports, care planning and care conferences. Many of the care aides in this study told me that they did not go to care conferences, they did not bother to access the care plans at all, and that they did not have time to communicate with each other at shift changes. This result is similar to the findings of multiple other investigators who overwhelmingly report that care aides do not have sufficient time to attend care planning conferences (Anderson et al., 2005; Eaton, 2000; Parsons et al., 2003;Secrest et al., 2005). In order help all care aides reach their ideals they need to know what the other staff members are experiencing, and whether their own experiences resonate with others. Isolating care aides from routines in which care is assessed, planned, and evaluated does not help the care aides to function to the best of their abilities. Based on the results of my study, care aides should be involved in the shift reports, care conferences, and care planning, and they need to be given sufficient and protected paid time to attend to these activities. If it is recognized that care aides are providing most of the care during the day, they must be recognized as important members of the health care team.

The next recommendation is concerned with social hierarchies that my participants perceived were embedded in the five facilities accessed for this study. Multiple participants described how ready access to care plans, care conferences, and the computer/internet seemed to be awarded to hierarchial levels of nursing staff. The result was an undesirable fragmented culture marked by a lack of unit cohesiveness, leading to isolation and the theme of “working alone” for care aides. My participants’ experiences and descriptions of some RNs and some LPNs who perpetuated role hierarchies/role isolation and separation to such an extent that they ignored a care aide’s request for help, or ignored a resident who had an unmet need, was a distressing discovery. Because this study is limited to an exploration of my participants’ experiences, perceptions, and perceived realities, it is likely that other dimensions of these stories exist but were not revealed to me. However, my participants overwhelmingly reported feeling isolated and unsupported. Managers should focus on team building, dissolving role barriers between care aides and health care professionals, and reducing tasks symbolized by rank as well as other forms of status and rank - for everyone’s benefit. My participants indicated that strict delineation of roles was extremely undesirable for them and their narratives suggested that the residents suffered because of it.

My next recommendation for practice pertains to basic assumptions contained in any model of cultural change that includes the component of permanent assignment. Permanent assignment assumes two ideals: first that the relationships between care aides and the residents are pleasing or agreeable to both parties, and second, that the care is always of high quality. In my study, multiple participants complained about inadequate flexibility in assignment and described the work as a constant struggle, particularly if they were assigned to challenging residents. This is not a new result. Several coping mechanisms for stress, strain or distress related to challenging residents have been described in the literature, including: reducing commitment or engagement in care and providing minimal care only; dissociating from work obligations, using alcohol or medications, reporting sick or late for duty (Goergen, 2001; Jervis, 2002b; Rosowsky & Smyer, 1999). My participants described using all of these coping mechanisms. McGrew (1999) described how care aides "traded" or "passed" residents to other workers when their stress levels become excessive (p. 162), but in my study, the care aides were unable to find relief. They struggled day after day after day, with a defined set of very challenging residents. My study illuminated the inherent conflict between the permanent assignment (family) component of the Eden Alternative® model and the "First Available Bed Policy" as it exists in British Columbia. The conflict was not because of the Eden model, but it occurred because the permanent assignment component of the model was not a good fit with an existing policy. While the purpose of the "First Available Bed Policy" is to reduce wait times, complex problems occurred when residents with a multiplicity of physical and mental health issues were permanently assigned to the care aides. Therefore, organizations currently considering implementing a model of cultural change that includes the component of permanent assignment should make it a practice to review all existing policies to determine if those policies are a good fit with the proposed model of cultural change. In addition, if a model of cultural change is chosen and it contains the permanent component, the organization must review workloads and make provisions for care aides to obtain periodic relief from their permanent assignments if the workloads are high. Otherwise, many care aides will be unable to continue to provide quality care to residents and may ultimately be lost to burnout.

My final recommendation for practice relates is focused on the importance of teamwork in the long-term care setting. Many of my participants described using sick time to cope with fatigue, and emotion stress related to working with challenging residents permanently assigned to them. They described feeling isolated from their colleagues because they worked by themselves with residents. They described being unable to share successes and weaknesses due to a lack of colleagial fellowship. These feelings of isolation from colleagues as a result of permanent assignment have not been reported in any of the literature pertaining to the Eden Alternative®. My participants indicated that teamwork and rotating assignments would help them feel more confident and professional. Self-managed teams, used almost exclusively in the manufacturing industry, have been suggested as a method to increase productivity and reduce sick time in the health care industry (Yeatts et al., 2004). Care aides who work in teams feel more empowered at work, better able to persist during stressful conditions, better able to maintain their composure, and better able to coordinate resident care (Janes et al., 2008). From a safety perspective (safety of residents and staff), considering that multiple participants described lifting very heavy residents by themselves, teamwork would be a definite improvement. Some of my participants indicated that they were already in the process of giving up on the permanent assignment component of the Eden Alternative® in their facilities and reverting to teamwork. Therefore, teamwork has the potential to resolve several significant lapses in caring practices that may occur in permanent assignments if those permanent assignments consist of multiple dependent frail residents, multiple heavy residents, and multiple challenging residents.

Recommendations for Education

The initial and continuing educational support for care aides is becoming increasingly important for managers, legislators, and the nursing profession. Education is critical to support care aides when they adjust to the role, and to foster retention and development throughout their careers. Although nineteen of my participants indicated that they were drawn to the work simply because they "needed a job", once they were in the job they held ideal values about what their roles could contribute to the residents' lives. However, they frequently reported feeling subservient, afraid, unsupported, alone, overwhelmed, frustrated, powerless, de-motivated, and demoralized. Care aides are the most numerous staff in the long-term care settings. Their close proximity to residents and family members means that they are in an advantageous position to report their observations and to offer suggestions to tailor the care they provide. It is particularly important to ensure that care aides have appropriate professional communication skills, specifically an enhanced ability to provide clear objective clinical reports, as well as negotiating skills, and conflict resolution skills. These communication skills need to be offered as part of the initial and continuing education support for care aides. Enhancing their abilities to communicate clearly and professionally with nursing staff, managers, residents, and families may help avoid or mitigate interactional problems. Continuing educational support may seem to be a "luxury" in the current fiscally restrained context, but it would appear to be one strategy aimed at supporting care aides to not only learn how to do tasks, but how to negotiate the complex interpersonal relationships and interactions they encounter with residents and families. Inherent in this recommendation is the need for RNs and LPNs to be familiar with the resident/care aide relationship and to be willing to mentor, role model, and problem solve when problems arise. Supervising RNs and LPNs are professionally accountable for the delegated nursing activities, and these activities include interactional activities, not just care tasks. Essentially, supporting care aides' continuing learning about interactional and communication skills may lead to better interpersonal relations between care aides and those in most frequent contact with them. Group based support, such as found in on-site in-service education, or even off-site education opportunities may also contribute to team-building cohesiveness within unit teams, allowing individuals to share and learn from their peers, and perhaps, slow the loss of care aides due to burnout, overwork, and frustration.

Recommendations for Policy

For the purposes of this document, the term "policy" shall mean a plan, a course of action or a rule or regulation that is intended to influence and determine decisions or actions. My study also raises some questions about the effectiveness of the trend in health care organizations for "Zero Tolerance" or "No Abuse" policies. Nearly every participant indicated to me that he or she had endured multiple unpleasant interactions with residents and/or families of residents. Managerial emphasis on where conflict was rooted was described and perceived by many of my participants as a rigid doctrine or protective fallback mechanism. My participants often perceived and described their managers as seemingly unwilling or unable to act on their behalf to protect them from abuse despite the "No Abuse Policy". Multiple participants indicated that they were afraid and/or felt threatened, and these participants all stated that that their managers failed to support them and protect them. Again, I recognize that my focus was solely on my participants' experiences and perceptions, however, any indications of abuse are worrying. Care aides should never have to participate in any activities that are unsafe/increase the risk for injury, have no apparent health benefits for residents, appear to be of a sexual nature, and/or make care aides feel very uncomfortable. Perhaps the priority intervention is for RNs and LPNs and managers to work together to problem solve known residents' situations that may pose a risk to care aides. Fundamentally, however, managers must consistently reinforce policies and procedures that have been established for the safety of the residents and the staff. Procedures are needed to regularly and systematically evaluate the efficacy of these policies.

My final recommendation concerns the potential for gradual erosion of critical cultural and organizational changes that are implemented to increase the quality of life for residents. The Eden Alternative® model and philosophy was perceived by my participants as having been negated in the study facilities by inadequate numbers of personnel and the selective application of some but not all principles. According to the Eden Alternative®, "substantially more staffing hours will be dedicated to direct patient care than the conventional institutional facility can offer (Thomas, 2003, p. 155) and "we will track all standard parameters of quality of care" (p. 155). "We" is never defined. "How" is never defined. I question why the resident care loads for the care aides in my study increased so substantially, and why the care aides described an erosion of Eden principles if the facilities in the study were registered with the Eden Alternative® company trademark. It may be argued that the short staffing was a temporary feature imposed by external forces and that ideally, the situation will be quickly reversed, but my participants believed that short-staffing was the new norm which clearly contravenes the Eden Alternative® model. Facilities that purport to subscribe to the Eden Alternative® model/philosophy should be in compliance with *all* standard Eden parameters of care including resident/care aides ratios. I suggest that there could be some tracking issues pertaining to organizations that have registered, particularly in countries other than the United States, and these require regular and neutral follow-up.

Areas for Further Research

Although my study offers a rich in-depth understanding of a small number of care aides' experiences and perceptions of long-term care, the results are contextually limited and thus have limited transferability to other settings. Overall, much more qualitative and quantitative research needs to be conducted to assess if the results from this study are an anomaly or if they are indeed consistent with experiences of care aides from within the province and from other provinces and countries. Of particular interest is to determine the extent to which my results are specific to Eden Alternative® based facilities, or whether they are common to many long-term care agencies. I believe that there is an urgent need to study more Eden facilities. All of the facilities accessed in this study seemed to be reflecting the early neighbourhood stage of the model. Considering that the more developed neighbourhood model and the greenhouse model are considered to be the ultimate Eden organizational models of care, it would be prudent to access universal or versatile workers from these types of facilities to determine the influence of the more developed model on employees. For example, my participants perceived the versatile worker/universal worker role as a subservient role. These results have not been confirmed and it is possible that versatile workers who work in a more developed Eden model such as a Greenhouse may feel very differently about their roles. It would be interesting to determine how such profound organizational changes can be achieved with less distress for care aides, and how current staff can be helped to successfully make the transition between old and new models of care. What is important, however, is that the philosophical and theoretical ideals of the model are operationalized in the daily lives and roles of residents and staff.

Similarly, the benefits as well as the potential shortcomings of the ‘visiting’ professional role, as well as the perceptions of registered nurses who have taken on the role of ‘visiting health professionals’ have not been investigated. The Eden Alternative® is known to provide opportunities for organizations to save money by expanding the duties of the care aides and reducing the numbers of RNs and LPNs (Monkhouse, 2003; Widdes, 1996). However, RNs and LPNs have a unique knowledge base that is shaped by their educational programs and they are educated to provide assistance, model professional behaviours, exercise professional judgments, and use basic conflict resolution strategies in situations of conflict (for example, threats). 'Visiting' health professionals may or may not be able to provide consistent protection, and assistance. My participants clearly sought more continuous support and consultation with their supervising nurses.

Third, the Eden Alternative® model/philosophy needs to be compared with other cultural change models. Several tools are already available that could be used to measure and compare care aides' abilities under different cultural change models. For example, a tool called the Individualized Care Instrument (ICI) (Chappell, Reid, & Gish, 2007) is available. This tool has been used in one study to compare the abilities of care aides to provide individualized care in several facilities that implemented cultural change models to the abilities of care aides to provide individualized care in facility that has not implemented a cultural change model (Caspar et al., 2009). The ICI is a 34 item Likert scale used to measure the staff's reported ability to provide individualized care. It could be used to compare care aides' abilities to provide individualized care in facilities that have implemented permanent assignment versus facilities that use teamwork. Another tool is the Relational Care Scale (RCS) (McGilton, Pringle, O'Brien-Pallas, Wynn, & Streiner, 2005). This tool is a six-item tool designed to "evaluate the relational care that nursing staff provide to residents living in nursing homes"

(p. 53). This tool is completed by the residents rather than the care aides. This tool could be used to compare the relational abilities of care aides who have permanent assignments to care aides who work in teams, or, it could be used to compare the relational abilities of care aides who work in homes that have implemented a cultural change model to the relational abilities of care aides in homes that have not implemented a cultural change model. Edvardsson and Innes (2010) who evaluated twelve such tools designed to measure person-centered care (including the ICI but not the RCS) concluded that existing tools have not been used very much, therefore while they are promising, they are limited because they require use and evaluation to determine their applicability, reliability and validity.

Fourth, my participants were very critical of organizational expectations of efficiencies. They perceived that their managers failed to consider all the various aspects of care and as a consequence, incorrectly calculated that there was ample time to complete all required care. They described feeling frustrated with mechanical prescriptions for time management that ignored their relationships with residents and ignored important caring components. Again, this was their perceived reality. However, it is clear that more investigations are needed to determine how much time is required to complete care for residents. In a similar vein, more research must be done specifically about the quality of mealtimes for all residents who live in nursing homes. Very distressing findings have previously been reported specific to palliative, dysphagic and dependent residents (Kayser-Jones, 2000; Kayser-Jones & Pengilly, 1999; Kayser-Jones & Schell, 1997; Porter et al., 1999), but further studies would help to reinforce the full extent of the difficulties, which should be disseminated to a wider group in order to facilitate changes that would enhance the quality of life for residents.

My participants also described their beliefs that their managers did not care about their roles because the managers were focused only on task efficiencies, resident/family experiences, and resident/family levels of satisfaction. These participants perceived that the management was not interested *at all* in their experiences at work, their levels of satisfaction, or their relationships with residents. These perceptions and experiences are not necessarily correct or incorrect; they simply reflect my participants' perspectives. A reverse qualitative study of managerial expectations and perceptions of care aides would help to balance these views/perspectives and could lead to greater insights on what is attainable and what is not attainable in long-term care.

Similarly, the care aides in this study perceived themselves as nurses, and believed that the residents, and perhaps even some family members, saw them as nurses. This fundamental belief has not been clearly revealed or explored in any other empirical research about care aides but it affected all of my participants' perceptions. Therefore, more qualitative research must be done to extend understanding of this phenomenon and to explore its implications for the profession and discipline of nursing. As scope of practice changes occur for both RNs and LPNs, it is timely that we look again at the implications of delegated nursing activities and of the perception of "nurses" as a professional and occupational entity.

There is evidence to suggest that some families' visions of appropriate care for residents contrasted with the philosophies contained in the cultural change model and contrasted with care aides' views of what constituted appropriate care. These families seemed to be in a state of continuous conflict with care aides because the care was not provided in a way they felt best. Considering that: a) the versatile/universal workers (care aides) in the Eden Alternative® model are the main contacts for families, b) in this study, there was plenty of evidence to suggest that the care aides were not coping well as the main contacts for complaints, and c) the families had expectations that the care aides were unable to meet, there are few studies devoted to family members' expectations and perspectives of organizational cultural changes. I would recommend a qualitative study designed to explore family members' expectations and perspectives of organizational cultural changes.

A few of the care aides in this study described very stressful encounters with residents who consumed alcohol and marijuana to such an extent that they became intoxicated and aggressive towards the care aides. I could find very little research about the use of alcohol and marijuana in nursing homes and very little research pertaining to the efficacy and enforcement of 'no abuse policies' even though these policies are widely advertised in all healthcare institutions. These two areas urgently require further investigation.

Another primary concern for the care aides was the ratio of care aides to residents. All of the care aides interviewed were assigned to ten or eleven residents and they considered that this ratio was too low to provide the basic necessities. According to the ultimate Eden model, each resident should receive six hours of care per day (Thomas, 2003, p. 147). This workload represents an erosion of Eden principles and is most likely due to fiscal constraints. It is difficult to balance the claims of cost efficiencies (Thomas & Johansson, 2003) with the claims of increased numbers of hours of care (Thomas, 2003). Therefore, it would be interesting to follow a facility undergoing changes consistent with the Eden Alternative® to determine if the model can be implemented according to the principles without additional staffing and funding. This would require a study blending quantitative and qualitative approaches.

Some aspects of cultural change models that allow for expanded roles for care aides have not been challenged empirically. For example, after they have attended a five-hour medication administration course, some care aides now administer topical and oral medications to residents in long-term care. No studies have been performed to determine if this course is comprehensive enough to allow care aides to administer medications in a safe manner. Similarly, I could find no studies designed to track safety, sanitation, and efficiencies of the other expanded duties (housekeeping, laundry, and cooking). Medication errors are potentially fatal, but food handling and sanitation errors also have the potential to cause life threatening health complications for residents. Therefore, these types of studies should be a research priority to protect the safety of residents.

I believe that there is a need for a rigorous qualitative study devoted to managers' expectations and perspectives of cultural change models. There are a number of articles written by managers who believe that positive changes have occurred but many of the articles lack critical reflection and do not draw on any empirical evidence. The voices of managers who do not write articles about the implementation of cultural change models in long-term care facilities have not been heard.

Finally, there are no research studies describing the effects of selective application of components of cultural change models. For example, this study provides evidence to suggest that selective application of the permanent assignment component may not be in the best interests of the residents or the care aides, especially if workloads are high and the population of residents is diverse. Many care aides in this study experienced high levels of stress due to an inability to obtain relief from their permanent assignments. They described how the permanent assignments also resulted in care aides losing meaningful contacts with residents not assigned to them, and residents who were isolated from other workers because they were perceived as being contained or restricted by the permanent assignment. The Eden Alternative® model is not the only model that utilizes permanent assignments for care aides. The GentleCare model also incorporates permanent assignments. Further qualitative and quantitative studies evaluating the risks and benefits of permanent assignments in long-term care facilities are needed to assist managers/administrators to make the decisions that will shape and affect services provided to residents.

Limitations

In this study, as with all research, limitations must be acknowledged. The following are the primary limitations in this study. First, the results of this study are limited because the care aides recruited for the study had varying levels of experience with cultural change. Some were working before the Eden Alternative® was first implemented in the five facilities, so they had experienced the initial benefits of the model, and in subsequent years, they experienced the decline of important principles. Other participants did not begin working until after various principles of the model of cultural change had eroded significantly. Therefore, this study should not be perceived as an evaluation of the Eden Alternative® model/philosophy. Much of the anger and frustration experienced by my participants were because many of the fundamental principles were not properly maintained in any of the five facilities. While I may have achieved my goal of articulating the voices of my participants, their voices, perceptions, and experiences of a cultural change model may not be transferable to other facilities and contexts. Second, recruitment was limited to care aides who consented to participate. The perceptions and experiences of care aides who declined to participate may differ from those who willingly participated. In addition, the perceptions and experiences of RNs, LPNs, managers, residents, and family members were not examined. Fourth, this study is a small study, limited to five facilities that structured and organized the care of residents in similar manner. No participants were recruited from facilities that had introduced components of a different cultural change model. Fifth, data collection was limited to interviews only. Although observational data is not considered to be a requirement for a focused ethnography, observation of the organizational cultures would have added strength to the study. Observation was not feasible because it was very important to me that the participants felt safe, comfortable, and free from feelings of pressure and scrutiny during data collection. Although I initially considered observation, I felt that this method of data collection (for this particular vulnerable population) could lead to distress and suspicions about the researcher's goals, which could have impeded later interviews.

With regard to the participants' experiences and perceptions, this study was about what the participants believed. The data is "the softest of soft data" (Morse, 2009. p. 579) as it consists only of participants' recollections of experiences and perceptions. Participants' beliefs are interesting, genuine and valid, but they are perceptions (Morse, 2009). With regard to the analysis, the study is interpretive - the analysis is mine, and my interpretation is one of many possible interpretations. Necessarily, the study was limited by the time and context of doctoral work, and my emerging ability as a qualitative researcher. Nevertheless, I believe that this study provides unique and valuable insight into the realities of care aides' working lives and experiences, particularly within the context of some components of a philosophical model of care that is rapidly expanding in popularity in the United States, Canada, Japan, Australia, and Europe. My goal at the start of my dissertation work was to explore the experiences of care aides primarily in terms of relationships with challenging residents. During the course of my research, it became very clear that I could not understand the nature of these relationships until I understood the context of the working environment. My choice to expand my research goal to include an understanding of how some of the components of the Eden Alternative®

model/philosophy (as well as the subsequent erosion of the model) influenced the care aides' experiences, was based on the reality that the topic was critically important to them. The permanent assignment and versatile worker components of the model have been so broadly accepted as a benefit, that the effects of the roles and permanent assignments within the model have not been challenged or even considered as something worthy of examination. This examination is particularly important given the context of expanded ratios of residents to care aides, high frailty/dependency levels of residents, reduced presence of registered nurses, and policies that can result in an extremely diverse population of residents who reside in the same facility. My participants felt that this dimension of their experiences needed to be told. The evidence for this is in their long detailed narratives. All I had to do to elicit their accounts was to acknowledge to them that what they are doing matters; what they are experiencing matters; and what they are feeling and perceiving matters.

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Appendix A

Comparison of Studies Used to Estimate Sample Size

Authors	Year	Purpose	Method	Sample Size
Berdes & Eckert	2001	An American study exploring the experiences of racial differences between nursing home residents and nurses' aides in three nursing homes (30 residents, 30 aides)	60 semi-structured interviews lasting from 30 minutes to 1 ½ hours	60
Bowers, & Becker	1992	An American study exploring the perspectives of nurse aides about their work – how they organize their workloads, what they think about the work, and their thoughts about quality of care (3 nursing homes)	Constant Comparison: Participant observation (40 shifts) and 30 in-depth interviews	30
Bowers, Esmond, & Jacobson	2000	An American study of six nursing homes and the responses of nurse aides to chronic short staffing	Constant Comparison: 38 in-depth interviews and participant observation	38
Cole	1989	A British study based in one mental health hospital and two elderly care hospitals, aimed towards exposing nursing auxiliaries' beliefs about themselves and their work	12 interviews	12
Foner	1994	An American study of one 200 bed non-profit nursing home, aimed towards description of the work of nurse aides and analysis of the effects of racial and	Ethnography: participant observation, 14 formal two hour interviews, 20 informal interviews that	34

		ethnic differences between nurse aides and residents	occurred during meal breaks or brief breaks on the job	
Graneheim, Isaksson, Ljung, & Jansson	2005	A Swedish study of the experiences of nursing home staff about their interactions with residents who suffered from dementia and exhibited behavioural disturbances	Phenomenology: 6 narrative interviews lasting 34 to 68 minutes	6
Jackson	1997	An American study of five nursing homes aimed towards description and analysis of the knowledge aides used to guide their care-giving decisions and factors that affected their abilities to give adequate care	Triangulation: participant observation, 8 semi-structured interviews (30 minutes to 2 hours), card sort, questionnaire given to 70 subjects	8
Chipchase & Prentice	2006	An Australian study of the indicators that expert physiotherapists use to determine their patients' capacities for mobilization	Focused Ethnography: 12 one hour, single session, semi structured interviews	12
Kelly & Patterson	2006	An American study designed to gather data to help understand how caretaker's knowledge and attitudes influence diets selected for their children (grades 1-3)	Focused Ethnography: four focus groups, each lasting for 1.5 to 2 hours plus field notes about the classrooms, school cafeteria and community	17
Sedgwick & Yonge	2008	A Canadian study of the professional socialization of undergraduate fourth year nursing students during a rural preceptored clinical experience	Focused Ethnography: 18 semi structured interviews, one focus group (managers and other staff), field notes, one student	18

			journal	
Bathum & Baumann	2007	An American study of the perspectives of Latina women immigrants about the concept of a sense of community	Focused Ethnography: 10 open ended interviews each 40 to 90 minutes plus participant observation of community activities	10
Scott & Pollock	2008	A Canadian study exploring how the organizational culture of a nursing unit shaped nurses' utilization of research	Focused Ethnography: 29 interviews (1-4 hours each) and 120 hours of participant observation, field notes	29
DuongTran & Garcia	2009	An American study of the health knowledge, beliefs and attitudes of Mexican young adults living in Mexico City	Focused Ethnography: one focus group lasting 1 hour and 20 minutes	15
Neal, Brown, & Rojjanasrirat	1999	An American study describing perceptions of the implementation of a nurse case coordinator role on a psych unit	Focused Ethnography: 24 hours of observation, 13 interviews lasting 30 minutes, field notes	13
Green, Meaux, Huett, & Ainley	2009	An American exploratory study describing parents' experiences parenting a school-aged child after heart transplant	Focused Ethnography: 11 interviews, 1 ½ to 2 hours long, field notes focused on contextual observations	11
Ensign & Bell	2004	An American study documenting the illness experiences of homeless youth from 3 sites in one city	Focused Ethnography: observation, field notes, 30 interviews, two focus groups	30

Oakes	2005	An American study designed to understand how the employees of assisted living facilities interpret the concept of autonomy (unpublished dissertation)	Focused Ethnography: 38 interviews (30-60 minutes) including responses to 3 vignettes, and observation of assisted living communities	38
Avery	2000	An American study designed to describe caregivers' experiences of seeking community based care for elderly family members in declining health (unpublished dissertation)	Focused Ethnography: 18 in-depth interviews and two focused group discussions with 4 people, field notes	22
Pasco	2003	A Canadian study designed to uncover the experiences of Filipino-Canadian patients' as they interact with Canadian nurses (unpublished dissertation)	Focused Ethnography: 23 interviews, participant observation (attending traditional festivals), field notes and a personal diary	23
Gul	2007	A Canadian study: the experiences and perceptions of competence of BScN students studying in Pakistan and their supervisors' views of their competence following a four-year university program. unpublished dissertation	Focused Ethnography: semi-structured interviews with 24 participants, participant observation in nursing services and review of institutional documents	24

Appendix B

Letter of Support

December 22, 2009

Elizabeth Andersen, RN, BTSN, MN
Address
City deleted to protect identity of participants,
British Columbia
V1W 4Y1

Dear Elizabeth,

Thank you for meeting with me to discuss your research proposal. As I said when we met, I would be happy to have you recruit participants for your study from our complex care homes, specifically XXXX, XXXX, XXXX and XXXX Home, once all of the approvals from your ethics board and the XXXX Health Research Ethics Board have been obtained. I also look forward to the results of your study.

Please let me know if there is any other information you may need from me.

Sincerely,

Identity deleted
Director of Residential and Palliative Services
Area deleted
XXXX Health Authority

Contact information deleted to protect identity of participants

Appendix C

Recruitment Poster

Help Wanted!

Resident Care Attendants:

What is the Purpose of the study?

The study is designed to hear **your voice** about your relationships with residents

One hour confidential interview at a time and place suitable for you

No Cost to You

UNIVERSITY OF ALBERTA

Call Elizabeth
250 – 300 - 8286

Who am I?
I am a University of Alberta doctoral candidate and registered nurse. This is my research project to complete my PhD. I am interested in exploring ways to support you (resident care attendants). This study has received agency approval and approval from the University of Alberta and XXXX Research Ethics Boards.

Appendix D

Demographic Questionnaire

Participant Pseudonym: ___________________________

What type of facility do you work in?
☐ Assisted Living
☐ Nursing Home/Long-term Care
☐ Rehabilitation
☐ Other _______________________

How many beds are in your facility?
☐ less than 50 beds
☐ 50 to 100 beds
☐ more than 100 beds

How long have you worked at this particular facility? __________________________

How long have you had your present position? _______________________________

In total, how many years of URHC experience have you had? ______________________

Are you casual or permanent? ____________________

If you are permanent, what is your shift schedule like?
☐ days/nights
☐ days/evenings
☐ other __________________

Do you work full time or part time? ___________________

Please estimate how many hours you work per week.__________________

What is your age?
☐ less than 20 years
☐ 20 to 30 years
☐ 31 to 50 years
☐ 51 to 70 years

What is your nationality? __________________________________

What is your general education? _____________________________

How much/what training have you had to prepare you for this role? ____

How did you become involved in health care work?_______________________________

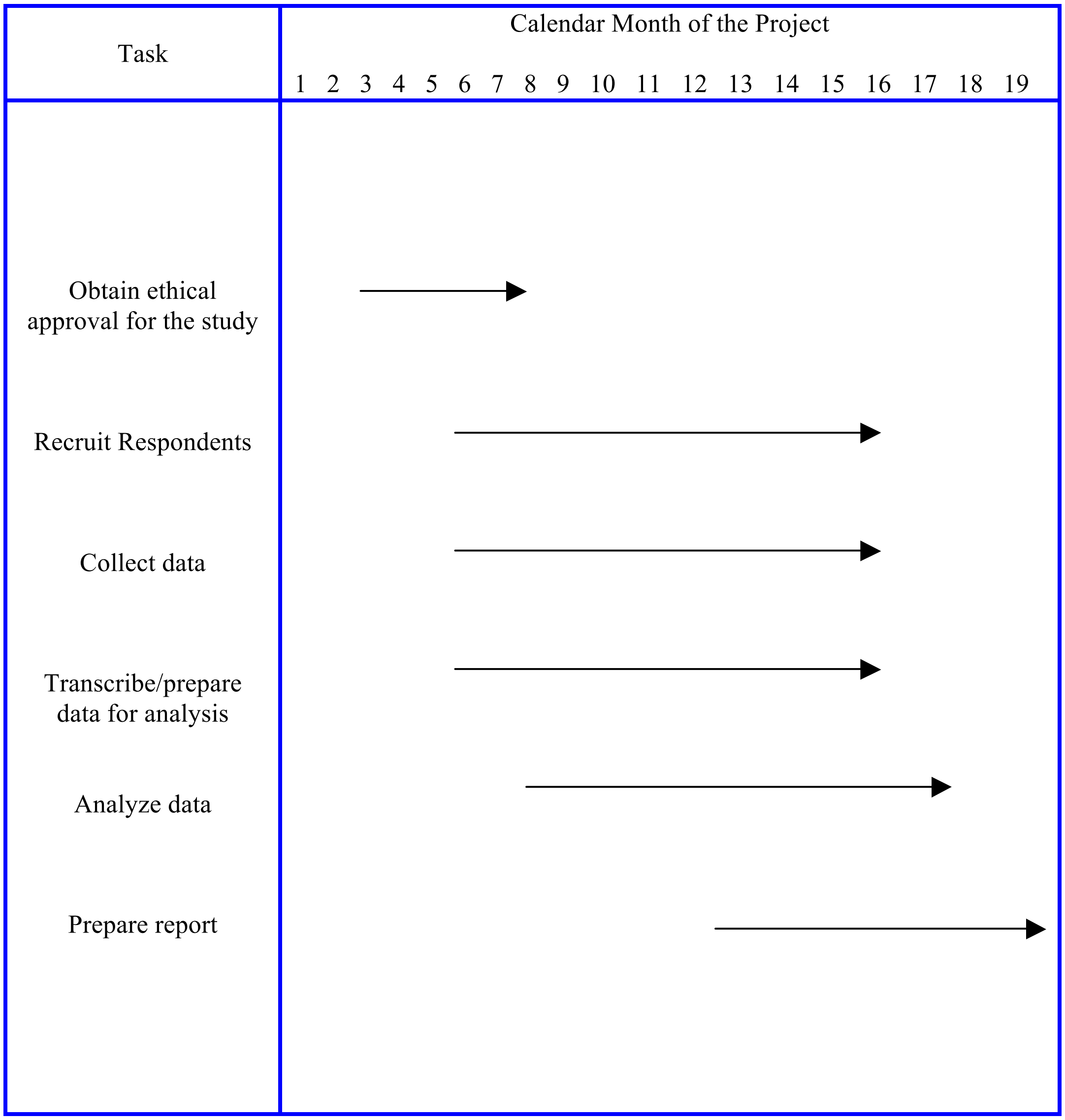
____

____

____

Appendix E

Time Line



Appendix F

Master List Linking Participants with Pseudonyms

	Name	Participant Pseudonym
1		Andy
2		Paula
3		Joanne
4		Allison
5A		Carol
5B		Brenda
6A		Jennifer
6B		Diane
7		Kathy
8		Linda
9		Jane
10		Judy
11		Mary
12		Susan
13		Cheryl
14		Doris
15		Betty
16		Janice
17		Michelle
18		Shirley
19		Barbara
20		Doug
21		Dawn
22		Wendy

Appendix G

Information Sheet and Consent Form

FACULTY OF NURSING
Dr. Judith Spiers
Associate Professor
Telephone: (780) 492-9821
Fax: (780) 492-2551
Email: jude.spiers@ualberta.ca

Flesh-Kincaid Grade Level is 7.67

Title:	Exploring the Nature of Relationships between Unregulated Healthcare Workers and Residents in Long-term Care Settings
Sponsor:	The University of Alberta, Faculty of Nursing
Investigators:	Judith Spiers RN, BA, MN, PhD (Principle Investigator and Supervisor) Elizabeth Andersen, RN, BTSN, MN Doctoral Candidate

This consent form is only part of the process of informed consent. It should give you the basic idea of what the research is about and what you will have to do. If you would like more detail about the information below, or information not included here, please ask. Take the time to read this carefully. You will receive a copy of this form.

Background

You work in a long-term care setting. Your role is to provide care to the residents. The work can be physically and emotionally tiring. There is very little research about your experiences at work, even though you have a major role in the care of fragile and vulnerable people. Elizabeth would like to talk to you to gain an understanding of your work and experiences.

What is the Purpose of the study?

- We want to hear your voice about your relationships with residents.
- We are interested in the positive ways you develop relationships with a variety of residents.

- We are also interested in your experiences of strained or difficult relationships with residents, and the strategies that you use to address them.

Exploring the Nature of Relationships between Unregulated Healthcare Workers and Residents in Long-term Care Settings

What Would I Have to Do?

Being in the study is entirely your choice. If you agree to be in the study, Elizabeth will interview you at a time and place of your choice. You can talk on the phone or in person. The interview will take about one hour to 1 ½ hours to complete. If it is OK with you, the interview will be recorded. You may ask to stop the recording at any time. Elizabeth will ask you about your experiences and ideas about caring for residents. You do not have to answer a question if you do not want to.

The interview will be typed for later analysis. This is called a transcript. You can choose to participate in a second interview by phone, in person, or by email if you or Elizabeth would like to follow up.

Will My Interview be Kept Private?

When you are interviewed, Elizabeth will use a false name for you and a false name for your work place. These are called pseudonyms. Your transcript will be combined with transcripts from about twenty other people from about three other agencies. If Elizabeth thinks that a certain word or phrase might pose a risk to your identity, she will replace the word or phrase with a sign ####.

Only Elizabeth and her supervisor Jude Spiers will have access to the recording and transcripts. All notes, transcripts and recordings will be kept in a secure locked cabinet. Elizabeth will not discuss your interview with anyone other than her committee.

Elizabeth will keep the consent form and the master list linking your false name to you in a second separate locked cabinet at a different location. Data and consent forms will be kept for a minimum of 7 years as required by the health research ethics board. She will destroy them after that. Before then, if Elizabeth wants to do another study using the same data she will ask the ethics board to approve the study.

The results will be published as a dissertation. This will partially fulfill the requirements of a Doctoral Degree in Nursing from the University of Alberta. A summary of the results may be reported in an article published in a professional journal. A summary of the results may be used for teaching and learning activities. Any report will be anonymous. You will not be identified and your personal information will not be disclosed.

Exploring the Nature of Relationships between Unregulated Healthcare Workers and Residents in Long-term Care Settings

What are the Risks?

We do not know of risks associated with being in this study. It is possible that some of the questions may make you feel uncomfortable. If you feel uncomfortable or upset at any time, you can take a break or stop completely. There is a small chance that someone will find out that you were part of the study. They will not know what you actually said. All quotes will be identified with the false names only. We will not tell anyone, including your managers at your workplace that you have participated in the study.

If you share knowledge of elder abuse which is any action that causes an older person physical, emotional or mental harm or damage to, or loss of, assets or property, it must be reported to: The BC Centre for Elder Advocacy and Support.

Will I Benefit if I Take Part?

There are no direct benefits for you. People in similar studies have reported that they have enjoyed talking about their experiences. The goal of this study is to gain knowledge and insight into your work. Solving existing problems at work is not a goal.

Do I Have to Participate?

Participation in this study is your choice. You may stop the interview at any time. Simply let Elizabeth know that you want to stop. You can withdraw from the study at any time. Your participation will not impact your employment.

If you decide to withdraw prior to transcription, your interview tape and any associated notes will be destroyed. Elizabeth cannot "wipe" the information out of her memory, but she will not use anything you said in the final product.

If you decide to withdraw from the study after your interview has been transcribed and analyzed, your information will be part of the final product. However, Elizabeth will not use any of your quotes as examples.

Will I be Paid for Participating, or do I Have to Pay for Anything?

There are no costs to you. You will receive a $30.00 gift certificate. This is to acknowledge your time and effort. Your expertise and wisdom are critical to the research. You will be reimbursed for travel and child care costs.

Exploring the Nature of Relationships between Unregulated Healthcare Workers and Residents in Long-term Care Settings

Signatures

Your signature on this form indicates that you have understood to your satisfaction the information regarding your participation in the research project and agree to participate. In no way does this waive your legal rights nor release the investigators, or involved institutions from their legal and professional responsibilities. You are free to withdraw from the study at any time. If you have any concerns about your rights as a study participant, you may contact

Christine Newburn-Cook, RN, PhD
Associate Dean of Research
Nursing Research Office
Faculty of Nursing, University of Alberta
4-103 Clinical Science Building
University of Alberta
Edmonton, Alberta T6G 2G3
Email: christine.newburn-cook@ualberta.ca
Telephone: (780) 492-6832
Fax: 1-780-492-2551

If you have further questions related to this research, please contact:

Judith Spiers, RN, BA, MN, PhD
Associate Professor, Faculty of Nursing, University of Alberta.
(Principle Investigator and Supervisor)
Email: jude.spiers@ualberta.ca
Telephone: (780) 492-9821
Fax: (780) 492-2551

Elizabeth Andersen, RN, BTSN, MN Doctoral Candidate
Email: eaa@ualberta.ca
Telephone: 250-300-8286

Exploring the Nature of Relationships between Unregulated Healthcare Workers and Residents in Long-term Care Settings

Consent Form

FACULTY OF NURSING
Dr. Judith Spiers
Associate Professor
Telephone: (780) 492-9821
Fax: (780) 492-2551
Email: jude.spiers@ualberta.ca

Do you understand you have been asked to take part
in a research study? ☐ Yes ☐ No

Have you read and received a copy of the attached
Information Sheet? ☐ Yes ☐ No

Do you understand the benefits and risks involved in
taking part in this research study? ☐ Yes ☐ No

Have you had an opportunity to ask
questions and discuss this study? ☐ Yes ☐ No

Do you understand that you are free to withdraw
from this study at anytime, and that you do not have to give a reason?
☐ Yes ☐ No

Do you understand that if you do not wish to answer a question,
you do not have to answer it and you do not have to give a reason?
☐ Yes ☐ No

Has the way your identity will be protected been explained to you?
☐ Yes ☐ No

Do you understand who will have access to your study data?
☐ Yes ☐ No

This study was explained to me by ______________________________

I agree to take part in this study
☐ Yes ☐ No

Signature of Participant ____________________________________

Printed Name ____

Date ______________________________

Signature of Witness ______________________________________

Exploring the Nature of Relationships between Unregulated Healthcare Workers and Residents in Long-term Care Settings

I believe that the person signing this form understands what is involved in the study and voluntarily agrees to participate.

If two people wish to be interviewed together, they will hear each other's experiences.	Signature and Date
These two people agree to keep any information heard in the interview confidential.	Signature and Date

Signature of Investigator or Designee _______________________________

Date ______________________________

Addendum for multiple Participants:

Judith Spiers, RN, BA, MN, PhD
Associate Professor, Faculty of Nursing, University of Alberta.
(Principle Investigator and Supervisor)
Email: jude.spiers@ualberta.ca
Phone: (780) 492-9821
Fax: (780) 492-2551

Elizabeth Andersen, RN, BTSN, MN Doctoral Candidate
Email: eaa@ualberta.ca
Phone: 250 300 8286

The University of Alberta Health Research Ethics Board (HREB) at the University of Alberta, Edmonton, Alberta, which administers the ethics review process for all faculty, staff, and students at the University of Alberta, and the

XXXX Health Research Ethics Board of British Columbia have approved this research study.

A signed copy of this consent form has been given to you to keep for your records and reference.

Appendix H

Telephone Information Sheet and Consent Form

FACULTY OF NURSING
Dr. Judith Spiers
Associate Professor
Telephone: (780) 492-9821
Fax: (780) 492-2551
Email: jude.spiers@ualberta.ca

Flesh-Kincaid Grade Level is 7.68

I would like to tell you about the study and obtain your consent to participate before I ask you some questions. Is that OK with you?

The study is called "Exploring the Nature of Relationships between Unregulated Healthcare Workers and Residents in Long-term Care Settings". It is sponsored by The University of Alberta, Faculty of Nursing. The investigators are Dr. Jude Spiers and me, Elizabeth Andersen.

Background

You work in a long-term care setting. Your role is to provide care to the residents. The work can be physically and emotionally tiring. There is very little research about your experiences at work, even though you have a major role in the care of fragile and vulnerable people. I would like to talk to you to gain an understanding of your work and experiences.

What is the Purpose of the study?

- We want to hear your voice about your relationships with residents.
- We are interested in the positive ways you develop relationships with a variety of residents.
- We are also interested in your experiences of strained or difficult relationships with residents, and the strategies that you use to address them.

What Do You Have to Do?

Being in the study is entirely your choice. This interview will take about one hour to 1 ½ hours to complete. If it is OK with you, I will record it. You can stop at any time. I will ask you about your experiences and ideas about caring for residents. You do not have to answer a question if you do not want to. The interview will be typed for later analysis. This is called a transcript. You can choose to participate in a second interview by phone, in person, or by email if you or I would like to follow up.

Will Your Interview be Kept Private?

I will use a false name for you and a false name for your work place. These are called pseudonyms. Your false name will be: ______________. Your transcript will be combined with transcripts from about twenty other people from about three other agencies. If I think that a certain word or phrase might pose a risk to your identity, I will replace the word or phrase with a sign.

Only my supervisor Jude Spiers and I will have access to the recording and transcripts. All notes, transcripts and recordings will be kept in a secure locked cabinet. I will not discuss your interview with anyone other than my committee.

I will keep the consent form and the master list linking your false name to you in a second separate locked cabinet at a different location. Data and consent forms will be kept for a minimum of 7 years as required by the health research ethics board. I will destroy them after that. Before then, if I want to do another study using the same data I will ask the ethics board to approve the study.

The results will be published as a dissertation. This will partially fulfill the requirements of a Doctoral Degree in Nursing from the University of Alberta. A summary of the results may be reported in an article published in a professional journal. A summary of the results may be used for teaching and learning activities. Any report will be anonymous. You will not be identified and your personal information will not be disclosed.

What are the Risks?

We do not know of risks associated with being in this study. It is possible that some of the questions may make you feel uncomfortable. If you feel uncomfortable or upset at any time, you can take a break or stop completely. There is a small chance that someone will find out that you were part of the study. They will not know what you actually said. All quotes will be identified with the false names only. We will not tell anyone, including your managers at your workplace that you have participated in the study.

If you share knowledge of elder abuse which is any action that causes an older person physical, emotional or mental harm or damage to, or loss of, assets or property, it must be reported to: The BC Centre for Elder Advocacy and Support.

Will You Benefit if You Take Part?

There are no direct benefits for you. People in similar studies have reported that they have enjoyed talking about their experiences. The goal of this study is to gain knowledge and insight into your work. Solving existing problems at work is not a goal.

Do You Have to Participate?

Participation in this study is your choice. You may stop the interview at any time. Simply let me know that you want to stop. You can withdraw from the study at any time. Your participation will not impact your employment.

If you decide to withdraw prior to transcription, your interview tape and any associated notes will be destroyed. Elizabeth cannot "wipe" the information out of her memory, but she will not use anything you said in the final product.

If you decide to withdraw from the study after your interview has been transcribed and analyzed, your information will be part of the final product. However, Elizabeth will not use any of your quotes as examples.

Will You be Paid for Participating, or do You Have to Pay for Anything?

There are no costs to you. You will receive a $30.00 gift certificate. This is to acknowledge your time and effort. Your expertise and wisdom are critical to the research. Where would you like me to send the gift certificate?

Your participation in this interview indicates that you have understood to your satisfaction the information regarding your participation in the research project and agree to participate. In no way does this waive your legal rights nor release the investigators, or involved institutions from their legal and professional responsibilities. You are free to withdraw from the study at any time. If you have any concerns about your rights as a study participant, you may contact:

Christine Newburn-Cook, RN, PhD
Associate Dean of Research
Nursing Research Office
Faculty of Nursing, University of Alberta

4-103 Clinical Science Building
University of Alberta
Edmonton, Alberta T6G 2G3
Email: christine.newburn-cook@ualberta.ca
Telephone: (780) 492-6832
Fax: 1-780-492-2551

If you have further questions related to this research, please contact:

Judith Spiers, RN, BA, MN, PhD
Associate Professor, Faculty of Nursing, University of Alberta.
(Principle Investigator and Supervisor)
Email: jude.spiers@ualberta.ca
Telephone: (780) 492-9821
Fax: (780) 492-2551

Elizabeth Andersen, RN, BTSN, MN Doctoral Candidate
Email: eaa@ualberta.ca
Telephone: 250-300-8286

The University of Alberta Health Research Ethics Board (HREB) at the University of Alberta, Edmonton, Alberta, which administers the ethics review process for all faculty, staff, and students at the University of Alberta, and the Interior Health Research Ethics Board of British Columbia have approved this research study.

Is it OK to begin recording? (If yes, proceed; if no, begin taking notes).
☐ Yes ☐ No

Do you understand you have been asked to take part in a research study?
☐ Yes ☐ No

Do you understand the benefits and risks involved in taking part in this research study?
☐ Yes ☐ No

Have you had an opportunity to ask questions and discuss this study?
☐ Yes ☐ No

Do you understand that you are free to withdraw from this study at any time, and that you do not have to give a reason?
☐ Yes ☐ No

Do you understand that if you do not wish to answer a question, you do not have to answer it and you do not have to give a reason?
☐ Yes ☐ No

Has the way your identity will be protected been explained to you?
☐ Yes ☐ No

Do you understand who will have access to your study data?
☐ Yes ☐ No

Do you agree to take part in this study?
☐ Yes ☐ No

Appendix I

Budget

Detailed Budget for Entire Budget Period Direct Costs Only	Dollar Amount Anticipated
Material Resources:	
Office Supplies	$275.00
Photocopying	$400.00
Printing	$400.00
Fax	$50.00
Qualitative Data Analysis Software	$600.00
IC recorder/digital voice recorder	$300.00
CDs or electronic flash memory data storage device	$250.00
Locking Filing Cabinets $160.00 X 2	$320.00
Travel:	
Parking at $10.00 per day	$400.00
Mileage allowance at $0.45 per kilometre	$600.00
Honararium:	
$30.00 X 25 participants	$750.00
Transcription Services	
Quote 1: $2.50 per audio minute, first 5 interviews free 90 mins per interview X 20 interviews = 1800 mins X $2.50 = $4500 plus GST Quote 2: $1.94 per audio minute, first 7 interviews free 90 mins per interview X 18 interviews = 1620 mins X $1.94 = $3143.00 plus GST	$3143.00 to $4500.00
Total	$7488.00 to $8845.00

Appendix J

Guiding Questions

Note: these are guiding questions only. Some or all of the probes will be used, depending on the flow and direction of the conversation.

1. Grand tour question: Can you tell me about your work and role at X facility? What is the purpose of your role? What is important to you in your role?
2. I am interested in the relationships between caregivers and residents in long-term care. Can you tell me about the kinds of relationships that you like to establish?
3. Do you think it is possible to predict ahead of time which residents might be easy for you to form a relationship with, and which residents might be more difficult for you to form a relationship with? Why or why not?
4. Thinking back, (and without naming any names) are there any specific residents with whom you have had a difficult relationship?
5. What made the relationship difficult for you?
6. What do you do when you are having a difficult time relating to a resident?
7. Why do you think you do X?
8. From your experience, how do other care aides usually respond when they are having a difficult time relating to a resident?
9. Why do you think these situations occur?
10. Thinking back, can you think of some things that made the situation worse?

11. Can you think of some things that made the situation better?
12. Do you have any specific tips – what works well for you?
13. Has anybody suggested any strategies to you? Have you tried them? If so, were they successful?
14. Is there anything else that you would like to discuss concerning your relationships with residents?
15. If you could give a new worker some advice, what would you say?

Appendix K

Advance Submission of Proposal to Director of Nursing

Date

Elizabeth Andersen, RN, BTSN, MN
Address deleted
British Columbia
Contact information deleted

Name of Director of Nursing/Nursing Administrator
Address of facility
City deleted, British Columbia

Dear ……………………………………,

I am a registered nurse, currently employed by the (name of post secondary institution), in the Faculty of Nursing. I am also a graduate (PhD) student in the Faculty of Nursing at the University of Alberta. I am writing to seek your support and permission to conduct a research study with some of your unregulated health care workers.

I am proposing to conduct a qualitative research study to explore the experience of strained or difficult interpersonal relationships between unregulated health care workers and residents in long-term care institutions; how unregulated health care workers perceive these relationships, their beliefs about these relationships and the environmental factors that influence them. I wish to interview approximately 20-30 unregulated health care workers from at least four long-term care facilities in the city of XXXX and the surrounding area.

The findings from this study may be of interest to nurse educators and nursing home managers or administrators who may be able to use the findings as a basis for discussion groups and teaching sessions. It is possible that unique, innovative, compassionate and adaptive strategies may be brought to light and shared.

I have attached my proposal for your review. I would appreciate an opportunity to meet with you at your earliest convenience to discuss the proposal, specifically how the data will be collected.

I will be seeking written permission from you to enter your facilities after ethical approval has been obtained as outlined below. However, my submission for ethical approval will be greatly enhanced if, after you have read the proposal, you would kindly indicate in writing that you would be willing to consider allowing me to recruit participants from your facilities. I will be happy to prepare a draft letter for you.

I will seek Approval for the proposal from the Health Research Ethics Board (HREB) at the University of Alberta, Edmonton, Alberta (which administers the ethics review process for all faculty, staff, and students at the University of Alberta) and the XXXX Health Research Ethics Board of British Columbia. If there are other ethical or administrative review processes I would need to complete in order to work with your agency, these will also be done.

Please feel free to contact my supervisor: Judith Spiers, RN, BA, MN, PhD, Associate Professor, Faculty of Nursing, University of Alberta. Email: jude.spiers@ualberta.ca
Phone: (780) 492-9821 Fax: (780) 492-2551

I look forward to meeting with you.
Thank you
Elizabeth Andersen eaa@ualberta.ca enc: Research Proposal

Appendix L

University of Alberta Research Ethics Board Approval and Renewal

Health Research Ethics Board

308 Campus Tower
University of Alberta, Edmonton, AB T6G 1K8
p. 780.492.9724 (Biomedical Panel)
p. 780.492.0302 (Health Panel)
p. 780.492.0459
p. 780.492.0839
f. 780.492.9429

Approval Form

Date:	September 27, 2010
Principal Investigator:	Judith Spiers
Study ID:	Pro00013860
Study Title:	Exploring the Nature of Relationships between Unregulated Healthcare Workers and Residents in Long Term Care Settings.
Approval Expiry Date:	September 26, 2011

Thank you for submitting the above study to the Health Research Ethics Board - Health Panel . Your application, including revisions received September 26, 2010, has been reviewed and approved on behalf of the committee.

A renewal report must be submitted next year prior to the expiry of this approval if your study still requires ethics approval. If you do not renew on or before the renewal expiry date, you will have to re-submit an ethics application.

Approval by the Health Research Ethics Board does not encompass authorization to access the patients, staff or resources of Alberta Health Services or other local health care institutions for the purposes of the research. Enquiries regarding Alberta Health Services administrative approval, and operational approval for areas impacted by the research, should be directed to the Alberta Health Services Regional Research Administration office, #1800 College Plaza, phone (780) 407-6041.

Sincerely,

Beverley O'Brien, DNSc.
Chair, Health Research Ethics Board - Health Panel

Note: This correspondence includes an electronic signature (validation and approval via an online system).

UNIVERSITY OF ALBERTA   Alberta Health Services   Covenant Health

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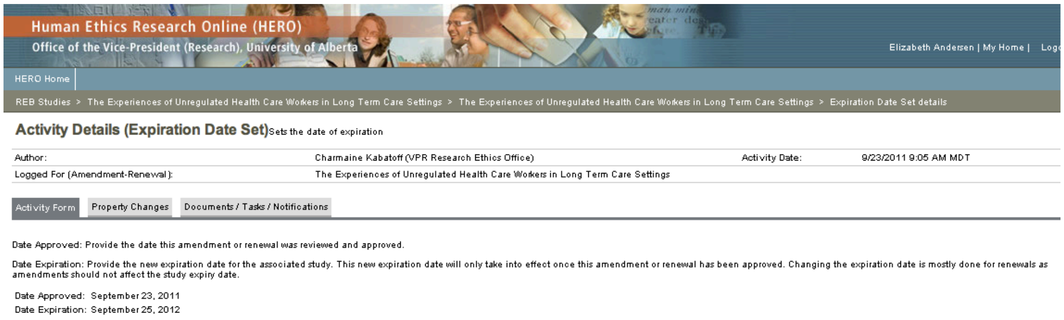

Activity Details (Expiration Date Set) Sets the date of expiration

Author:	Charmaine Kabatoff (VPR Research Ethics Office)	Activity Date:	9/23/2011 9:05 AM MDT
Logged For (Amendment-Renewal):	The Experiences of Unregulated Health Care Workers in Long Term Care Settings		

Date Approved: Provide the date this amendment or renewal was reviewed and approved.

Date Expiration: Provide the new expiration date for the associated study. This new expiration date will only take into effect once this amendment or renewal has been approved. Changing the expiration date is mostly done for renewals as amendments should not affect the study expiry date.

Date Approved: September 23, 2011
Date Expiration: September 25, 2012

Appendix M

XXXX Health Research Ethics Board Approval and Renewal

Certificate of Research Ethics Board Delegated Approval has been removed to protect the identity of the participants