Oral Care in Long Term Care Homes - An Institutional Ethnography

by

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Abstract

Purpose: The enigma of poor oral health of residents in long-term care (LTC) homes remains unsolved despite many years of research and intervention. The purpose of this study was to explore why resident oral health in LTC homes remains poor despite many years of research on causes of the problem and interventions to address it. Exploring how institutional processes and social relations influence care providers' experiences around providing oral care has the potential to inform strategies to address the longstanding issue of poor oral health of residents in LTC.

Methods: I investigated how oral care happens and why it happens the way it does, using institutional ethnography from the standpoint of the healthcare aide (HCA). The social organization of oral care in the LTC homes was explored through the observation of the HCAs' day to day practices and their interaction with institutional texts. Data were collected at two LTC homes through 96 hours of naturalistic observation, 21 in-depth interviews, and document review. As part of the data analysis, and based on what I was observing, hearing in interviews, and reading in texts, I created text-work-text (TWT) mappings to illustrate how oral care was socially organized in LTC homes. In addition, I created an additional TWT map for bowel care, as a comparison to oral care.

Findings: Health care aides were primarily responsible for providing oral care to residents in LTC homes, despite having very little textual guidance as to what, when or how care was to be provided. Texts that were available to inform them in providing oral care were underutilized because the HCAs did not consider the texts helpful. The HCAs used their own discretion, primarily relying on their personal experiences, to inform the oral care they provided for their

residents. In contrast, bowel care was an effectively textually mediated process and HCAs relied on several texts to provide them with guidance.

Implications: Exploring the social organization of work around oral care in LTC homes has illustrated institutional processes that may contribute to poor oral health for residents in LTC homes. Addressing these processes could help existing efforts of those seeking to improve the state of oral health of residents in LTC. Processes may be improved through a multifactorial approach including revision of texts that guide care, better oral health education for care providers, access to dental professionals in LTC settings, and policy changes at national and provincial levels around oral healthcare in LTC.

Preface

This thesis is an original work by Arlynn Brodie. The research project, of which this thesis is a part, received research ethics approval from the University of Alberta Research Ethics Board, Project Name “Oral Care in Long Term Care Homes”, No. Pro00083521, March 5th, 2019.

Dedication

To my parents and families with loved ones living in Long Term Care homes.

Acknowledgement

I am, and forever will be, grateful for the guidance and patience of my co-supervisors, Dr. Tammy Hopper and Dr. Sienna Caspar. Their mentorship throughout this journey has been invaluable, challenging me intellectually and encouraging me to persevere. Many thanks to committee members Dr. Sharon Compton and Dr. Susan Slaughter, whose wisdom inspired me to keep my vision alive by reminding me why my work was important.

As experts in your fields, you have contributed to my learning as an academic, as a researcher and as a person. I am privileged to have worked with you during this rewarding journey. Thank-you!

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Chapter One: Introduction

Canada's population is aging. For the first time in history, older adults (65+ years) outnumber children under the age of 14 (Statistics Canada, 2016), and they are the largest segment of the Canadian population. Those over the age of 85 represent the fastest growing segment of the total population, increasing by 19.4% between 2011 and 2016, which is four times faster than the rate of the general population's growth (Statistics Canada, 2016). Although older adults are often healthy, the risk of developing the most common forms of dementia increases as one ages. Current prevalence estimates vary, but approximately 500,000 Canadians over the age of 65 have some form of dementia (Government of Canada, 2019).

Individuals with dementia will eventually become completely dependent on others for care, and often reside in long-term care homes. LTC homes provide health care services including skilled nursing care and supervision 24 hours a day, 7 days a week, for people who are not independent in most activities of daily living (Statistics Canada, 2017). Whereas the majority of older adults in Canada live in private homes, approximately one-third of adults over the age of 85 live in collective dwellings such as LTC homes or senior residences (Statistics Canada, 2017) and approximately half to two-thirds of those in LTC homes are living with dementia (Wong et al., 2016). The high prevalence of dementia in LTC means that many, if not all, residents will require assistance with activities of daily living, including oral health care; indeed, Yoon et al, (2018) studied the prevalence of oral health problems of residents in LTC homes across Canada and found a need for improved oral health care in this context.

Although aging need not be associated with poor oral health, there are challenges to maintaining oral health in older age, particularly for those in LTC settings. Indeed, for individuals in LTC, poor oral health is a long-recognized problem (Yoon et al., 2018; Andersson

et al., 2017). Reasons for this situation are unclear, and although researchers have documented possible factors that contribute to poor oral health among individuals in LTC, (Bilder et al., 2014) and developed interventions (Albrecht et al., 2016; Weening-Verbree et al., 2013), the problem of poor oral health in LTC remains. Could the institutional organization of LTC be a contributing factor? This possibility is not fully addressed in the literature and represents a gap in knowledge about oral health care in LTC homes. The purpose of this study is to explore oral health care in LTC settings, using institutional ethnography as the method of inquiry. In the sections that follow, I provide an overview of the literature on oral health and oral health care of older adults in LTC, as well as background on ethnography and institutional ethnography as a conceptual framework for my study.

Oral Health, Aging and Long-Term Care

Oral health is a key indicator of overall health well-being and quality of life. The World Health Organization defines oral health as "a state of being free from mouth and facial pain, oral and throat cancer, oral infection and sores, periodontal disease, tooth decay, tooth loss, and other diseases and disorders that limit an individual's capacity in biting, chewing, smiling, speaking, and psychosocial wellbeing" (World Health Organization, [APA], n.d.).

Aging affects oral health; even in otherwise healthy older adults, there are physiological changes in the oral cavity that occur. These changes include decreased thickness of the epithelium of the oral mucosa, decreased salivary gland function, altered dentin, increased pathology, and increased fibrosis of the periodontium (Kim et al., 2021; Razak et al., 2014). As a result of these changes, older adults have an increased tendency towards high levels of tooth loss, dental caries, periodontal disease, xerostomia and oral pre-cancer/cancer (Hopcraft et al., 2012; Lopez et al., 2017). Additionally, the oropharyngeal biome of the elderly undergoes changes that

can foster growth of microorganisms, such as yeasts that become opportunistic oral pathogens (Belibasakis, 2018). When oral health is poor, the effects extend beyond the oral cavity (i.e., the physiological structures and functions of the mouth and teeth) and may significantly affect quality of life. For example, dental decay, dry mouth and broken teeth can negatively impact a person's ability to chew, thus causing problems eating, which can lead to nutritional deficiencies; further, individuals with poor oral health may avoid eating socially and engaging in mealtimes (Amerine et al; 2014; Brown, 2018; Donnelly et al., 2016; Razak et al., 2014). The oral-systemic link to poor overall health is well documented in the literature; older adults specifically are at increased risk of morbidities such as aspiration pneumonia (from aspiration of bacteria present in plaque in the oral cavity), (Pace & McCullough, 2010) and cardiovascular disease (Najafipouret et al., 2013).

In the presence of co-morbid health conditions or other disorders, such as dementia, poor oral health is exacerbated. Cognitive impairment can make it difficult for individuals to perform their own oral care and, in some cases responsive behaviors (i.e., resistance to oral care) may limit caregivers' ability to provide necessary assistance (Adam & Preston, 2006; Foley et al., 2017). Other barriers to promotion of good oral health among individuals living in LTC include residents' limited access to dental hygienists, negative attitudes and/or lack of knowledge of caregivers around providing oral care, lack of oral care supplies, and the adverse effects of polymedicine on oral health (De Visschere et al., 2015; Dounis et al., 2012; Mathews et al., 2012).

Decades of research have emphasized the need for improvement in the oral health of older adults in residential care (MacEntee, 2000; Mathews et al., 2012; Moore & Davies 2016; Syrjala et al., 2012; Yoon et al., 2018). Researchers focused on the potential causes and

contributors to poor oral health among LTC residents and identified gaps in the oral health knowledge of LTC home staff (Boczko et al., 2009; Paterson, 2000; Wårdh et al., 2012; Young et al., 2008). Gaps in knowledge were attributed to a lack of formal oral health curriculum in the education programs of healthcare personnel responsible for providing oral care to residents (McKelvey et al., 2003; Young et al., 2008).

With lack of knowledge highlighted as an important contributor to poor oral health among LTC residents, researchers studied the effects of educational interventions for care staff. Generally, outcomes of such programs were unsustainable over time (van der Putten, 2013), or not systematically measured (Weening-Verbree et al., 2011). Research focusing on the introduction of daily mouth care programs, using a variety of interventions for older adults who were dependent for care in LTC, also yielded limited success (Beck et al., 2009; Janssens et al., 2014; Le, 2011; Visschere, 2010). Amerine et al. (2014) tested a different intervention, by having a dental hygienist, as a champion of oral care, work alongside, and in collaboration with, a Certified Nursing Assistant in LTC homes. The dental hygienist was responsible for "establishing standardized oral health care protocols, providing ongoing oral health education, and delivering oral health preventive services" (Amerine et al., 2014, p.169). The outcomes for resident oral health were positive. Nevertheless, this model of care is not one that has been widely adopted in LTC settings in Canada, and oral health of residents in LTC continues to be a problem. Griffiths et al. (2021) reported that no common knowledge exists amongst care home staff as to how to provide mouth care for residents, and formal education programs for healthcare workers is lacking. Further, Patel et al., (2021) and Griffiths et al., (2021) determined that care providers were not aware how to identify, report or refer an oral health concern. In summary, despite years of dedication to this problem, the research has not translated into improved oral

health for residents in LTC. The apparent systemic nature of the issue of poor oral health suggests that a different approach, such as an ethnographic study of LTC homes around the provision of oral care, may be appropriate to help more fully understand oral health and oral care in LTC.

At this juncture it is important to note that LTC has been the subject of many studies over the past 50 years (see Estabrooks et al., 2020 for a summary). The focus has been on detailing the concerns about poor quality of care and safety in these settings, and include calls to action to address chronic understaffing and underfunding (Bowers, Esmond, & Jacobson 2000; Jansen 2011). Yet, the issues of poor quality of care remain. It is within this context that oral health care, specifically, was explored.

Ethnography and Institutional Ethnography

Ethnography, as a qualitative research methodology, is a combination of firsthand investigation and description of cultures, carried out by social scientists (Hammersley, 1983). Ethnography involves writing about people or writing an account of the way of life of a particular group of people. Ethnographic inquiry can be described as a suite of methods to understand beliefs of people who have a shared culture and can describe the way things are done. Schlechty & Noblit (1982) describe the process of ethnographic study as multiple layers of discovery and the interpretation of this work as uncovering the 'hidden obvious.' Completing an ethnographic study, utilizing an observational approach in a naturalistic setting, could reveal aspects of oral care that are unknown, and that may have an impact on appropriate models of care.

Ethnography research requires the existence of a culture-sharing group. The LTC home exhibits the qualities of such a group where the beliefs, language, behaviours and issues are

present among residents and staff, who live and work together within a common shared environment. This environment is ideal for an ethnographic study because it is likely that residents and staff of a LTC home have developed a shared language, patterns of behaviour and attitudes which have discernable patterns (Creswell, 2013) that can be observed. An issue, theory, or theme (Hammersley & Atkinson, 1995), such as poor oral health, is selected by the researcher, and then the researcher examines people interacting in their ordinary setting, looking for patterns in their social world. In the current research, staff in a LTC home are observed as to what they do, what they say, how they interact with others, and what items or 'artifacts' they make and use to communicate with each other (Creswell, 2013) around oral health care. Whereas ethnography can take several forms, for the purposes of this study, I have chosen to use institutional ethnography as the method of inquiry.

Institutional ethnography (IE) begins with an exploration of the lived experiences of people directly involved in an institutional setting. However, the individuals are not the direct foci of investigation. Instead, the organizational processes are under scrutiny, as these processes are thought to have effects on activities and experiences of people who work or spend time within an organization. Thus, the IE researcher does not focus on the individuals, but on the social processes that shape their activities (Smith, 2005).

According to Smith (2005), IE is not about the testing of a hypothesis, but is more about discovering 'how things actually are' and refers to IE as a method of inquiry rather than a methodology. This method of inquiry helps to uncover how the everyday experiences of people in local settings are organized by, and linked to, the work of others (Smith, 1977). Smith further describes IE inquiry as a method that allows researchers to examine human experiences in a new way, by talking about and examining everyday behaviour and activity instead of examining

abstract theories. According to Smith, discussing everyday experiences becomes a means of discovering new knowledge and describes this new knowledge as 'embodied knowing,' which is knowledge that comes from the person who is living the experience. Institutional ethnographers learn from people's everyday knowledge of their lives and 'doings' and do not impose pre-conceived interpretations (Smith, 2005). These lived experiences create some understanding around the social organization of institutions.

It is important to differentiate between the 'organizational culture' of an institution and the 'social organization of institutions' because they are not synonymous terms and thus cannot be used interchangeably. A study of organizational culture would examine the consistent, observable patterns of behaviour in organizations. According to Smith (2005), an IE study would not examine the organizational culture itself, but would go beyond, to examine the patterns of behaviour to determine why and how the behaviour exists and why we repeat the behaviours. Smith (2005) maintains that the social relations of everyday life actually organizes what goes on, and the interplay of social relations, being coordinated purposefully, constitutes social organization.

Concepts of Institutional Ethnography

Social Relations

Dorothy Smith (1987) describes the concept of social relations as something different from the way we usually talk about relationships between people. According to Smith (2005), social relations are activities and practices through which people's lives are socially organized. It is within the study of social relations that we find people's ordinary activities coordinated purposefully by something beyond their own motivations and intentions (Caspar, 2014). Social relations are people participating in social activities, often unknowingly, as they competently

coordinate their own actions within organizational rules (Campbell & Gregor, 2008). For example, HCAs working in an LTC home will go through the daily routine of communicating with other care providers in 'report' and then continue with the tasks of toileting, bathing, and feeding residents. While providing this care, the HCAs interact with the residents, other care providers, and possibly the residents' family members during their shift. The HCAs act competently through the day, completing many tasks that are familiar and commonplace. These series of actions performed by the HCAs are routinized and many are performed without conscious reflection (Campbell & Gregor, 2008). Additionally, the work of the HCA affects the experience of others; it is this flow of activity or work that further constitutes social relations (Caspar, 2014).

The interconnectedness of the work of the HCAs among themselves, and with other healthcare providers, illustrates social relations. These relations have been described as "something that links individuals together" (Rankin et al., 2010, p. 335). Using the IE method of inquiry, by looking beyond the obvious and observable, the social relations can be uncovered. According to Smith (2005), the social relations of everyday life organize activities during a given day in an institutional setting, often without the conscious knowledge of the participants.

Ruling Relations

Power relations in social organizations are described by Smith (2008) as ruling relationships. Ruling takes place when the interests of those who rule dominate the action of those in the setting (Smith, 2008). Ruling relations are determined by the distribution of power within a social structure and are the complex set of rules by which the social setting is organized (Smith, 1990). Smith (2001) describes these rules as 'extralocal' because they are created outside the local setting. An example of rules 'extralocal' to an LTC home would be those of the

provincial legislation that dictates regulations to which LTC homes must adhere. These extralocal policies are referred to as 'boss texts' because they are positioned at the top of a hierarchy of subsidiary institutional texts that exist in LTC homes, which have been created in response to these extralocal rulings (Bisaillon, 2012). Boss texts, therefore, coordinate organizational relations so 'how people work' is in accordance to the requirements of the boss text (Bisaillon, 2012).

Texts

Texts are documents that exist as paper, images, electronic forms, numbers and forms that coordinate, mediate and authorize people's activities within an organization (Smith, 2001). When using an IE method of inquiry, the social organization of an institution (e.g., a LTC home), is explored through the activities of individuals, how those individuals interact with material objects, such as texts, and how texts co-ordinate the activities. Texts create a common ground of communication and are embedded into social organization. Texts can also have the power to hold people to acting in particular ways, although people may not recognize how their activities are being shaped by the texts (Campbell & Gregor, 2008). Smith (2001) states that it is difficult to explore an organization without describing people's activities in texts, because texts are coordinators of people's activities and can impose or dictate social behaviors within the organization.

Texts may also be replicable. Smith describes replicable texts as concrete forms of work or images "…that can be stored, transferred, copied and produced in bulk" allowing them "to be activated by users at different times and in different places" (Smith, 2006, p. 34). An example of a replicable text in an LTC home would be the physician fax form that transmits information that

is produced, copied, and then stored in the resident's chart. A text that is not replicable would be one that was transitory and discarded after it was used, such as a piece of note paper.

Texts are not viewed as inert sources of information about an organization (Smith, 2002); instead, they are to be examined as they coordinate people's activities. For a text to be 'activated' it needs to be actionable. The activated text, therefore, can be seen to be organizing or causing social action. Smith (2005) says it is the activism or utilization of texts by people that enables the texts to coordinate the social organization of institutions.

Disquiet

In IE, a disquiet can be described as a moment of disconnect between the actuality of a person's experience and the institutional realities (Smith, 2005). The disquiet may be imposed by regulatory bodies who govern the structure of the organization by putting in place policies that create replicable texts used by workers in an institution. An example of a textually mediated work practice that could cause a disquiet for HCAs would be the existence of a daily oral care policy that has been introduced by the manager of a facility, yet there are no oral care supplies available, and the daily brushing requirement is not written in the resident's mouthcare plan. In this case, there is a disconnect because the HCA, according to policy, is to provide daily brushing but is not able to because of the absence of supplies and direction imbedded in the care plan.

Discourse

Written and spoken conversations create a discourse among individuals. Discourse may be defined as a way of organizing knowledge, ideas or experience that is rooted in language and its concrete contexts, such as institutions (Merriam Webster, 2017). Language, therefore, is a key constituent of institutional relations (Campbell & Gregor, 2008). In IE, discourse is

explained as multiple relations that include texts and their intertextual conversation as well as the activities of people in actual sites who produce them (Campbell & Gregor, 2008). Intertextual conversation in an LTC home, for example, would be the conversation an HCA and a nurse would have when the nurse, as they complete a report, questions an entry made by the HCA into another daily care document that the nurse is using to complete the report. This conversation between the HCA and the nurse exemplifies a link between texts and content, illustrating intertextual conversation. Institutional ethnographers refer to institutional discourse as shared professional, managerial or scientific ways of knowing and communicating that is more than jargon (Smith, 2006). Discourse in IE represents forms of knowledge that carry institutional purposes (Smith, 2006). This understanding of discourse is always inclusive of the person who is activating the text (De Vault & McCoy [of Chapter 2], 2002).

Problematic

The problematic is defined as a process of questioning that arises from a wondering or concern that warrants further investigation. The problematic in IE is not the problem that needs to be understood, nor is it a research question per se (Campbell & Gregor, 2004). Discovering the problematic helps determine where the place the inquiry should begin (Campbell & Gregor, 2008). According to Smith (1987), IE begins with a puzzle, something troubling going on for a group of people who share a common location within an institutional regime. Every IE investigation begins with issues or concerns involving people and their relationship with an institutional order (Caspar, 2014). The process of IE explores a particular problematic that is present and being lived by someone in their everyday world. The concept of the problematic, as described by Smith (1987), comprises a possible set of questions that may have not yet been posed. It is this statement by Smith that resonated with me and provided the impetus to pursue

doctoral studies to explore what lies beyond the obvious problem of poor oral health of residents in LTC.

Framework for the Problematic. Caspar (2014) provides a framework for discovering a problematic that I will use here. I will discuss the enduring problem of poor oral health in LTC with a focus on the experiences that shaped my questioning. Sharing this information will allow me to clarify my motivations and assumptions as I conduct my research (Caspar, 2014). My personal experiences and observations have shaped my questions and the lens through which I will approach my study using an IE inquiry. My research will be shaped by three predominant influences, myself as a daughter, a dental hygienist, and a researcher.

Daughter. As a daughter, I first began questioning the provision of oral health in institutions when my father became hospitalized and bed ridden with end stage cancer. While the staff provided care, such as warm blankets, oral care was intermittent and was completed only when requested by a family member. After my father's passing, I was determined to improve the oral health of individuals who could not provide their own oral care, so I began the pilgrimage into LTC, first by contacting directors of care and explaining how oral health of residents was important and presenting a formula for success which included assessment, treatment, and referral for further dental treatment as required.

Dental Hygienist. As a clinician, I have experienced many instances where poor oral health was a serious issue for residents in LTC. When residents become reliant on staff for their oral care, they must follow whatever oral care regime exists for that LTC home. In my experience, there are few standardized oral care protocols for residents in LTC. One story that illustrates this problem occurred quite recently, as I was providing tooth-brushing to an older resident with early-stage dementia. Her dentition was almost complete and was well-restored,

exhibiting many years of good dental care, but there was heavy plaque and inflammation around most of her teeth. I asked her if she wanted me to floss her teeth and she began to cry. At first, I was not sure if my question was related to her tears. She then managed a faint, “yes please” and closed her eyes and cooperated as I flossed all her teeth. She explained in short sentences that she had always flossed her teeth and she could no longer do it herself. She said she missed being able to properly care for her teeth and having that ‘fresh’ clean feeling. Flossing, for this person, was clearly an important component of her personal care. The question arose: where would flossing be identified as part of her care plan?

In my experience as a dental hygienist working in LTC, it seemed that care provider conversations about a resident’s oral health were unplanned, uncoordinated and without adherence to a particular protocol. The provision of daily oral care for residents seemed to be left up to the discretion of the care providers, who determined if they had time and deemed it necessary. I also questioned if it was somehow the culture of LTC homes that contributed to the apparent apathy that existed around the provision of oral care for residents. Further, I questioned why daily oral care was relegated to the grooming section of the care plan. Poor oral health is a medical disease, yet, providing daily oral care was viewed as a grooming task such as brushing hair.

While providing oral health assessment and treatment as a dental hygienist for many years in LTC, I have been increasingly concerned with the inability to improve or stabilize the overall oral health status of residents. We know health care aides (HCAs) are responsible for providing oral care for LTC residents (Chalmers et al, 1996), but I have always wondered what might be influencing the ability of the HCA to provide oral care to residents in LTC. Smith

(2005), as an institutional ethnographer, might pose the question, what is shaping the work of the HCA around the provision of oral care?

Researcher. As a researcher, I have reviewed the literature on evidence-based practice related to oral health care in LTC. There are many interventions to address the problem of poor oral health care in LTC, yet an apparent lack of translation of such knowledge into care exists (Beck et al., 2009; Visschere et al., 2010). After 20 years of feeling powerless to effect any substantial change in the oral health of residents living in LTC, I began to explore other possible explanations for the lingering problem. Over the years, I hypothesized that poor communication between care providers around issues of oral health could be the basis of the problem. It became evident that the problem of poor oral health in LTC was complex and that there must be additional contributing factors that had yet to be identified. I had a growing sense that there was something else, or something bigger going on, and this unsolved mystery led me to formalize my inquiry through the pursuit of a doctoral degree.

Thus, the problematic for this study developed from my experiences working in LTC homes as a dental hygienist. Smith (2006) suggests that the problematic forms the foundation for the study questions. As I was formulating the problematic, I had many questions around the provision of oral care to residents of LTC homes. These questions formed the foundation of the development of my study and are as follows:

1. How is oral care prioritized in LTC homes?
2. Who is responsible for the oral health needs of the resident?
3. How do staff obtain information regarding the oral health needs of a resident?
4. Who determines what the daily oral care regime will be for each resident?
5. Once determined, is personalized oral health information documented?

6. If an oral health issue is identified by staff, how, and to whom, is the information communicated?
7. Who provides oral care to residents? How and when does it occur?

Residents living in LTC with poor oral health often have dementia and are reliant on others to assist with care. The responsibility for care is shifted from self to surrogate and the health of the resident is the responsibility of others. The expertise of many care providers is necessary, and these providers must collaborate to provide such care. So how is it that the residents who live in LTC generally have such poor oral health?

At this point in my writing, it is important for me to be reflective around how my experience as a dental hygienist, working in LTC settings for many years, may influence my research. I am conscious of the biases, values and experiences that I am bringing to this qualitative study and understand the importance of explicitly stating my position (Hammersley & Atkinson 1995). My experiences as a dental hygienist working in LTC homes, and my experience looking after the oral health needs of a palliative family member, may shape the findings, interpretations, and conclusions of my study. Creswell (2013) suggests that not only is it important for the qualitative researcher to share experiences but also to discuss how these past experiences could shape the interpretation of the phenomenon being studied.

Twenty years of providing oral care for residents in LTC homes has made me acutely aware of how many residents suffer from the effects of poor oral health. As a dental hygienist, I understand how poor oral health can negatively affect systemic health, so witnessing so much oral disease over the years has been disturbing. Optimistically, I have been working towards improving the oral status of residents one intervention at a time, but with only limited success.

Creswell (2014) states the writing of a qualitative work cannot be separated from the author, how it is received by readers, or how it impacts participants or sites involved in the study. The writing of this study will be a reflection of my own interpretation and will be shaped by my experience. My writing is therefore, 'positioned' within my experiences as a dental hygienist working in LTC.

Standpoint

Standpoint refers to the entry point that allows the researcher to position themselves in the everyday expert knowledge of peoples' daily activities (Rankin et al., 2010). According to Smith (2006), before researchers begin to explore the problematic, they need to identify their standpoint. By identifying a standpoint, the researcher positions their research in the experiences and concerns of a particular group of people. In this study, I took the standpoint of the HCA, primarily because HCAs provide the majority of resident care and may play a primary role in making daily oral care decisions for residents in LTC.

Purpose and Potential Significance of the Research

The purpose of this study was to explore why resident oral health in LTC homes remains poor despite many years of research on causes of the problem and interventions to address it. I investigated how oral care happens and why it happens the way it does, using IE inquiry from the standpoint of the HCA. Exploring how institutional processes and social relations shaped HCAs' experience around providing oral care has the potential to inform strategies to address the longstanding issue of poor oral health of residents in LTC.

Chapter Two: Method

General Study Overview

Campbell and Gregor (2008) describe the type of data IE researchers collect as everything that people know how to do and everything that their daily lives require them to do. DeVault and McCoy (2002) described the procedures of research within IE as: (a) identifying an experience, (b) examining the processes or texts that affect the experience, and (c) investigating how those processes affect the activities within the experience. To accomplish these procedures, IE researchers draw on a number of classic ethnographic investigative techniques such as undertaking observations, interviewing key informants, and writing detailed fieldnotes (Campbell & Gregor, 2008). My IE study was not focused on the usual ethnographic practice of studying groups of people, instead I used observations, interviews and textual analysis to understand *how* the experience of the HCA in providing oral care was socially organized by institutional processes of the LTC home. Consistent with IE inquiry, my methods of data collection were interconnected, with data from one information source informing data collected from others.

I applied to the Research Ethics Board at the University of Alberta for approval to conduct the study in December 2018 and the study was approved to proceed in March 2019 (Pro00083521). I conducted the study in two phases over the next six months. Phase 1 involved naturalistic observation of HCAs in two LTC homes (Site 1 and Site 2). Phase 2 involved in-depth interviews with HCAs and other health care professionals at the two study sites. I identified and collected texts during both phases of the study. Recruitment of participants and data collection were conducted sequentially, beginning with Site 1 followed by Site 2, with some

overlap in recruitment occurring towards the end of data collection at Site 1 (see Table 2.1 for the data collection timeline).

Table 2.1

Data Collection Timeline

Month / Activity	April 2019	May 2019	June 2019	July 2019	August 2019
Contacted the DOC at Site 1 and met to discuss the study	**X**				
Site 1 Posted notice of study posters and set date for participant information meeting		**X**			
Site 2 Contacted the DOC and met to discuss the study and place notice of study posters onsite		**X**			
Site 1 Held HCA study information meeting		**X**			
Site 2 Information meeting with potential HCA study participants			**X**		
Site 1 HCA observation and interviews			**X**	**X**	
Site 1 LPN, RN and DOC interviews				**X**	
Site 2 HCA observation and interviews				**X**	**X**
Site 2 LPN, RN and DOC interviews					**X**
Three additional interviews to obtain data clarity					**X**

Study Sites

I conducted my study at two LTC homes in Winnipeg MB, Canada. According to the *Canadian Institutes for Health Information*, "long-term care (LTC) homes provide a wide range of health and personal care services for Canadians with medical or physical needs who require access to 24-hour nursing care, personal care and other therapeutic and support services; LTC homes with similar characteristics can be called different names across the country" (https://www.cihi.ca/en/long-term-care-homes-in-canada-how-many-and-who-owns-them, retrieved December 12, 2021). In Manitoba, they are referred to as Personal Care Homes, however, for the purposes of this thesis, I will refer to the sites as LTC homes.

Regulatory oversight of LTC homes in Manitoba is provided by the Ministry of Health and Seniors Care, which establishes province-wide goals and standards for the delivery of services for seniors through *Personal Care Home Standards Regulation.* These standards provide some direction for staffing under section *22(1) Nurse in Charge of Care*, which states, "the operator shall designate a registered nurse or a registered psychiatric nurse to be in charge of administering nursing services in the personal care home." To clarify, RNs are regulated health professionals who have a bachelor's degree in nursing, LPNs are also regulated and have completed a diploma in nursing, and HCAs are unregulated care staff who have completed a certificate program ranging in length from five months to one year. In past years, a RN provided direct care to residents in LTC homes; however, the role of RNs in LTC settings has changed. Today, RNs delegate most caregiving duties to LPNs and HCAs (Anderson et al, 2005; Willmot, 1998). Thus, it is customary for RNs in LTC homes to have administrative roles with very limited personal contact with residents. Indeed, this was the structure and staffing in place at both of my study sites.

To ensure that the organizational context of the study sites was similar, they had the following comparable characteristics:

1) similar in size (number of residents),
2) classified as not-for profit, and subject to regulations of the same Regional Health Authority,
3) home to residents assessed as having complex care needs including dementia, and thus requiring the presence of skilled nurses twenty-four hours a day, seven days a week,
4) similar in staffing mix (i.e., a registered nurse (RN) supervised a licensed practical nurse (LPN) who was a team leader who supervised the HCAs, and,
5) located within reasonable proximity so that they were readily accessible for observations to take place during all shifts and for extended periods.

During my search for LTC facilities interested in my research, I was advised by a colleague to contact the Director of Care (DOC) at a certain LTC home. After meeting with the DOC and the Staff Educator/Unit Manager, they expressed interest in the study and agreed to request consent for the study from their board of directors. Consent was granted in approximately two weeks, and this LTC home was designated as Site 1 for the study.

After the introductory meeting at Site 1, I met with the DOC and mentioned I was still looking for another research site; he suggested I contact the previous DOC from Site 1 who had recently moved to another LTC home. I followed up by email and scheduled an introductory in-person meeting with the DOC at the prospective second site. He was interested in my research and said he would contact the board of directors for their approval. The board of directors consented to my study at this LTC home one week later and it was designated as Site 2 for the study.

Site 1

This LTC home is a faith-based home. The building, which opened in 2000, was three-stories with residents living on all three floors. Each floor was divided into two wings. One wing on the third floor was a secured dementia unit, and one of the wings on the ground floor was dedicated to offices and meeting rooms. All rooms were designed for a single occupant and each room had its own washroom; some of the rooms were equipped with ceiling lifts. Each wing has a central dining area and a recreational space with tables and a television. The basement of the building had a staff lounge and maintenance offices.

The building was home to 100 residents. Two wings on the second and third floor are home to twenty residents per wing, with only twenty residents on the main floor because offices are located in the other wing. Each HCA was responsible for providing care to 10 residents during the day and evening shifts. To assist the HCA during the early morning of the day shift and alleviate the workload, a 'helper' HCA came in at 6:30 a.m. and stayed until 10:30 am. The HCAs worked with the same residents for two weeks and then were assigned a new resident list. Many of the HCAs had worked at the facility for more than ten years.

Site 2

This home was a First Nations owned and operated LTC home and opened in 2011. The building was one-story and was home to 80 residents. The LTC home was divided into five pods; the third pod housed the kitchen and service area, each of the other pods contain between 10 – 15 private rooms with en-suite bathrooms. Each pod had its own dining room and quiet room. There was a central activity area that was used by residents of all pods during recreational activities. The HCAs were always assigned to care for the same residents during every shift they worked, consistent with 'permanent resident assignment' that is recognized by many as a best practice in

dementia care (Castle, 2011). Residents of the care home were predominantly Indigenous. Some of the staff were Indigenous, but they were not the majority.

Phase 1 – Naturalistic Observation: Recruitment, Eligibility and Data Collection

Recruitment and Eligibility of HCAs

For Phase 1, which was focused on naturalistic observations, study participants were HCAs in each LTC home. Purposive sampling was used. Inclusion criteria for HCA participants were as follows: agreed to sign the study consent form, were willing to be shadowed during their entire shift, agreed to be interviewed and complete a Post-Interview Consent Form (See Appendix A for Consent materials).

Site 1. Participant recruitment was initiated by placing Study Information Posters (see Appendix B) at multiple locations throughout the site. Three weeks later, I set up a study information meeting for the HCAs who were interested to learn more about the study. Eight HCAs attended and at the conclusion of the meeting six HCAs volunteered to participate in the study. The two HCAs who declined to be involved in the study then left the meeting. I went through the Study Information Letter, (see Appendix C), and study requirements with the six study participants and asked for questions. They asked few questions. The Consent to be Interviewed form was signed by each of the six study participants and each HCA was given a Study Information Letter when they left the meeting. I was told by the HCAs that they were familiar with the process of conducting research at their site because they had participated in various other studies conducted by researchers from the University of Manitoba. The HCAs eagerly shared how many years they had been working at the site, the majority stated they had been employed there since it opened. I subsequently worked with the staffing nurse to create an observation schedule.

Site 2. Participant recruitment at Site 2 involved placing recruitment posters in visible locations, such as in the nursing stations and chart rooms. The posters had the day and time of the upcoming study information meeting. The information meeting was held two weeks after the study information was posted. Twelve HCAs participated in the information meeting. Of the twelve attendees, nine HCAs agreed to participate in the study. The three HCAs who were not interested left the meeting and I reviewed the study requirements and Information Letter with the remaining nine participants. I encouraged questions from the group, and they responded with over thirty minutes of questioning. I would later understand why they had so many questions. The HCAs had never been involved in any of the research studies that had taken place at this site and they were very concerned about how their confidentiality would be protected. All nine HCAs signed the informed and voluntary consent forms and took the Information Letter with them when they left. Although nine HCAs had agreed to participate in the study, I only required six participants. Because of summer holiday scheduling this did not end up being an issue; three HCAs were away on holidays while I was onsite. I worked with a staffing nurse to create the HCA observation schedule.

Based on my past experience working in LTC settings, I was aware of the importance of trust in the researcher-participant relationship. I realized my approach to introducing the study to the HCAs would be critical to the recruitment of study participants. Important in garnering support and trust was to provide study participant anonymity, to accomplish this, each participant was identified by their site and a number. For example, an HCA from Site 1 would be identified as HCA 1-1. In addition to clearly detailing the study procedures, I also shared my background as a dental hygienist, and how working in LTC for twenty-four years provided me with a general

understanding of their work as HCAs. By listening and answering their questions, I was able to demonstrate my understanding and appreciation for their work as HCAs.

Data Collection: Naturalistic Observations

Naturalistic observation in LTC homes has advantages because the setting has not been created or manipulated, thereby, helping to establish authenticity in the behaviors being observed. However, observation of people in their everyday environments may cause reactivity, whereby the behavior being observed is influenced by and may change, because the participant is being observed (the 'Hawthorne Effect'; Wickström, & Bendix, 2000). Because of the potential for this effect, it was important for me to be openly, yet unobtrusively, observing the HCAs as they went about their daily work, making sure my stance remained observational without intervention. I achieved this stance by shadowing and observing HCA behavior without intruding, controlling or manipulating the environment in any way. I also assured them, as in the recruitment phase, that I was not investigating them, but rather that I was exploring what was affecting them and how they did their work related to oral care.

When conducting an IE, one of the challenges of observation is deciding what is useful to observe, attend to, and record. I conducted observations in the LTC homes and shadowed the work of the HCAs noting how they did their work, where the work took place, and with whom. During my early observations, because I was unsure as to what would become important to my study, I recorded, via field notes, almost everything I saw and heard. These observations formed the basis of my inquiry, which included describing the care practices of the HCA within the overall organization of care. It was necessary to include details of information exchange and to note texts used, or referred to, during the observation period.

Each observation began at the start of the HCA's workday and concluded at the change of shift meeting, or report, held at the end of the shift. The HCAs were shadowed during day shifts (07:00–15:00 hours) and evening shifts (15:00–23:00). The primary focus for observing the HCAs throughout an entire shift, was to create a chronological accounting of their work practices around oral care during their shift on a typical workday. By describing their work, I was able to begin to explicate their lived experiences in the LTC home. Three HCAs were observed once on their day shift and an additional three HCAs were observed during an evening shift for a total of six HCAs at each site. During my observations, I wrote my detailed field notes in a binder, one for each site. I also noted questions I had as a result of the events or activities I observed. The notes taken during my observations guided my subsequent interviews with the HCAs and other staff members.

Phase 2 – Interviews: Recruitment, Eligibility and Data Collection

Recruitment and Eligibility of HCAs and other Staff Members

Phase 2 was focused on in-depth interviewing; participants were the HCAs who I observed, as well as the RN or LPN who worked the same shift as the HCAs I observed. The DOC or Assistant Director of Care (ADOC) was also interviewed in each site. All study participants had agreed to be interviewed when they signed their consent forms and each interviewee also completed a Post-Interview Consent Form (see Appendix A). I completed a total of 21 interviews with 18 study participants at both study sites (three participants were interviewed twice). See Table 2.2 for details of the study participants, organized by study site and phase of the study.

Site 1. I completed interviews with the HCAs immediately after I had observed them during their shift. All of the six HCA interviews were held in their staff quiet room and totaled

two hours and nine minutes of recorded interview time. Three interviews were completed with other health care providers including the ADOC, a RN, who was also responsible for staff education, and an LPN. Two of the three interviews were held in the offices of the ADOC and the RN, the third interview was held in the staff quiet room. Their combined recorded interview time was one hour and twenty-eight minutes. Once I began my data analysis, I realized I needed more clarity, so I interviewed the LPN at Site 1 a second time, for an additional 20 minutes. In total, I conducted ten interviews with nine people at Site 1.

Site 2. Interviews with the six HCAs were completed in the chart room after their shift was over. The combined interview time for the HCAs was one hour and fifty-five minutes. Two of the HCAs requested not to be audio recorded so instead, I took detailed notes during the interview. Three more interviews were completed, one with the DOC, another with a RN and a third with an LPN, totaling fifty minutes. I met with the DOC in his office and interviewed the LPN and RN in the chart room. One week after I was finished onsite, I returned to re-interview the DOC and the RN for a total of forty-nine additional interview minutes. In summary, I conducted 11 interviews with nine people at Site 2.

Table 2.2

Study Participants by Study Site and Phase

Phase One - Naturalistic Observations	**Site 1**	**Site 2**
Health Care Aide	6	6
Phase Two - Interviews	**Site 1**	**Site 2**
Health Care Aide	6	6
Licenced Practical Nurse	1	1
Registered Nurse		1

Registered Nurse (staff educator)	1	
Assistant Director of Care	1	
Director of Care		1
Additional Interviews	**Site 1**	**Site 2**
Licensed Practical Nurse	1	
Registered Nurse		1
Director of Care		1

Data Collection: Interviews. Interviewing in IE attempts to identify points of connection between individuals working within the institutional context, not to generalize about the group of individuals being interviewed, but to find and describe social processes that have generalizing effects (De Vault & McCoy [of Chapter 2], (2002). IE purports that interviewees are subject, in various ways, to discursive and organizational processes that shape their activities (De Vault & McCoy [of Chapter 2], 2002). During the interviews, I asked questions that would help me understand the organizational linkages and social relations between the LPN or RN, the DOC and their relationship with the HCAs, in relation to the provision of oral care in the LTC homes. The following objectives were addressed:

1. to identify the discourses and institutional work processes that shaped the everyday work of the HCA (Caspar, 2016),
2. to describe how these processes influenced the communication of residents' oral care information among HCAs and other health care providers working in LTC,
3. to describe how each of the above influences the provision of oral care by HCAs in their everyday work, and,

4. to describe how the discourses and institutional work processes of the HCAs influenced the communication of residents' bowel care information among themselves and other health care providers working in LTC.

At this point, it is important to describe how the fourth objective became relevant and necessary to include in the interview process. The initial intent of my study was to observe the work of the HCAs, in an attempt to gain a better understanding of oral care in LTC homes. During my observations, however, I became aware of the abundance of conversation that occurred between the HCAs around resident bowel care. I wondered why this aspect of care was given so much attention by the HCAs. There seemed to be little or no conversation between the HCAs around other ADLs, including oral care. I was curious as to why this was the case. From this point onward, which was day two of my observations, I also began to observe conversations and create field notes on the work of the HCAs around resident bowel care.

Within IE, interviews are not structured. They are better described as 'talking to people' (Devault & McCoy, 2002). According to Smith (2005), adhering strictly to an interview script limits the institutional ethnographer to what they have already anticipated and inhibits the process of discovery. All interviews, therefore, began with a general question "Can you tell me what a typical day looks like for you here at (name of LTC home)." Following the IE method of inquiry, all other questions evolved out of the course of the conversations and interviews as they would normally arise (Smith, 2005). Each interview informed the ones that followed; thus, the interviews and the subsequent interview questions were iterative in nature. The focus of these interviews was to identify the institutional work process that shapes the interviewee's 'everyday work' (DeVault & McCoy, 2002).

To maintain the standpoint of the HCA, I remembered that, as an IE researcher, my involvement in the study was to make discoveries for the HCA, extending the knowledge of how things are put together in their everyday lives, often without them knowing (Smith, 2006). It was important for me to note any potential gaps between what the HCA experienced and the institutional goal of providing oral care. I was careful to maintain the standpoint of the HCA while identifying these gaps and noting gaps that may be potential points of disconnect, or disjuncture.

Data Collection: Texts. At the heart of the IE method of inquiry is the *text*; in an institution, texts are an integral part of what people know and do (Campbell & Gregor, 2008). For example, texts in LTC homes organize sequences of activities that are coordinated, recognizable, and reproducible (Turner, 2006). It is important to reiterate that texts are not analyzed in isolation, or separately from how they enter into and coordinate sequences of action (Campbell et al., 2006), but are integral parts of what people do.

During my observations, at both sites, the HCAs interacted with a number of documents throughout their workday. I identified these 'institutional texts' from observing the everyday practice of the HCA and making notes of the texts that informed, or were a result of, the HCAs' daily work practices. Of specific interest was the replicability of many of the texts and how these texts organized what the HCAs did and influenced their working relationships amongst themselves and their supervising LPN or RN. Additional knowledge of how these texts related to the work of the HCA was gleaned from the interviews with the HCAs. The texts I observed, and those referenced by the HCA during their interviews, formed the foundation for data analysis and the creation of text-work-text maps (discussed in the *Data Analysis* section that follows). I retrieved copies of official institutional texts from the ADOC at Site 1 and the DOC at Site 2.

In addition, other texts that originated outside of the LTC home were also of interest. These are official texts developed by the Winnipeg Regional Health Authority (WRHA) and the Ministry of Health and Seniors Care. These 'boss texts' (Smith & Turner, 2014), while influential to the HCAs daily work, may be invisible to them. I obtained boss texts online at the provincial government websites.

Data Analysis

My analysis included data from observation field notes, recorded interviews, and texts relevant to the work of the HCAs. IE researchers concur that data analysis begins early in the research process. From this understanding, I began to observe the behaviors of the HCAs in providing oral care in the LTC homes, explore how things work with respect to this care, and attempt to make sense of the social organization of HCAs in providing oral care in the LTC homes in my study. During my analysis, I asked the question, what was connecting and coordinating these experiences?

I needed to understand the relationship between the everyday provision of oral care by the HCAs, and how the institutional rules and norms, reflected in texts, affected how the HCAs provided oral care. Unlike other ethnographies, my role was not to create themes from my data; instead, according to Campbell et al. (2006), it was to listen to the talk and watch the actions of the participants to determine the social relations coordinating their experiences. The idea was to explicate how the experiences came to happen as they did (Campbell et al. 2006). Observing the social organization of the LTC home and how the HCAs experience it in the way that they do, informed my analysis (Campbell et al., 2006). By taking the standpoint of the HCA, I was able to see how their activities could be textually mediated by the institutional rules of the LTC home.

The data were grouped after reviewing the observation notes and the transcribed interviews. Grouping the data resulted from recording what was happening during my observations and listening to the HCAs talking and expressing their expertise of their day-to-day activities in their workplace. I grouped the data by isolating recurring events, or specific language used by the HCA at both study sites. I was looking for a pattern, or according to Campbell and Gregor (2008), something that was organized to reoccur. The recursivity of the data exposed a pattern of organization which I was then able to group. When observing and taking notes, I used coloured highlighters to highlight the aggregating of my observational data into groups; oral care, bowel care, environment, spoken and written communication, and questions requiring follow-up.

As mentioned, during my observations I became aware that the HCAs spent significant time on, and discussion of, bowel concerns and care. They participated in frequent, descriptive conversations with each other, and occasionally with the nurses, around the bowel movements of residents in their care. What became interesting to me was the lack of HCA conversation around anything to do with oral care. Thus, my question became, why was this the case? On day two of my observations, I began to note the HCA work practices around bowel care, as a point of comparison to the work that was occurring around oral care. As I continued to observe, I made notes on what I saw and heard around bowel care and I asked questions about bowel care during the interview process. I remember thinking how I wished oral care was given as much attention as bowel care. It was then I realized I had an opportunity to explore why, from an IE perspective, oral care may not be as important as bowel care in LTC homes. When I shared this wonder about the primacy of the focus on bowel care with one of my supervisors (S.C.), she encouraged me to delve deeper into that initial observation. Her own experience in IE and LTC settings was

instrumental in providing the foundation for the next steps in my analysis. She encouraged me to consider why bowel care would receive this type of focus in the work of HCAs and to explore the behaviors further.

While observing, there were many instances when the HCA would speak to a document or text, reference a document or make notations in a document, but I also became aware there were other documents available to the HCA that were not used or referenced. Many of these texts seemed crucial to the communication of information, or lack of, between the HCAs and the nurses. It became clear that an illustration to describe the flow of communication and utilization of these documents, between the HCAs and the nurses, would be helpful to clarify what work occurs around the provision of oral and bowel care. I began to display written textual communication and spoken communication pathways in a mapping format that was central to my analysis.

Text-Work-Text Mapping as an Analysis Strategy

A tenet of my research was to use the strategies and techniques of IE to explicate the steps taken by the HCAs to provide oral care for residents in LTC homes. Based on what I was observing, hearing in interviews and reading in texts, I created text-work-text (TWT) mappings to illustrate how oral care was socially organized in LTC homes. Smith (2005) explains how the mappings of this 'act-text-act sequence' can demonstrate the social complexities that can exist, and how texts organize action. The IE process of mapping institutions as work and texts is unlike other forms of graphical mapping of organizations or institutions. For example, the mapping does not produce an organizational structure or a workflow diagram. Instead, the analytic procedure results in an account of the text-based work and practices that produce and shape the activities of an institution (Turner, 2006). My TWT mappings were created by observing the

work of the HCAs who may not have been aware of how their regular, routine textual work contributed to the overall functioning of LTC homes and their outcomes (Turner, 2006). Additionally, because some aspects of the work of HCAs is organized to extend beyond their everyday work experiences, outside forces, people, events or organizations affect them almost invisibly (Turner, 2006). These occurrences are also included on the mappings. The TWT mapping process I undertook uncovered that which may have remained invisible and provided a textually mediated roadmap to understanding how oral care worked in the participating LTC home study sites.

The first step in the mapping process was to determine which texts should be represented in the maps with a specific emphasis on the texts that coordinated the social activities of the HCAs. My focus was to identify the texts that were used in the daily work of the HCAs. I was interested in identifying the information HCAs accessed regarding the oral health needs of the residents, where that information was stored, whether they accessed the information, how they accessed it, and finally, if they shared it and with whom was it shared. The second step was to determine whether the subsequent co-ordination of these activities influenced the process of oral care. Textual analysis and the creation of these maps, therefore, created a visual representation of how the texts were inter-connected and informed the oral care process at both LTC home study sites.

The TWT maps illustrated both unofficial and official texts. Unofficial texts were those created by the HCA as they went about their daily work; these included writing resident care details on pieces of paper they would later hand in to their nurse prior to, or during report at the end of their shift. Official texts were of two types; the first were those created by the LTC site

(institutional texts), and the second were 'boss' texts considered extralocal and created by the Winnipeg Regional Health Authority (WRHA).

It was necessary to complete three TWT maps: an oral care map for each site and one combined bowel care map representing both study sites. This approach helped me to identify the relationships between the texts and the everyday practices of oral care and bowel care for comparison purposes. I then analyzed the content of the texts included in the three TWT maps. The mapping illustrated what texts existed and what work was created from each text and who completed the work. As I was putting together the maps, I noted what I thought were areas of disjuncture and was cognisant of any differences between the oral care and bowel care maps.

While completing the mapping process, I discovered I needed more information to provide clarity around some of my findings and to validate others, so I conducted an additional three interviews. At Site 2, I re-interviewed an RN and DOC I had previously interviewed, and at Site 1, I re-interviewed an LPN. This validation process proved valuable, as I was able to 'check in' to ensure I had all the data I needed and that it was accurate. Information provided during the additional interviews confirmed the correct positioning of a particular text within the maps and confirmed accuracy of the TWT oral care and bowel care maps. The additional interviews, therefore, verified the completeness of my data collection and analysis. I completed the analysis by suggesting changes that could close the disjunctures identified in the TWT maps.

Study Rigour

Whereas many perspectives exist regarding the importance of validation in qualitative research, all would agree that demonstrating trustworthiness contributes to the validity of the research and its findings. Maxwell (2012) claims it is difficult to eliminate the influence of the researcher on the study and the 'lens' the researcher uses during the research process. Lincoln

and Guba (1985) suggest the validity or trustworthiness of a study concerns the defensibility of interpretations made by the researcher based on the collected data, and concisely describes the quality of the investigation and the evidence articulated in the findings. Creswell (2014) identifies eight possible validation strategies used by qualitative researchers; I used the following four validation approaches in my research: prolonged engagement and persistent observation in the field, rich and thick description, triangulation, and clarification of researcher bias.

Prolonged Engagement and Persistent Observation

Creswell (2014) suggests that spending a significant amount of time in the field enables the researcher to build trust with study participants and to determine what data collection is relevant to the study. My study design included observing each of the twelve HCAs, individually, during their entire shift (six HCAs in two LTC homes), which totaled almost ninety observation hours. I observed the HCAs for the entirety of their shift, beginning with report before their shift and ending with report at the end of their shift. By observing during these exchanges, I was also witness to the HCAs' between- shift conversations that occurred during shift change. These conversations, which provided data that connected the shifts, and my detailed descriptions of activity that I observed, contributed to rich and robust data. My total HCA observation time proved sufficient to gather the data required. During my notetaking at both sites, I documented when I was not seeing or hearing anything new and felt I had reached data saturation. My time engaged at the sites during my study was lengthy, towards the end of my observations, I was becoming familiar to staff and residents, all the while keeping my distance. My engagement in the field also included interviewing the HCAs I had been observing and other healthcare providers from each site. I completed twenty-one interviews varying in time from 12-

35 minutes which resulted in over six hours of transcribed data; I also spent many hours tracking down and reviewing the relevant texts I would include when describing my findings.

Rich and Thick Description

Creswell (2014) states a description is rich if it includes "abundant, interconnected details" (p.252). By spending a significant amount of time observing in the field, I became familiar with the setting of the LTC home and began to understand the setting from the standpoint of the HCA. My prolonged engagement and persistent observation facilitated my understanding of what elements were most important to be focusing on during my observations, and what was most relevant to my study of oral care in LTC. These strategies facilitated a rich detailed description. The inquiry process of the study, which included naturalistic observation, interviews, detailed fieldnotes and textual documentation also contributed to the overall rich description of my data. In addition, I completed my interviews with HCAs directly after I observed them, this provided the opportunity for me to ask questions I had highlighted in my notes during my observations, thus contributing to data detail. I also re-interviewed three healthcare providers to seek validation that my findings were accurate, contributing to the overall accuracy of my data.

Triangulation

The primary purpose of triangulation is to deepen understanding by collecting data from various sources on the same topic to create a stronger account of the research (Barusch et al., 2011). By observing and interviewing the HCAs and completing textual analysis, I was able to obtain data from three sources. Collecting data from a variety of sources provided multiple perspectives; this provided me with a more comprehensive understanding than if I had used only a single method of data collection. I also gathered data from a variety of study participants

including HCAs, LPNs, RNs and Directors of Care. Triangulation enabled cross-checking of my data and the opportunity to search for regularities that emerged from all my data sources. Resultant data similarity, from triangulating my data sources, validated my research data.

Clarification of Research Bias

To clarify my biases, it was necessary for me to be reflexive. Hammersley and Atkinson (2007) suggest reflexivity is a process by which researchers reflect on and examine their relationship with, and effect on, the study participants. Hammersley and Atkinson (2007) also suggest that researchers should not attempt to eliminate the effect of the researcher completely, but should understand the effects; thereby, identifying the researcher's position in the study. I recognize that my observations and analysis may have been influenced by my professional experience as a dental hygienist working in LTC homes. As a qualitative researcher, however, it was not desirable for me to eliminate the influence of my past experiences, but to use my previous knowledge to enhance my work. I conducted my observation and fieldwork, understanding that as long as I attempted to describe phenomena as they were and not what I perceived them to be, my previous experience would enhance the understanding of what I was seeing. Additionally, my familiarity with the LTC environment proved to be beneficial by providing a level of comfort for me as I was immersed in my work at the LTC homes. My previous knowledge offered me a sense of knowing that allowed me to focus more completely on the work of the HCAs.

As I observed, however, I was continually checking in with my previously perceived ideas to maintain as much objectivity as possible as to what I was seeing so I would portray it as accurately as possible from the standpoint of the HCA. I maintained this approach during my interviews, making sure what I was hearing was that of the interviewee and was influenced as

little as possible by my previous experiences. I also reflected on how my presence may have affected the behaviour of the study participants. During my observations, I made notes when I perceived my presence may have influenced behaviour of the HCAs.

Being reflexive and clarifying my biases contributes to the transparency, and ultimately the rigor of my study. Additionally, during the data collection phase of my research, I continued to meet monthly with my supervisors to discuss my process, these meetings also contributed to the overall transparency of my research process.

The rigor of the study could be improved through more in depth interviewing, additional study sites with different funding or operating models and increased observation time with each HCA, to increase familiarity of researcher presence and reduce reactivity to being observed that may have influenced the findings.

Chapter Three: Findings

How Oral Care Happened

TWT Maps as a Graphical Illustration of Oral Care Work

Three TWT maps were created – two for oral care and one for bowel care, as a comparison - to represent how oral care happened. After completing the bowel care mappings for both study sites it became apparent that the mappings were identical. Rather than having two identical maps, one map was completed representing both sites. The following key was used for all maps:

- circles indicate textually mediated work - the activity performed as the HCAs or LPNs do something in response to or with the texts
- squares represent texts, which exist on their own or are a result of previous work (circles)
- black lines indicate an established pathway between activities that typically occurred
- blue lines represent a mandatory quarterly review pathway required by a boss text
- broken blue lines indicate a quarterly report pathway initiated by the LPN at their discretion (not informed by a boss text)
- broken purple lines illustrate a pathway initiated by the HCA at their discretion (not informed by a boss text)
- orange lines represent an obligatory pathway completed by the HCA in response to a requirement of a boss text
- broken yellow lines represent a discretionary pathway initiated by the LPNs
- red lines indicate a mandatory regulated pathway required by an extralocal boss text
- green lines represent a pathway of boss text-informed protocol if treatment is required

Figure 3.1: Oral Care Text-Work Concept Map; Site 1

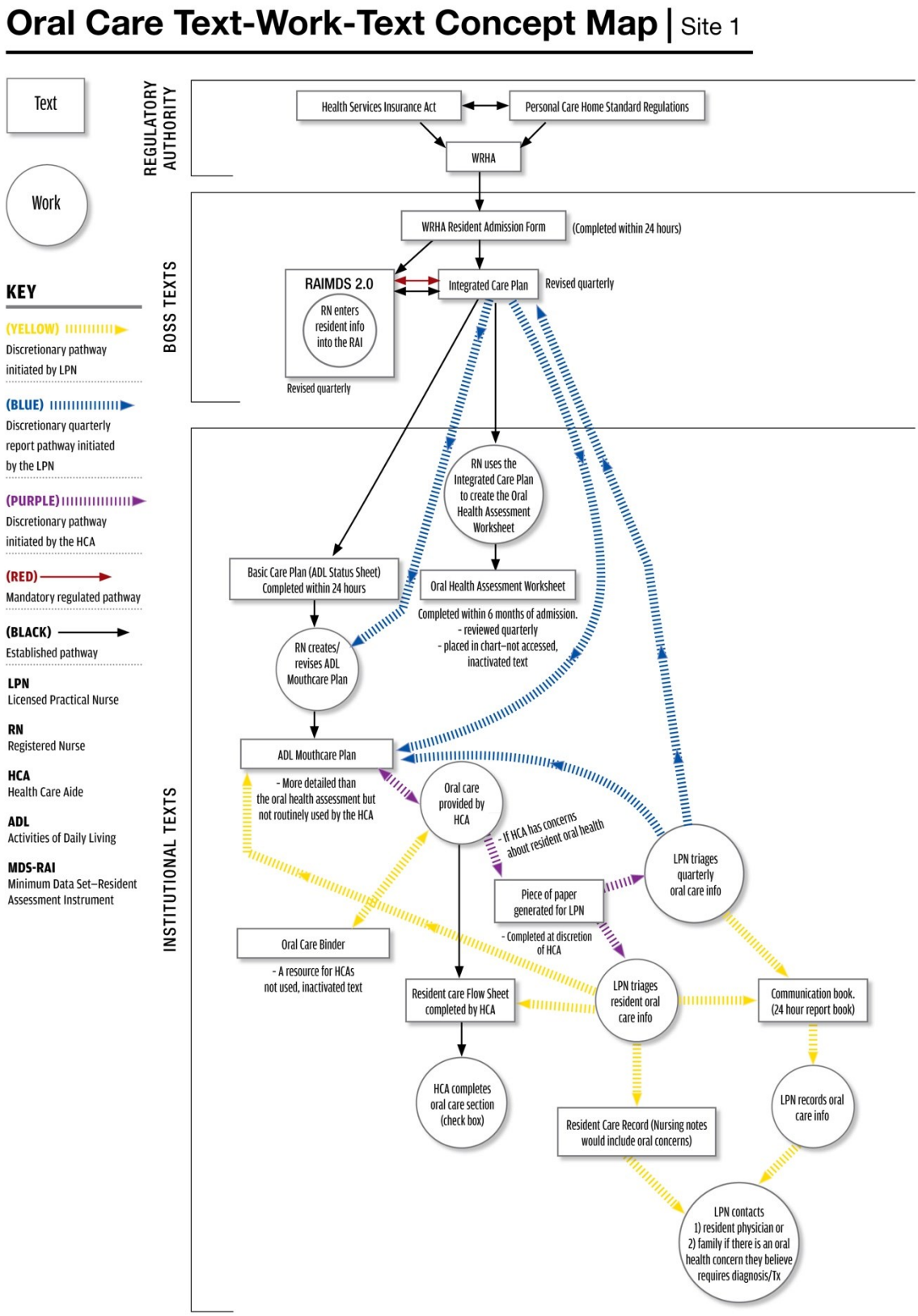


Figure 3.2: Oral Care Text-Work-Text Concept Map; Site 2

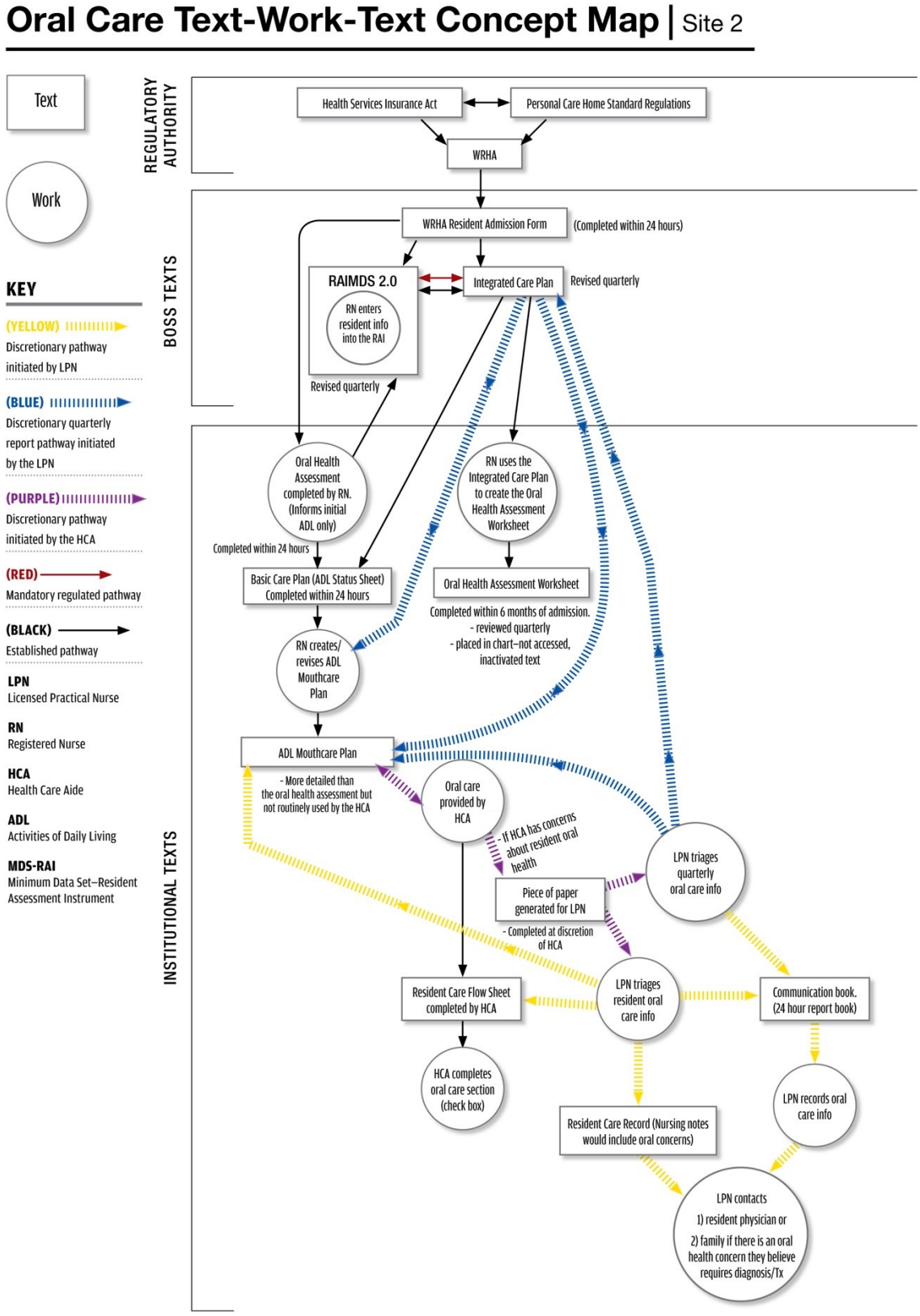
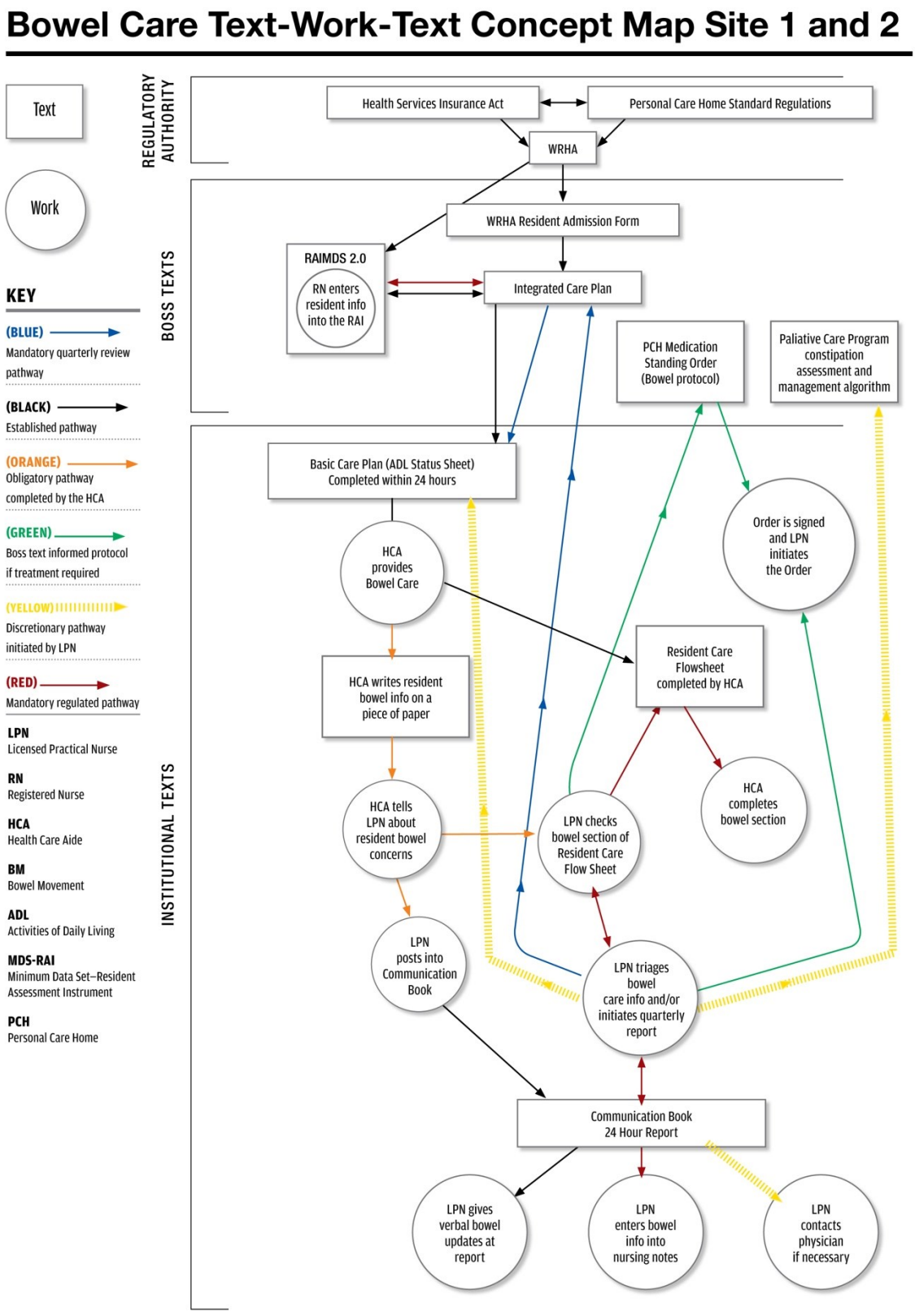


Figure 3.3: Bowel Care Text-Work-Text Concept Map; Sites 1 and 2



The resultant mapped sequences were chains of action in which the HCAs' experiences were located, bringing their activities into relation with others (Turner, 2006). Thus, the TWT maps contributed to a working knowledge of the oral care process and made visible those elements constituting oral care in LTC homes. I also identified texts that existed in the LTC homes but were inactivated and unactionable, meaning they existed but did not generate any further action or work. Because active texts organize relations within textual discourse (Smith, 2002), how and why these texts remained inactivated was instrumental to the understanding of the process of oral care in LTC homes. The inactivated texts were points of disjuncture, or gaps, which were explored to come to an understanding of why they occurred.

After completion of the Oral Care TWT maps, it was noteworthy that they were very similar at both sites. The only significant difference between the two TWT maps was the completion of a resident Oral Health Assessment by an RN within twenty-four hours of a resident admission at Site 2. This oral health assessment informed the initial ADL Status Sheet from which the ADL Mouthcare Plan was derived.

To further understand the TWT maps, it is helpful to briefly describe the boss texts and the institutional texts, specifically their origins and roles in how oral care happened in the LTC study sites. Boss texts were created to satisfy ministerial requirements of care for residents in LTC homes in the province of Manitoba. Accordingly, these boss texts carried a certain type of authority as they were created in response to these extralocal rulings; thereby, they were positioned at the top of the hierarchy of texts that existed in the LTC homes. Three boss texts that influenced oral care in my study sites were the *Resident Admission Form*, the *Resident Assessment Instrument Minimum Data Set 2.0* (*RAI)* and the *Integrated Care Plan*. These boss texts coordinated work by requiring specific people to carry out specific practices (Bisaillon,

2012). The influence of boss texts on the process of oral care in the study sites will be explicated in Chapter Four.

Institutional level texts in LTC settings were created to guide the behaviour, accountability and compliance of health care staff in the provision of resident care, as regulated by the authorities overseeing LTC homes. As I observed at both study sites, the HCAs and the LPNs recorded resident information on a variety of paper-based institutional texts. Many of the texts, once completed, were placed in a paper-based health record commonly referred to as the 'chart.' Institutional texts that coordinated the work of the HCAs around oral care are detailed in the following sections.

HCA Workday. To become familiar with the HCA's daily work activities, specifically those around oral care, I began my observations at the beginning of the HCA's workday. While observing, I was cognizant of any texts that impacted the work of the HCAs around the provision of oral care. I was also aware of texts that were present but were not activated and, therefore, did not organize the activities of the HCAs. I observed the HCAs during their entire shift. There were occasions when I noted that, as a researcher, I may have influenced the behaviour of the HCAs during their workday. For example, in one instance a resident was yelling out and rather than leaving the door to the resident's room open, which was the usual behaviour, the HCA closed it. I believe this was out of courtesy, so I did not have to deal with the disruption. In another instance, while I was observing during the morning breakfast rush, an HCA called her partner to look for toothpaste for a resident who did not have any in his room. I believe my presence likely influenced this behaviour. Additionally, towards the end of my days of observation, the staff and residents became increasingly familiar with my presence, assimilating me into their environment. Both the HCAs and residents began asking me questions to assist

them in their daily routine. For example, an HCA asked me if I knew where Mr. (X) was and in another instance a resident told me he was "ready to go outside now."

Both day and evening shifts began with a meeting of the HCAs and their supervising LPN along with the LPN or RN from the previous shift. This meeting was referred to as 'report,' during which the HCAs were given resident health information for their upcoming shift. Reporting times were similar at both of the study sites, lasting approximately five to ten minutes. Day shift for the HCAs started at 7:00 a.m. at both sites and at Site 1 it ended at 3:00 p.m. and at Site 2 it ended at 2:30 p.m. The evening shift hours for the HCAs were the same at both sites, beginning at 3:00 p.m. and finishing at 11:00 p.m.

Day Shift Report. The HCAs at both sites began their day shift by meeting with the RN from the night shift. The RN conducted report by updating the incoming HCAs and LPN on all aspects of resident health care needs over the past 24 hours and specifically during the previous shift. For example, if there was an issue regarding the oral health of a resident, the information would be communicated to the incoming shift during report. Interestingly, during my observations over eight weeks at both sites, no resident oral health concerns or information were brought forward during the day shift report. It may be that there were no oral concerns reported because none existed, or it may be oral care concerns were identified but not reported. Conversely, resident bowel care information was reported frequently.

After observing a number of beginning of shift reports, I noted there were differences in the formality of reporting between the two study sites. The atmosphere of report at Site 1 was casual, and many HCAs did not seem engaged in the process; some were looking at their phones or having side conversations with others. Site 1 report began with an HCA reading scripture from the Bible followed by the LPN providing updates on resident care. Some HCAs walked in late,

often sitting outside the meeting room because there were not enough chairs for everyone inside. Occasionally, I also had to sit outside the room and found it difficult to hear the LPN or RN reporting from inside the room.

While the process of report at Site 2 was similar, the experience was more formalized. For instance, background conversations between the HCAs did not occur when the LPN was presenting their report and the staff seemed generally more engaged. A recent policy prohibited the use of cell phones while on shift except to take a picture of a wound; consequently, I did not observe staff using cellphones during report at Site 2.

At both sites, information deemed pertinent by the RN was provided orally; it typically addressed the residents' status over the previous 24 hours and gave specific details regarding their care needs for the upcoming shift (e.g., bowel care, appointments and preparations for laboratory testing). The RN read notes from the *24-Hour Report Book*, which was a paper-based institutional text where resident health information had been recorded during their shift. Bath and bowel lists, which detailed a bathing schedule and outlined which residents required bowel care intervention for the upcoming shift, were also reported. Report always seemed to be rushed, with the RN only mentioning the most serious resident concerns. The reporting was unidirectional, for example, the RN did all the talking with no provision for questions from the incoming staff. Accordingly, I did not observe the HCAs ask questions about the RN's report. When report was finished, the HCAs left, hurrying to begin work. Only as they began their shift, re-stocking their carts with fresh linen and personal care items, did they have an opportunity to speak among themselves about resident care.

Evening Shift Report. The format of the evening shift report was similar to the day shift report, except the evening reporting was more casual and was not reported with the same

urgency. During the day shift report, the HCAs rarely had time to share their concerns regarding the residents, but because the evening shift report was relatively less rushed, the opportunity for two-way communication did occur, resulting in some dialogue between the LPN and the HCAs and between the HCAs themselves. However, I did not observe any sharing of information about oral care of residents during the evening shift report. Additionally, when the evening report was finished, the HCAs did not seem in a hurry to start work. This was in contrast to the day shift HCAs, who began their shift right away by awakening residents for breakfast. The evening HCAs were not required to complete a specific task at the start of their workday; instead, they began their shift by visiting with residents and restocking the carts with resident personal care items.

Oral Care: What, how and when

On both the day and evening shifts, the HCAs completed oral care for residents early on in their shift. One of the first tasks for the day shift HCAs was to wake residents and provide morning care for ADLs, including oral care. After the evening meal, the evening shift HCAs prepared residents for bed and completed tooth-brushing along with the other ADL grooming tasks. While observing, I soon became aware that the HCAs considered oral care and tooth-brushing to be synonymous. Appropriate oral care should include other procedures such as flossing, tongue brushing and interdental cleaning, but I did not observe these practices in the LTC study sites. Interestingly, a key institutional text, the pictorial *ADL Mouthcare Plan*, located in the bathrooms of both LTC homes, states that oral care "equals teeth, gums and tongue" (see Appendix D), and lists several interdental cleaning items to use for care. The impact of this institutional text on the work of the HCAs is discussed in detail later in this chapter.

Tooth-brushing was either completed by the resident, the HCA or a combination of both, depending on the resident's ability to complete the task. Denture care, which included brushing, soaking and rinsing dentures, was most often completed by the HCA and not by the resident. I did not observe the LPNs to be involved in daily oral care of the residents.

The day shift HCAs completed whatever tooth-brushing or denture care they could fit in before taking residents to the dining room for breakfast. Most often the HCAs were rushed for time in the morning, and oral care was difficult for the HCAs to complete with the rest of their morning ADL care. The HCAs had a limited amount of time allotted to them by the LTC home administration for waking and readying residents for breakfast. For example, the HCAs began waking residents for breakfast shortly after 7 a.m. and were expected to have their eight to ten residents in the dining room for breakfast between 8:00 a.m. and 8:15 a.m. Accordingly, the HCAs would have, on average, seven minutes per resident to get them to the dining room for breakfast. Some residents, of course, required more assistance than others, and HCAs may not have had adequate time to provide the assistance.

Because they had limited time, HCAs found alternative ways to provide oral care, such as doing oral care while the residents were sitting on the toilet. Further, tooth-brushing was sometimes completed at bedside or in a wheelchair away from the sink. These behaviors were observed at both study sites. One HCA provided her rationale for tooth-brushing while the residents were sitting on the toilet.

Interviewer: *Oh, I have another question. So oral care is generally done as you said in the morning but do you ever do mouth care when they're toileting or when they're bathing? Is there any other opportunities?*

HCA 2-4: *There is a few people that it is easier to get it done while they're using the washroom. We do it for them while they're in there. I've never had to give anybody mouth care while they're having the*

bath. Yeah, sometimes it's just easier if it's somebody that's going to be sitting on the toilet for10 minutes, it's kind of hard for us to wait for them to get off before we can get to their mouth care and washing their face.

When I interviewed the ADOC at Site 1, she confirmed that while brushing residents' teeth while they sat on the toilet was not an ideal practice, it was a timesaving measure the HCAs had initiated to get the tooth-brushing done before breakfast.

Interviewer: *So oral care when the residents are on the toilet, is that something healthcare aides have created?*

HCP1-1: *To do at the same time, yeah. There are time constraints, that's what they say to me. Okay, so while they're sitting [on the toilet], so you do the same time, you do it with them. Ideally, it's not right, especially demented residents……We keep on reminding them but of course, they said, "We don't have time we don't have time."*

Additionally, there appeared to be ambiguity among the HCAs as to when tooth-brushing should be provided. Some HCAs stated it should be completed in the morning and evening and other HCAs maintained it was exclusively a morning task. All the HCAs I interviewed, regardless of the shift worked, agreed that at a minimum, resident tooth-brushing should occur in the morning before breakfast. One HCA simply stated; "*we do it before breakfast" (HCA 1-6).* Other HCAs had differing opinions:

HCA 1-4: *So we brush her teeth before she goes to breakfast. So done for the day and the next one is evening time.*

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Interviewer: *Okay, so when you can do oral care, to someone you can, when does it happen?*

HCA 2-2: *Like it's not every day.*

Interviewer: *But in a day, would it be in the morning, night?*

HCA 2-2: *In the morning, just always in the morning. After they get up, you just do some work.*

Interestingly, during my observations and interviews I heard several times how the day shift HCAs were upset about what they perceived to be a lack of proper oral care provided during the evening shift. For example, one HCA believed tooth-brushing and denture care were often overlooked before residents went to bed. Accordingly, she voiced her concerns when she was getting a resident up in the morning: *"She has an upper denture only; don't think the denture was done" (HCA 2-6).* Another HCA shared her frustration with the lack of oral care competed during the evening shift:

> *HCA 2-4:* *During the day, I try to get it done as much as I can and it's not very pretty. Some of them, the way I find their mouths is just, it's horrible and just thinking about it that people can leave these people with their dentures in all night or not brushing their teeth, they have food from the previous night. It's not pretty.*

It was clear based on the observations and interviews that HCAs were consistently providing oral care in the morning before breakfast, but that they were uncertain if oral care should occur at night, if it was actually being provided, and the best way to assist residents with it. I paid careful attention to the work of the HCAs to determine if they were accessing a guiding document or text that was influencing how and when they brushed residents' teeth. As a result, I located the institutional text titled *the ADL Mouthcare Plan* (see Appendix D), which identified recommended mouth care products and general procedures for each resident. This institutional text was designed by the RNs at both my study sites as a resource for the HCAs. Further exploration determined that the *ADL Mouthcare Plan* was adapted from a form used by the University of Manitoba School of Dental Hygiene at their Center for Community Oral Health. A review of this text established that the *ADL Mouthcare Plan* did not specify a time for oral care, only that oral care was to be completed twice daily. Thus, the HCAs did not refer to this text for guidance on *when* during the morning shift to brush residents' teeth and seemed to rely on their

own experiences and understanding to determine that residents' teeth should be brushed before breakfast.

To summarize, oral care for residents consisted of tooth-brushing and denture care. When the HCAs were able to complete tooth-brushing, they did it before breakfast and after the evening meal. The morning shift HCAs seemed rushed as they prepared residents for breakfast; as a result, they found creative ways to get brushing done while completing other ADL tasks such as toileting. The *ADL Mouthcare Plan* was an institutional text designed to inform the work of the HCAs around the provision of oral care. Because the *ADL Mouthcare Plan* was an institutional text specifically designed to provide resident oral care information for HCAs, it is worthy of exploration and explanation about where it fits within the TWT mapping and its impact on the oral care process, along with other institutional texts.

ADL Mouthcare Plan

The *ADL Mouthcare Plan* was potentially the first text related to oral care that an HCA could access during their shift to provide guidance on resident-specific oral care requirements. The *ADL Mouthcare Plan* was created from the *ADL Status Sheet or Basic Care Plan* (see Figures 3.1 & 3.2) by an RN and was located in the bathroom of each resident. At Site 1 it was located inside the bathroom vanity mirror and at Site 2 it was located on the outside of the vanity mirror. The *ADL Mouth Care Plan* is a pictorial chart illustrating oral care products and outlining the various dentate scenarios and general oral care procedures. (See Appendix D). Missing from the ADL Mouthcare Plan was *when* to provide the care and the level of assistance the resident required in oral care. Further, my observations indicate that despite the *ADL Mouthcare Plan* and being prominently displayed in the residents' washrooms, few HCAs referred to the Plan for

guidance when providing oral care for their residents. Two HCAs described why they did not use the *ADL Mouthcare Plan* to inform their work:

Interviewer: *So, I noticed that you have your oral care ADL sheet on one side of the mirror. Do you find it useful? Do you access it? Tell me about that sheet.*

HCA 1-5: *But it's not readily—it is there but it's a time crunch still, you're having to do several people, get to it. But once you're in a routine and know the residents, you got it down pat, you know. So you can go through your day, you don't have to do that every day. You got it.*

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Interviewer: *Okay. So I notice like inside the washroom, there's the ADL sheet and it has the pictorial sheet for oral care. Is it useful or is it used? Talk to me about that.*

HCA 2-4: *We are told when we start here that that's there honestly. I don't think it's used as much as it should be because I don't think a lot people do—like it's so hard to find the time because we only have about an hour to get 20 people out of the bed. So to spend those extra minutes, it's hard to have everybody out for breakfast.*

The HCAs did, however, describe two situations where the *ADL Mouthcare Plan* could be useful for the HCAs. They described how part-time staff could find the *ADL Mouthcare Plan* useful and, secondly, that it was helpful when oral care was provided to a resident for the first time.

Interviewer: *Do you find those sheets that are on the inside of the cabinet in the washroom, the [oral] healthcare sheets, useful?*

HCA 1-3: *Yes, maybe for the one like part-timer, they're not used to resident, they just—but us, we know, I'm 20 years already. I don't look to that anymore.*

Interviewer: *Oh, that's good. So when the resident first comes to live here, how do you know what oral care is required for them?*

HCA 1-3: *They put that-we open the cabinet in the washroom, it's in there. Whatever the mouth care, it's their partial, full dentures, like this*

one is only two thirds. It's everything within there. So if new in the facility, they will look in the cabinet.

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Interviewer: *So, the ADL sheet that's on the inside, there's pictures of oral care. Do you find them useful or do you use them?*

HCA 2-5: *We look at them. Say if it is a resident I don't know, I'm going to have a quick look at it to see what kind of care needs to be done on that person. A lot of times, you'll talk to them, you ask them what they need. If you can't, then that's when you go to that.*

Thus, when residents or staff were new, then the HCAs indicated they referred to the *ADL Mouthcare Plan* to inform their work and the text was activated when oral care was provided for the resident (see Figures 3.1 & 3.2). In most cases, however, the *ADL Mouthcare Plan* was generally underutilized by the HCAs; in IE terminology, it was an 'inactivated' text. An activated text would be one that organizes or causes social action, such as initiating the provision of oral care for residents by the HCAs. Because the *ADL Mouthcare Plan* was not used often to coordinate the social organization around oral care, standardized textual work practices around the provision of oral care did not occur. This resulted in a gap or disjuncture; the text was created to inform the work of the HCAs by providing resident oral care information, but in most cases the HCAs did not use it or did not find it useful. This inactivated text calls to question whether the context of the text provided the necessary information for HCAs to provide effective oral care for residents**.**

Resident Care Flow Sheet

The Resident Care Flow Sheet was another institutional text designed by the LTC home to monitor compliance with and ensure accountability for resident care by the HCAs (see Appendix E). It comprised a grid format with the residents' room numbers and all the ADLs listed, including hygiene assistance, bowel and bladder, pain, skin condition, nutritional intake,

sleep pattern, and oral care. HCAs had to check a box to indicate that they had performed ADL care in those categories for each resident on their shift. They indicated with a check mark, C for completed, R for refused or N/A for not applicable. In addition to the check box, there was a small space on the form to provide additional comments under the Oral Care category. The flowsheets were the same at both sites, except that at Site 2, oral health was separated into an Oral Care and Dentures category and there was no space to write additional comments. During my observations, in almost all cases the oral care boxes were checked off as completed for each resident.

The DOC at Site 2 acknowledged that the checkbox format of the oral care section of the *Resident Care Flowsheet* was not ideal:

> *Interviewer:* *Yeah, it's more vital. It's, you know…a shave is an appearance but oral care is a health issue.*
>
> *HCP 2-2:* *Yeah, I would agree with that. We have to sign off on the sheet, that it's done. [oral care] But it's just a checkmark [approach]*

Still, the checkbox indicated accountability with oral care. Unlike the *ADL Mouthcare Plan,* which was a read-only text, the *Resident Care Flowsheet* required the HCAs to interact with it. *The Resident Care Flowsheet*, therefore, was an institutional text that was activated by the HCAs, thereby contributing to the text-work-text coordination of oral care in the LTC home. By completing the routine textual work of checking off the oral care boxes, the HCAs were contributing to subsequent and ongoing activities of the LTC home. For example, a nurse could refer to the completed oral care section of the *Resident Care Flowsheet* to see if a resident was continually refusing oral care. During my observations, I did not observe a nurse accessing the binder containing the *Resident Care Flowsheets,* but I was informed by an HCA on day shift that this could occur. Thus, this possible pathway is illustrated on my TWT map by a broken yellow

arrow as a pathway that could exist. Interestingly, the HCAs at Site 1 referred to the *Resident Care Flowsheet* binder, in which they documented resident care related to all the activities of daily living, as the "Bowel Care" binder. This finding seemed to corroborate previous observations that bowel conversations and resident bowel health were top of mind for the HCAs.

In summary, the *Resident Care Flowsheet* was an activated text, yet it was not effective in guiding oral care for residents. The checkbox configuration, with only minimal to no space for qualitative information about oral care provision, was insufficient to result in organization interaction that was textually mediated. Instead, any information that the HCAs needed to communicate to their LPN was through informal interaction on pieces of paper or via spoken exchange. This is another example of how the HCAs were left to making decisions on resident oral care without textual guidance.

Left to Their Own Devices

When I listened to conversations HCAs had with residents when providing oral care, it seemed that the information and values that HCAs had internalized about their own oral health influenced how they provided oral care for others. For example, two HCAs reflected on what they considered good oral care and rationalized this approach would also be appropriate for residents:

> *HCA 1-4:* *Something like—you do to yourself too. So what you require for yourself, it's your thinking, they need it too. So if I did it twice a day; they need it twice a day. Some other people need more but we cannot do it here more. So at least twice a day is good enough. So once[for] us for the day staff and one for the evening staff before they go to bed. So that's basically the oral care requirement for practice.*
>
> ******
>
> *HCA 2-4:* *I kind of try to think about it if it was my mom or even myself. I don't like going to bed without brushing my teeth. I don't like waking up with stinky breath. Same for them. They might not be*

able to remember to do it themselves but they need somebody to help them and that's why we're here.

Another HCA explained the importance of oral care and how residents should receive the same oral care as she provides to herself:

Interviewer: *So help me understand what oral care looks like here at [Site 1]?*

HCA 1-5: *Oral care is mostly done in the morning…So yeah, important, very important and I think that I always try to tell people that I could not go brushing my teeth. So I don't think a resident should go without brushing their teeth or taking care of gums because their response is, "Oh, that feels better." So it's a good thing and I know it's related to a lot of diseases if you don't do the mouth care. So it's important.*

Interviews with the HCAs clearly demonstrated how they relied on personal experience to provide oral care to their residents. Additionally, the HCAs reported that their formal oral care training was minimal. One HCA provided insight on her oral care education:

Interviewer: *Okay. So when you're in school, did you get much on oral care in terms of your training?*

HCA 2-4: *I think that was one of the shortest that we've learned. We had a set of so that our teacher gave us with a toothbrush and pretty much I'd brushed them. "Let's see how you do it." She said, "That's it." That was pretty much it.*

Interviewer: *So nothing on teeth.*

HCA 2-4: *Not really. It's just like brushing your own, she would say. You want breath, make sure you give them fresh breath as well, which is good but we didn't have a great big session on why oral care is important.*

I observed HCAs providing oral care for their residents using a variety of methods and routines and wondered if the absence of textual guidance required the HCAs to 'figure it out on their own.' For example, the ways in which the HCAs set up for and provided tooth-brushing varied. Tooth-brushing was either completed by the resident independently or assistance was

provided by the HCA. Typically, the HCA would set up the toothbrush and toothpaste then leave the room and return to assist with brushing if the resident was unable to finish brushing before going to breakfast. At other times, the resident would be handed the toothbrush with toothpaste while sitting on the toilet or in their wheelchair, but the resident did not do anything with the brush, so it was later rinsed and put away by the HCA when they returned to the room. If this was the case, the HCA would sometimes put it away without making any comment to the resident; in other instances, the HCA mentioned they would do tooth-brushing later. As previously mentioned, I did not observe other forms of oral care—such as flossing or interdental cleaning—being performed by residents or by HCAs, despite these procedures being listed on the *ADL Mouthcare Plan* as part of oral care at both study sites.

Observing the different tooth-brushing and denture care practices provided by the HCAs at both sites on both day and evening shifts raised the question of the guidance provided to the HCAs on how oral care should occur. It was clear the HCAs were not referencing an institutional text, such as the *ADL Mouthcare Plan*, to access proper procedure but were figuring out on their own how best to provide oral care for their residents.

At this point, it is important to clarify that my background as a dental hygienist assisted with the following observation. The HCAs helped residents in various ways with their tooth-brushing; sometimes the process was effective, and brushing did occur. Other times, as mentioned above, tooth-brushing was never completed. As I observed, I wondered how the HCAs knew whether the residents should or should not be assisted with tooth-brushing.

Independent for oral care?

To determine how the HCAs knew which residents were identified as independent for providing their own oral care, I reviewed the texts that referenced oral care. I identified two texts - the *ADL Mouthcare Plan* and the *Resident Care Flow Sheet* - and checked if information on the resident's level of independence was specified. As discussed previously, the *ADL Mouthcare Plan* was the text most specific for HCA guidance on oral care. Upon inspection, however, the *ADL Mouthcare Plan* only clarified whether the resident had teeth and/or dentures and provided suggested products to use while providing mouthcare. Guidance on *how* to provide the care was limited to "set-up, cue and observe," with no mention as to whether the resident was capable of brushing their own teeth or was unable to brush without assistance (see Appendix D).

In contrast, the *Resident Care Flowsheet* did have a checkbox for 'independent' located in the *Oral Care* section, but it did not provide textual guidance for the HCAs. For example, no information on the independence level of the resident was provided on the form. It was the HCA who checked the box if they thought the resident was independent for oral care and determined the level of assistance, if any, a resident needed with oral care. Consequently, oral care was limited to toothbrushing and denture care, and provided with various levels of assistance and variable degrees of success.

Furthermore, because resident independence for ADLs influenced how the HCAs provided care, I looked to another institutional text that described levels of independence for ADLs. This text was called the *ADL Status Sheet* or *Basic Care Plan* (see Appendix F). This form was created from the *Integrated Care Plan*, which is a boss text that will be described in greater detail in Chapter 4. An LPN completes the *ADL Status Sheet* for each resident by complying with requirements specified in the *Integrated Care Plan*. For example, the *Integrated*

Care Plan requires that the level of assistance for oral care be specified for each resident. Accordingly, under the oral care section of the *ADL Status Sheet* there is a space for the LPN to check "independent," "partial assist," or "total assist." This finding called into question why, if the descriptions of assistance were listed on the *ADL Status Sheet*, they were not transferred and similarly listed on the *ADL Mouthcare Plan*. Additionally, the HCAs did not access the *ADL Status Sheet* to determine the level of assistance required when providing oral care for their residents because the *ADL Status Sheets* were stored in the residents' paper charts, which were not easily accessible to the HCAs. If HCAs were looking for guidance on a resident's level of assistance for oral care, they would refer to the *ADL Mouthcare Plan* located in each resident's bathroom, where this information was not provided.

It is well understood that the central tenet of LTC home care is to promote resident independence whenever possible. Boelsma et al., (2014) explains that optimizing opportunities for people to be independent in care homes is considered very important. Accordingly, with no textual guidance specifying resident dependence for oral care, the HCAs were often observed to encourage residents to brush independently with no assistance. Again, I acknowledge that my experience as a dental hygienist has contributed to my observations that in many cases this approach was inappropriate, as the resident was clearly unable to brush effectively because of cognitive or motor impairments, or both. These observations prompted me to look further into how a change in resident independence level and other oral health concerns were communicated between the HCAs and their supervising LPN.

Reporting Resident Oral Health Status - When and What to Report

While there was no exchange of oral care information between the HCAs and the LPNs during my onsite visits at either study site, the HCAs reported if they had any resident oral health

information to report to their supervising LPN, they would give it orally or write it on a 5x5 inch piece of paper. The HCAs explained that before they started their shift, they would take a few pieces of the squares of paper from the chart room and put them in the pocket of their scrubs to make notes during their shift. It was interesting to learn that no formal reporting process was in place for the HCAs to report oral health concerns; the onus was on the HCA to use these recycled pieces of paper, using a process that they created in the absence of an institutional text to guide them. Some HCAs said they would then submit their piece of paper with notes during *report* at the end of their shift and other HCAs said they would speak to their supervising LPN at some point during their shift either reporting from memory or from their piece of paper. In this scenario described above, the HCAs would use their discretion as to what, how and when to report oral health concerns. This discretionary communication pathway is illustrated in Figures 3.1 & 3.2 by broken purple lines.

Accordingly, I then wondered if the HCAs evaluated changes in resident dependency for oral care and reported these changes to the LPNs. Zvěřová (2019), reminds us that over time, the dependency needs of residents living in LTC typically increase. Consequently, it would be important to monitor the ability of residents to provide oral selfcare. For example, monitoring resident tooth-brushing effectiveness would be an important observation that could impact subsequent oral care practices. Ideally, any changes in a resident's dependence for oral care would trigger changes to the *ADL Mouthcare Plan*, which in turn, should inform how the HCAs provided oral care for their residents (see Figures 3.1& 3.2).

This scenario, however, illustrates a disquiet; resident dependency level for oral care was not provided on the *ADL Mouthcare Plan*, so HCAs did not have this information to assist them when providing oral care. Because there is a gap in the information available to the HCAs, the

HCAs are left to fill that gap and figure out how to best provide oral care for their residents. Smith (2005) would describe this situation as a 'disquiet' between the experiences of the HCA and the institutional expectations.

In summary, the HCAs used their discretion to identify and report resident oral health changes or concerns to their supervising LPN. As previously demonstrated, despite receiving minimal formal education on oral care for residents, HCAs were responsible for recognizing resident oral health problems and reporting them. The LPN would then determine if any further action or reporting was required.

The Role of the LPN

Every quarter, at both study sites, the LPNs were responsible for generating quarterly reports to update the *RAI MDS 2.0.* The impact of this boss text on resident oral health will be described more completely in Chapter 4. To inform this quarterly update, it was typical practice for the LPN to reach out to the HCAs to provide them with resident health status changes and, if there were any resident oral health concerns, these would also be included in the information provided by the HCAs. It was common for the HCAs to provide these updates in a spoken report, relying on memory or on notes they made on pieces of paper. One HCA describes how the nurses ask the HCAs for resident health information to inform their quarterly reporting:

HCA 1-5: *No, they come and ask. The nurses come and ask us. "How they're doing, what's this?" So we update them. If we inform them ahead of time, they'll update that information as soon as we tell them. And then if they're doing it at that specific time, then they'll come and ask us, "Is this still updated? Is this what we're doing?" Yes, yes, no and they'll update it. But I try to let them know when it needs to be changed.*

Interviewer: *So if they had any new information that they were going to put on there they'd put it on there too and let you know?*

HCA 1-5: *Yeah, mostly they come to us to ask us. The nurses, they give*

> *meds and that's fine but we're doing the care. So they'll come and ask us. So it's pretty good.*

At this point, I wondered what reported oral health information the LPN would use from the information provided to them by the HCAs. In essence, my textual analysis did not reveal a guiding document that outlined protocol or standardized procedures for reporting oral health concerns or when a referral to an oral health professional was indicated.

In addition to including oral health changes in a quarterly report, the LPN could manually enter changes onto the *ADL Mouthcare Plan* in response to any new information provided by the HCAs in between the quarterly reports. The LPN would initial these changes on the *ADL Mouthcare Plan* and then type them into an updated *ADL Mouthcare Plan* at the time of the quarterly review (See Figures 3.1 & 3.2). One LPN describes her dependency on the HCAs for providing changes in resident oral health:

> *HCP 2-3:* *...I find that healthcare aides on my unit are pretty good at reporting any changes or you know, they notice anything wrong with the mouth and that. They're pretty good at reporting that kind of stuff and usually stay on top of it.*

The Oral Care Referral

The oral care referral was a process initiated by the HCA. As previously discussed, the decision to report a concern about a resident's oral health to their supervising LPN was left to the discretion of the HCA. Interestingly, the HCAs said that frequently they did not commit their referral notes to paper but instead would orally share their concerns with the LPN. In this example, the referral process for oral health issues would not be a textually mediated activity and the referral, if created, would be a result of informal communication between the HCA and the LPN.

Additionally, textual analysis did not uncover a guide or chart that outlined unhealthy oral conditions that would trigger the need for the HCA to report an oral health concern to their supervising LPN. Interviews with the HCAs demonstrated how they decided how to report resident oral concerns:

Interviewer: *So do you have any written criteria or items that would be flags for you around oral care in order to report.*

HCA 2-3: *I think it's kind of common sense. Some people like they will brush their teeth for a while and then all of a sudden, you're noticing they're not brushing their teeth. Okay, well, that's obviously something or their gums are bleeding. There's nothing really specific.*

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HCA 1-6: *Okay, if we have a concern like let's say the resident is it's hard or you can see that during like this, maybe they're in pain. So we will ask the nurse to assess.*

Similarly, the LPN's decision to refer a reported resident oral health concern is left to their discretion. Based on information provided to them by the HCA, the LPN could choose to initiate the referral process. The LPN may contact the resident physician to request the resident be seen the next time the physician was onsite, or the LPN could contact the resident's family member who would then be responsible for arranging dental care. This scenario is graphically depicted by broken yellow lines in Figures 3.1 & 3.2. When interviewed, one LPN explained how she would make a referral:

Interviewer: *And so if you saw something that was not quite right, then what's your next step?*

HCP 1-3: *First, I will go directly to the healthcare aide and tell them that they're not doing it properly or something and if there's some concern, inform I mean we consult the dentist, inform the family. That's the priority. They have to know what's the issues. We refer to dentist.*

This response by the LPN indicates the inclination was to first question the care practices of the HCA before considering referring for an oral care issue. I believe the response of the LPN to the HCA, in this instance, would influence the HCA's decisions about reporting future oral health concerns for referral. An oral care referral does not exist as a requirement of extralocal rulings but is a textually mediated pathway that could be activated at the discretion of the LPN if an HCA communicated a resident oral health concern on a 5x5 piece of paper or orally and more informally. Smith (2006) reminds us that a text has no force unless it is activated; thus, for the referral to occur, the LPN would have to follow through with action after receiving the piece of paper to activate the referral process. The actions of the LPN, therefore, are pivotal to the referral process. Furthermore, if an LPN made a referral regarding an oral health concern, the decision would not be based on protocol or guidelines in a boss or institutional text. Figures 3.1 & 3.2 illustrate, with broken yellow lines, the pathways of discretionary oral care decision-making by the LPN. Interestingly, this referral pathway was very different from the sequence of TWT activities that occur when an HCA reports a resident bowel issue to an LPN. At this juncture, I think it is particularly useful to compare the mostly absent textually mediated pathway of an oral health referral to that of the TWT pathway that exists for a referral for bowel concerns.

The Bowel Care Referral—An Effective, Textually Mediated Pathway

In contrast to the reporting of oral health concerns, the reporting of bowel concerns was well established (see Figure 3.3). Observing the HCAs and their work around bowel care provided a lens by which I was able to compare and contrast the social processes that influence both oral care and bowel care. Comparing bowel and oral care exemplified how institutional processes, mediated by texts, could affect the outcome of oral care in LTC homes.

The HCAs often spoke among themselves about the bowel care requirements of their residents and reported it was important to check the bowel list at the beginning of every shift, so they knew which residents required bowel care and what type of care they required. In addition, there was a 'bath and bowel binder' where HCAs would complete forms providing detailed bowel regularity information for each resident and initial alongside the resident's name when a bath was completed. Subsequent to this finding, I questioned if there was a binder for oral care, but there was not.

Bowel irregularity was understood by the HCAs and LPNs to be a problem that required referral, because constipation could lead to a significant health concern for the resident. One LPN described how she prioritized bowel care:

Interviewer: *Knowing what happens around oral care and knowing now what happens around bowel care, there's, to me there seems to be a clear prioritization around bowel care*

HCP 2-2: *Yeah, oh yeah*.

Interviewer: *more than oral care?*

HCP 2-2: *Yeah.*

Interviewer: *Why do you think that is?*

HCP 2-2: *Because even you, if you don't have your bowel movement after certain days, you start to get sick and you start to puke, you can't eat … and obstructure comes, sets in. So, we have to monitor all that, because it affects your health.*

As an IE researcher, it was necessary to investigate, beyond observing and interviewing, by searching for data that would explicate my findings. This search resulted in locating missing organizational details such as additional documents or texts. Accordingly, I located a boss text that influenced the work of the LPNs and HCAs around bowel management. The *Medication Standing Orders* boss text was developed by the Winnipeg Regional Health Authority (WRHA;

see Figure 3.3) and outlined bowel care for residents based on a bowel protocol designed to be more invasive the longer the resident goes without a bowel movement (see Appendix G). The HCAs were aware of the step-by-step protocol and communicated resident bowel concerns to their supervising LPN using established, textually mediated procedures. For example, at Site 1 an HCA reported bowel constipation to the supervising LPN that included a timeframe identified in protocol for resident bowel care:

HCA 1-3: *Something is stuck, it has been three days….*

The LPN replied that she would give that [resident] some prune juice. Accordingly, the LPN poured a glass of prune juice and spoke to the resident:

HCP 1-2: *I have mixed something for you, and you know any exercise will help your bowels.*

Interestingly, the LPN not only provided the prune juice intervention, but proactively educated the resident by suggesting that exercise would help reduce constipation. This dialogue, which included a prevention component, was intriguing so I again searched for texts that would explain the LPN's approach to bowel care management. Accordingly, I found a WRHA boss text titled *Palliative Care Program Constipation Assessment and Management Algorithm.* This text detailed preventive measures to mitigate constipation and one of the recommendations was to "encourage mobility and activity if possible." The LPN's response of requesting the resident to exercise, therefore, was textually mediated as she was referencing the text that outlined bowel management. Thus, the activation of the *Palliative Care Program Constipation Assessment and Management Algorithm* boss text made visible the LPN's choice to suggest exercise as a preventative measure to mitigate constipation in addition to providing the prune juice intervention.

If a resident was not responsive to the interventions listed on the *Medication Standing Orders* text, the LPN referred the resident to their physician for further treatment. The LPN would then be responsible for documenting the referral in the *24-hour Communications Book* and the *Nurse's Notes*. During shift report, the LPN would also provide an oral update as to the bowel status of the resident and whether the resident had been referred to the physician or hospitalized. This TWT pathway is illustrated in Figure 3.3 by a solid green line, reflecting a referral pathway that is informed by the boss texts *(i.e., Medication Standing Orders* and the *Palliative Care Program Constipation Assessment and Management Algorithm).* Unlike the oral care referral TWT pathway, the referral for a bowel issue was a well-understood, textually mediated process activated by the HCAs and the LPNs.

In summary, the bowel referral process was textually mediated by both boss and institutional texts and these were utilized effectively by HCAs and LPNs. The oral care referral process was not informed by either boss or institutional texts. Consequently, for an oral care referral to occur, the HCAs and the LPNs used their discretion as to whether to initiate a textually mediated referral.

Chapter Four: Boss Texts Influencing Oral Care in LTC Homes

Much of the HCA's work around the provision of oral care was influenced by texts which were visible and identifiable in their everyday work. Dorothy Smith (1990) explains, however, that there are complex, formal rules that are present within an organization; these rules affect work experiences and activities and are not visible and may not be fully known or understood by the individuals who work there. It was necessary, therefore, to go beyond the institutional texts that were immediately observable (i.e., the *ADL Mouthcare Plan* and the *Resident Care Flowsheet)* and identify the boss texts: those texts that were external to the everyday lives of the HCAs and LPNs but nevertheless influenced their work.

In this study, these boss texts included regulations and standards of practice, each exerting a force from outside the LTC home. To understand how the extralocal regulatory authority impacted the day-to-day work of the HCAs, specifically around the provision of oral care, I conducted a review of the regulatory framework for LTC homes in the province. The review served as a contextual introduction to the organization of LTC homes which, in turn, informed my research study.

As previously mentioned, the Manitoba Ministry of Health and Seniors Care is responsible for establishing province-wide goals and standards for the delivery of services for seniors, including those living in LTC. These goals and standards are stated in a regulation document called the *Personal Care Homes Standards Regulation* (MB Reg.H35/18) that exists under the *Health Services Insurance Act* (C.C.S.M. c. 2018, c H35). The regulation stipulates the quality of service required to protect residents living in LTC homes in 26 Standards of Care. Whereas the Ministry of Health and Seniors created regulations to guide the provision of care to

seniors, the five regional health authorities across the province of Manitoba are responsible for carrying out appropriate care.

The WRHA is one of these five regional health authorities and has jurisdictional oversight over my research sites. The WRHA has a strategic role in setting direction for the health authority and a fiduciary role in policy formulation. Consequently, the WRHA has a responsibility to create policy that aligns with legislation, setting standards and care expectations for residents in Personal Care Homes. Specifically, it oversees the day-to-day delivery of services for residents of LTC homes in the Winnipeg region.

The boss texts that influenced oral care in my study sites are detailed on the following pages and include the *Resident Admission Form*, the *Integrated Care Plan* and the *RAI MDS 2.0*; the latter two texts are maintained as two health records for each resident, and together constitute the electronic health record.

Resident Admission Form

The influence of a boss text on the ways in which HCAs provide oral care begins during the admission of the resident to the LTC home. The *Resident Admission Form* is the point of entry for residents in LTC. The *Resident Admission Form* is a standardized WRHA form completed by an RN who enters resident-specific care information during the resident admission process. Information collected by the RN includes ADL details, resident food preferences and family requests. Particulars entered onto the form are usually provided by the residents themselves or by their family members or other care providers. Accordingly, resident oral care details are collected on this form as one of the ADL items.

Consistent with IE inquiry, the RN who fills out the *Resident Admission Form* is part of a textually mediated process, whereby the resident applicant is seen through the lens established

by the form itself. Thus, the form becomes part of the decision-making process because the questions asked determine the information that is collected. Accordingly, the RN interacting with the LTC home resident through the instrument of the *Resident Admission Form* is a participant in a textually mediated relation (Campbell & Gregor, 2008). If resident oral care information is missing or incomplete on the *Resident Admission Form*, the deficiencies in oral care information are perpetuated during the subsequent completion of other texts. The type and amount of resident oral care information entered by the RN into the *Resident Admission Form*, therefore, is an important factor in determining how oral care is provided by the HCAs.

For example, the resident oral care information submitted on the form should be transferred to the *ADL Status Sheet*/Basic Care Plan (see Figure 3.1 & 3.2). If no oral care information was included on the form, and no subsequent oral assessment was completed, the HCAs were left to figure out how best to provide oral care for that resident. To alleviate this potential problem at Site 2, a RN completed an *Oral Health Assessment Worksheet* (see Appendix H) to validate the information on the *Resident Admission Form* prior to the care information being recorded in the *RAI MDS 2.0* or *Integrated Care Plan* (see Figure 3.2). This differed from the process at Site 1, where the assessment was not completed before the oral care information was entered into the *RAI MDS 2.0* and *Integrated Care Plan* (see Figures 3.1 & 3.2).

The resident's level of independence for ADLs was also documented on the *Resident Admission Form,* as per the *Personal Care Home Standards Regulations*. Accordingly, documentation of resident independence on the *Resident Admission Form* can inform HCAs as to the level of assistance required when providing oral care to residents. At both study sites, the level of dependence for resident oral care was transferred from the *Resident Admission Form* to the *ADL Status Sheet*. However, as discussed in Chapter 3, the level of assistance required by

residents for oral care was not transferred from the *ADL Status Sheet* to the *ADL Mouthcare Plan* where the HCAs could have accessed the information during oral care activities. This gap, as described in Chapter 3, is a disquiet between the actuality of the HCA's experiences and the actionable institutional realties (Smith, 2005) imposed by the *Resident Admission Form* boss text.

The Integrated Care Plan

The creation of an *Integrated Care Plan* for each resident is a requirement listed under sections 12(1)-14 of the *Personal Standards Health Regulation,* which states that within eight weeks after admission, each member of the interdisciplinary team must assess a resident's needs and an *Integrated Care Plan* must be developed to address those needs. Specifically, section 12(2)(a) of the *Personal Standards Health Regulation* states the *Integrated Care Plan* must include the level of assistance necessary to assist residents with mouth care and denture care. Oral health professionals, however, are not an integral part of the interdisciplinary team in LTC homes so they do not assess the oral health needs of residents on admission. Consequently, at both of my study sites, an RN completed the oral care section of the *Integrated Care Plan* for each resident on admission. Upon review, however, it was noted that the *Personal Care Home Standards Regulation* does not provide descriptors to assist the RNs in their determination of the level of assistance required for resident mouth and denture care. As a result, the RN completes the oral care sections of the *Integrated Care Plan* based on information obtained from the *Resident Admission Form*.

At this point it is interesting to provide some detail around an additional care plan that is developed by the RN while completing the *Integrated Care Plan*. Within 24 hours of a resident's admission, RNs at both study sites created a *Basic Care Plan* to facilitate an early understanding

of the needs of a new resident. The *Basic Care Plan* is not a boss text, but an institutional text developed by the LTC homes to consolidate the most critical resident information to facilitate good care during the early days after admission before the *Integrated Care Plan* is complete. Information documented on the *Basic Care Plan*, along with information from the *Resident Admission Form*, are used to create the *Integrated Care Plan*.

At both study sites, the *Integrated Care Plan* was completed within three weeks of a resident's admission by entering the information electronically into a regional computer system. Additionally, a paper copy of the most recent *Integrated Care Plan* was stored in the resident's chart. The completed *Integrated Care Plan* boss text details the care the resident will receive and can be electronically updated at any time as resident care needs evolve, but at least quarterly. The paper copy of the *Integrated Care Plan* in the chart is typically updated quarterly. The care plan review is completed by LPNs who update the plan as resident care needs change. Specifically, as previously mentioned, the LPNs rely on the HCAs to inform them of oral care information that needs updating, and they do so by writing notes on pieces of paper or by spoken report.

Resident Assessment Instrument (RAI)

The *RAI* is a boss text used in LTC homes as a standardized assessment tool designed to measure the quality of care residents receive in LTC homes. It was developed by interRAI, an international research consortium that develops comprehensive assessment tools designed for older adult populations, specifically for residents in LTC homes. The *RAI* was mandated for use in LTC homes in Manitoba by the WRHA in 2004 and consists of two primary components: the minimum data set *(MDS)* and the resident assessment protocols (RAPs) that are frameworks for additional assessment of MDS-identified problem areas (Rahman & Applebaum, 2009).

Like the *Integrated Care Plan*, the *MDS* is a multidisciplinary summary assessment that requires specific input on resident health from multidisciplinary team members such as nursing staff, dieticians, physiotherapists and social workers. The *RAI* requires MDS assessments be completed for each resident on admission, on a quarterly basis, when significant changes in health status occur, and annually (Rahman & Applebaum, 2009). As previously mentioned, whereas oral care professionals do not contribute to the multidisciplinary reporting, *RAI* oral health reporting is required under section L1 of the Full *MDS* Assessment and section K1 of the Quarterly *MDS* Assessment. The *MDS* also includes measures of residents' functional status and health conditions related to pain, cognition, activities of daily living and level of care provided required for these activities (Hawes et al., 1997).

The process for implementing the *MDS* begins with the *Resident Admission Form.* As discussed above, this form is completed for the resident during admission to the LTC home. Accordingly, any oral care information on the *Resident Admission Form* and included in the *Integrated Care Plan* should be transferred to the *MDS* at this time. If the information is not transferred or if the oral care information is incomplete, then the data on the RAI will likewise be incomplete or inaccurate. The MDS is best described as a preliminary screening to identify potential problems, which then trigger a RAP to help facility staff to evaluate 'triggered' conditions (p. 4-1, CMS, RAI Version 2.0 Manual) as part of a care plan. Without accurate information in the MDS, a RAP may not be triggered and oral care needs may go unaddressed.

Bowel Care Boss Texts — A Comparison with Oral Care Boss Texts

Observing the care process around bowel management was instrumental in understanding how oral care occurred in LTC homes. Textual analysis and TWT mapping revealed two boss texts that were specific to bowel care management and influenced the work of the HCAs. No

equivalent boss texts with an oral care focus were available. This absence indicates a lack of textual guidance informing the oral care process in LTC homes. It is useful to describe the role of these two additional boss texts related to bowel care in LTC homes, with a view to improving process and outcomes for oral care.

Palliative Care Program - Constipation Assessment and Management Algorithm

This WRHA text is a resource for the bowel management of residents in LTC homes (see Appendix I) and has three parts: a *Guidelines for Care Flowchart*, a *Medication Table* and a *Bowel Performance Scale*. The *Bowel Performance Scale* provides a pictorial scale of stool constipation that the HCAs use to assess the bowel status of their residents. During their shift, the HCAs completed their resident bowel assessments and then completed the bowel section in the *Resident Care Flowsheet.* As previously mentioned, the LPNs were required to check the HCA entries in the bowel section of the institutional text called the *Resident Care Flowsheet* and make resident medication or referral decisions based on the bowel status recorded by the HCAs. Furthermore, the LPN may speak to the HCAs for clarification or confirmation prior to providing an intervention listed on the *Medication Table*. The LPNs could also refer to the *Guideline for Care Flowchart* section of the *Palliative Care Program - Constipation Assessment and Management Algorithm* and use the decision-making tree when determining what bowel care intervention would be appropriate. In contrast, the HCAs and LPNs lacked similar pictorial guidelines to clarify what poor oral health would look like or flow charts to help them provide appropriate interventions to improve oral health.

Medication Standing Orders Form

This text was created by the WRHA and was designed to streamline the procedure of prescribing medications for residents in LTC homes. One of the sections on the form includes a

schedule of prescription orders for constipation ranging from suppositories to other medications suitable for a serious blockage. The form is completed by the LPN and sent to the pharmacy to be filled. The *Medication Standing Orders* form facilitated efficient medication distribution without the need for a physician's authorization every time medication for constipation was required. The HCAs understood that there was a bowel protocol and that residents' bowel issues could result in interventions including medication. One LPN described how the HCAs reported bowel irregularities when a resident had gone two or three days without a bowel movement:

> *Interviewer:* *Okay. So, maybe can you just tell me how bowel care is done here, not in terms of incontinence, but let's say, a resident maybe hadn't had a bowel movement.*
>
> *HCP 2-2:* *Yeah. So, a healthcare aide comes to me and say, okay so, so and so haven't had a bowel movement for two days, so two days I'm going to give them oral laxative, for instance I give lactulose, prune juice, whatever, so they work. So, they come by and say, oh whatever you gave them not work, so that's day three, so we'll start to look, okay so day three we start contemplating on suppository.*

Exploration of these two bowel boss texts illustrated their importance in bowel care management in LTC homes. The texts provided guidance to the HCAs and LPNs through established criteria, which assisted them in their decision-making around residents' bowel care. Comparable texts did not exist around oral care; consequently, HCAs and LPNs had no textual guidance about how to provide oral care to their residents. Thus, the regulatory review revealed there was an absence of boss texts to inform the provision of oral care in LTC homes.

Chapter Five: Discussion

The impetus for conducting this IE research was to explore what may have been missing in the historical approach to resolving the problem of poor oral health of residents in LTC homes. Conducting this IE study and taking the standpoint of the HCA revealed details of how oral care happens in LTC settings, how different types of texts influence oral care, and where gaps in care exist. The results of my study indicate that the HCAs used their discretion and figured out on their own how and when to provide oral care for their residents, and report issues with oral care or changes in a resident's oral health status. There was a lack of helpful institutional texts to guide the HCAs in oral care and a general lack of knowledge about what oral care included, beyond tooth-brushing and denture care. Additionally, boss texts designed by the regulatory health authority to assist LTC homes in complying with the *Personal Care Home Standards Regulation* were insufficient in detail to organize effective oral care by the HCAs and involvement of the LPNs in addressing problems or changes.

This finding is consistent with work completed by Janes et al., (2008) which described how Personal Care Workers (PCWs) made decisions based on what they would want for themselves or for their parent in specific care situations. Janes's theory of *Figuring it Out in the Moment* breaks down the thought processes of the PCWs as they are determining how best to provide care. Janes et al., (2008) describes four separate, interconnected phases of clinical decision-making PSWs use when providing person-centered care: melding, contextualizing, trialing and appraising. Janes refers to melding as a method of sourcing information to provide person-centered care. For example, PCWs gathered resident specific information by observing the resident, relying on their own experiences, and talking with their co-workers. Janes describes the contextualizing phase whereby the PCWs provided care for their residents in a way that was

the “best fit” for themselves and the resident. They approached this task with the attitude of “what is good for me is good for them.” I observed examples of these phases in my study, as HCAs provided oral care for their residents in the same way that they would for themselves, made determinations as to when and how tooth-brushing should be completed for residents, and relied on their own personal experiences when providing oral care to residents. The trialing phase is explained by Janes as one where the PCW may make mistakes in providing care but continues to learn, and the appraising phase is one where the PCW evaluates the effectiveness of providing that care.

Of specific interest is the fact that my study yielded similar findings to those of Janes et al., (2008), more than a decade later. Why, after so many years, is this approach still prevalent in the realm of oral care? The IE method of inquiry, which has not previously been applied to the problem of oral health in LTC homes, provided a different lens from which to view the problem and answer this question. Inherent in IE inquiry is the analysis of texts and how they mediate behavior. Thus, the question arises: what would a successful, textually mediated approach to oral care look like? In the following analysis, I discuss the implications of my findings on policy, practice, and future research on the provision of oral care in LTC homes.

Redesign Institutional and Boss Texts for Oral Care

Using the IE method of inquiry, I was able to map the process of oral care using text-work-text mapping, creating a pictorial illustration of activated and inactivated texts. My findings indicated that the existence of guiding texts and the activation of these texts could be crucial to a successful oral care program in LTC homes. Additionally, the texts would need to be perceived as useful by the HCAs and the LPNs to provide guidance.

Stanley reminds us that "texts are or are intended to be performative" (Stanley, 2018, p.3), and organizational work is controlled and managed through the medium of institutional texts. Accordingly, inactivated texts would not contribute to the work of providing oral care in LTC homes. Dorothy Smith (1999) speaks about texts being activated by people who use them to coordinate action and organize further action. For example, if texts existed that described how oral care was to be performed, they could be activated by the HCAs resulting in coordinated action for performing oral care in specific ways (Campbell & McGregor, 2008). Accordingly, the completion of an *Oral Health Assessment* for each resident on intake by an RN may provide a more thorough oral health evaluation for each resident.

Additionally, the *ADL Mouthcare Plan* should be redesigned with input from the HCAs, as primary providers of oral care and be informed by relevant boss texts. Accordingly, using an inclusive process, such as participatory action research involving HCAs and LPNs, could help to determine what changes need to be made to the existing texts and what textual guidance is currently absent. Caspar (2019) agrees that enabling self-determination of HCAs in the LTC setting is important in providing high quality, person-centered resident care. Accordingly, this could result in the creation of new guiding texts for providing oral care in LTC homes, thereby changing the social organization of the provision of oral care by the purposeful and coordinated activities of the HCAs and LPNs. At a minimum, institutional texts designed to inform oral care for residents should include information on the level of assistance required for oral care, indicators of oral disease and decision-making criteria for oral care referral to an oral health care provider. The concept of oral health as defined by the WHO https://www.who.int/health-topics/oral-health#tab=tab_1) as an indicator of health, well-being and quality of life will be important in guiding development of these texts.

The addition or activation of more institutional texts is likely not enough to resolve the problem of oral health in LTC. Bowel care textual analysis showed that boss texts provided context and guidance for the HCAs and LPNs. My findings suggest that it is the presence and activation of the bowel care-specific boss texts that have contributed to the successful bowel care management of residents in LTC homes. Additionally, the presence of boss texts introduces an element of accountability. Thus, it stands to reason, that if similarly designed boss texts were incorporated into providing oral care in LTC homes, comparable success could be realized, bringing positive change to the oral health of residents in LTC homes. Boss texts describing what constitutes poor oral health and what oral conditions require a dental referral do not exist. They need to be created.

When considering the RAI, the instrument itself is unlikely to change, however, the quality of the data entered into the MDS assessment may be improved if dental hygienists were the health professionals entering resident oral health data. Accurate oral health data, entered into the RAI, would inform appropriate resident oral care, which should result in better resident oral health in LTC homes. The research of Hoben et al. (2016), supports this theory by determining, "the *RAI* data demonstrated severe underdetection of oral/dental problems, and a lack of understanding of oral health predictors associated with oral/dental problems which resulted in validity concerns of the data" (p.11). Additionally, the oral/dental items of the *RAI-MDS 2.0* are completed only on the full assessment version on admission, and then annually rather than quarterly or when significant change occurs (Hoben, 2016). This research calls into question the value of the *RAI* as a boss text, as it relates to oral care of residents. The *RAI* was intended to facilitate clinical accountability, including oral healthcare; however, it has failed as a reliable determinant for the oral health of residents in LTC homes, a finding of the current study as well.

There are potential downsides to more ‘paperwork’ as a means to improving oral care that must be considered. Caspar (2014) noted that regulatory compliance may be the phenomenon of a paper compliance culture, which can result in the unintended consequence of diminished attention being paid to residents' quality of life. This occurs because regulatory demands, including the time required for completion of forms and reports, can redirect the work of healthcare workers. Based on Caspar’s (2014) research, it will be important to create and implement boss texts that provide guidance but do not negatively impact the provision of quality care.

It is also necessary to place a caveat on the boss text as a requirement for good oral care in LTC homes. Boss texts created by a regulatory authority such as the WRHA that fail to include measurement criteria with a mechanism for reporting and accountability would not be useful in driving change in the provision of oral care. For example, Jiang’s (2012) research found that despite the presence of a regulation requiring LTC residents in British Columbia to receive a clinical examination annually by a dental professional, the requirement was not adhered to because there was no mechanism in place to ensure compliance. Similarly, my study revealed there was no mechanism in place to ensure the provision of effective oral care and a general lack of accountability was observed.

There is no question that accountability for and prioritization of oral care for residents in LTC homes is necessary to ensure that the oral healthcare needs of residents are met. A study by Dharamsi et al. (2009) concluded that establishing better accountability and reporting structures was a means to ensure the provision of continuous oral care for residents in LTC homes. The creation of boss texts with criteria and measurable outcomes, and the development of supportive

institutional texts guiding the practice of oral care in LTC homes, may foster an accountability for the provision of oral care.

Improve Oral Health Education for HCAs and LPNs

My findings show that the HCAs have minimal oral health knowledge. They do not receive oral health education that is commensurate with the requirements of their role as oral health care providers in LTC homes. Additionally, research by Albrecht et al., (2016), determined that oral health educational interventions provided to LTC home staff were generally not effective. These findings are in agreement with research conducted by Hoben et al. (2017), which concluded that strategies to improve care aides' oral care knowledge are especially necessary. This knowledge is important both for the HCA's provision of daily oral care, and for the accurate identification and referral of oral health conditions to their supervising LPN. For example, oral malodour can be a sign of deteriorating oral health. An HCA, with appropriate education, would be able to recognize this as an oral health problem and notify their supervising LPN.

The effect of the HCA's oral health knowledge deficit is far-reaching. Not only does it impact the oral care of residents, but it also impacts the oral health data being collected and entered into the *RAI.* Accordingly, the research of Hoben et al., (2016) suggests there is a validity problem with the oral health data inputted into the *RAI* due to the lack of association of well-known oral health predictors with oral/dental problems. Hoben's results are not surprising; my study suggests it is the HCAs who are driving the data being communicated to the LPN, who then may or may not enter the results into the *RAI*. With limited oral health content knowledge, the HCAs are left to determine the oral health status of residents and to make judgement calls as to what they should report. Often, they report nothing. Hence, the data in the *RAI* underreports

oral health problems, leading to an inference that the oral health of residents in LTC homes is good. The long-term effect of inaccurate oral health data collection has perpetuated complacency in addressing poor oral health in LTC homes.

The overall strategy to improve the oral health of residents in LTC homes must include a concerted effort to educate HCAs and LPNs on the importance of oral health as it relates to overall health. This knowledge must be included in the competencies of their respective educational curriculums rather than provided in the form of in-services or staff training. Whereas onsite training is helpful it should be used as an adjunct to the educational curriculum. Efforts to improve the robustness of the oral health components of the formal education of HCAs and LPNs are critical to managing the oral health of future generations of aging adults in LTC homes. According to Forsell et al. (2011), it will be important to base oral health education on evidence from the literature, recognizing that currently, HCAs prefer to gather information about care of residents through conversation with colleagues, rather than through reading text. While oral communication pathways in LTC homes are identified in the literature by Cranley et al. (2020) as an important component to a desirable process of "shared decision making," text documents must also exist and be utilized to support quality care. When activated, these documents or texts will facilitate accountable communication between care providers.

Undeniably, advocating for appropriate oral health education for HCAs in Manitoba may be difficult because HCAs are unregulated health providers. Initial steps could include advocating for the creation of a Registry of HCAs. The Registry could be similar to that existing in British Columbia (BC), whereby care aides must first be registered with the BC Care Aide & Community Health Worker Registry before they can work in BC. Additionally, to improve the educational standards of HCAs in the province, the BC Registry has developed a process for

program recognition and lists educational institutions in BC that meet specific program standards. Creating a similar kind of Registry could help Manitoba transition to requiring a curriculum with oral health competency requirements for HCA education. This initiative would be a significant step towards adequately preparing the HCAs for their role in the oral health of residents in LTC homes.

Additionally, advocating for the inclusion of oral health education for LPNs in Manitoba could include collaborative discussions with the College of Licensed Practical Nurses of Manitoba and the educational Colleges offering LPN education. This would provide a starting point to discuss how to incorporate competencies covering the importance of oral health to overall health into the curriculum. Furthermore, the inclusion of clinical practice competencies related to oral health would be required.

Future Research and Policy Directions

Results of this study contribute to the growing body of knowledge supporting the need for future research and policy development to improve the oral health of residents in LTC homes. A national and provincial focus will be necessary to facilitate sustainable and progressive change. I have provided two examples below of large-scale national policy development that I believe would have a significant impact on the oral health of residents in LTC.

Basic Federal Dental Insurance Coverage for Seniors

The development of a federally funded dental program for seniors is integral to the successful resolution of poor oral health in LTC homes. Currently, across Canada, some provinces and territories have a provincially funded dental program for eligible seniors which covers the cost of basic dental care. However, the eligibility requirements and details of the programs vary widely. Some provinces, including Manitoba, offer no support for seniors' dental

care. Additionally, there is no existing national dental coverage plan for seniors, with the exception of the Indigenous Health Non-Insured health benefits for First Nations and Inuit.

A federal dental program for seniors, including a national framework with bilateral agreements with each province, is required to alleviate the cost burden of dental treatment on seniors. A standardized Canadian strategy to provide insurance coverage for seniors that fits a national eligibility standard is necessary. Additionally, there would need to be outcome and/or progress metrics which provincial and territorial jurisdictions would be required to track and report. For example, LPNs would no longer need to rely on their own discretion to initiate an oral health referral, nor would they have to consider who would be paying for the referral when making their decision to refer. Advocating for a program of dental coverage for seniors will be an important component in solving the poor oral health of seniors in LTC.

Access to the RAI for Dental Professionals

As previously stated, the RAI is an unreliable indicator of resident oral health in LTC homes. In addition, the extent to which oral and dental items in the RAI-MDS describe dental treatment has also been questioned (Jockusch, 2021). Currently, untrained non-dental personnel (typically the HCA), are required to identify and report oral and dental disease for inclusion into the *RAI-MDS*; however, oral health situations and treatment needs are not being identified. The lack of identification and reporting is due to the unfamiliarity of oral health conditions by the healthcare staff who are currently responsible for identifying and reporting oral health concerns. This raises the issue of why dental professionals are not seen as the more appropriate healthcare provider to enter resident dental information into the *RAI*. Alternatively, to improve the reliability and usefulness of the oral data being collected in the *RAI*, other healthcare providers could be provided additional education in oral health diagnosis and treatment. Because

longitudinal oral health data will be important to effect sustainable change in the oral health of residents in LTC homes, a resolution of the inaccuracies of oral health data currently being collected in the *RAI* will also be required.

Conclusions

Exploring the social organization of work around oral care in LTC homes has illustrated institutional processes that may contribute to poor oral health for residents in LTC homes. Addressing these processes could help existing efforts of those seeking to improve the state of oral health of residents in LTC. Of primary importance is recognizing that the issue of poor oral health in LTC will not be solved by one new policy or intervention. The problem is multifactorial, and the solution is complex. Coleman (2002) acknowledged there was a problem with the provision of oral care and stated that daily oral care interventions alone were not effective in "safeguarding the oral and general heath of the LTC population" (p.189).

It is disconcerting that the longstanding problem of poor oral health in LTC homes persists, and there has been no appreciable improvement in reports of oral health among LTC residents in the recent literature. More than forty years ago, nurse Virginia Henderson stated that strategies to improve the oral health of residents in nursing homes needed to include educational, research, and advocacy efforts and methods to improve practice (Coleman, 2002). Henderson also suggested that these strategies must begin with "the development of a culture, both institutional and professional, that promotes, values, and communicates oral health caregiving as fundamental to geriatric nursing practice as are restraint reduction and skin care practices" (Coleman, 2002, p. 193). Yet, in 2021, oral healthcare practices in LTC homes are still not prioritized as highly as other care activities, such as bowel care.

I realize the intractable issues related to poor quality care overall in LTC in Canada and around the world (Estabrooks et al., 2020). As noted previously in this document, and based on decades of research and governmental task-force reports, the problems of LTC undoubtedly influence all care, not just oral care. Older adults living in LTC are a vulnerable group; in addition, care aides are themselves a vulnerable group, being mostly older women from ethnic minorities (Chamberlain, 2019). As a society, we must address issues of equity in these settings – for residents and for care aides.

I embarked on this doctoral journey to search for an answer and the results have provided me with so much more. I have a greater understanding of the social organization of oral care in LTC homes, and the disjuncture between what the HCAs do and what they are accountable to do by the texts available to guide them, under difficult working conditions. I look forward to working on the next steps in policy and practice to improve oral care in LTC, using the findings of this study as a foundation for the work, and in alliance with other systemic approaches to change in the LTC environment.

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Appendix A: HCA Consent Form

CONSENT FORM for the Health Care Aide

Study Title: Oral Care in Long -Term Care Homes: An Institutional Ethnography

Principal Investigator & Study Coordinator: Arlynn Brodie **Phone Number: (780) 292-5808**

	Yes	No
I understand I have been asked to be in a research study.	☐	☐
I have read and received a copy of the attached Information Sheet.	☐	☐
I understand the benefits and risks involved in taking part in this research study.	☐	☐
I have had an opportunity to ask questions and discuss this study.	☐	☐
I understand I am free to leave the study at any time, without having to give a reason and it will not affect my employment	☐	☐
By agreeing to take part in this research I understand that the researcher will follow me throughout one shift, taking notes and observing my behaviour.	☐	☐
I understand that my collected data can be withdrawn up until 2 weeks after my interview date	☐	☐
The issue of confidentiality been explained to me and I understand who will have access to my personal information.	☐	☐
I give my permission to be audio recorded during the interview. I understand the recorded. information will be deleted from the recorder.	☐	☐
I am aware that I can request to review the recorded transcript of my interview.	☐	☐

Appendix A: HCA Consent Form

Signatures

I agree to take part in this study:

Name of Participant _____

Signature of Participant _____ Date: _____

You will be provided with a copy of this Information Letter and Consent form to take with you

I believe that the person signing this form understands what is involved in the study and voluntarily agrees to participate in the study.

Name of Researcher_____

Signature of Researcher_____ Date: _____

Appendix A: HCA Post Interview Consent Form

Post Interview Consent Form for the Health Care Aide

Study Title: Oral Care in Long Term Care Homes – an Institutional Ethnography

Principal Investigator & Study Coordinator
Arlynn Brodie
abrodie@ualberta.ca
780-292-5808

Supervisors:

Dr. Tammy Hopper, PhD, R-SLP
Professor
Department of Communication Sciences and Disorders
Edmonton, Alberta, Canada, T6G 2G7
tammy.hopper@ualberta.ca
780-492-2280

Dr. Sienna Caspar, PhD, CTRS
Assistant Professor, Therapeutic Recreation,
University of Lethbridge,
4401 University Dr.,
Lethbridge, AB, T1K3M4
Sienna.caspar@uleth.ca
403-329-2724

This study is being conducted in partial fulfillment of the requirements for Arlynn's graduate degree

Appendix A: HCA Post Interview Consent Form

Post Interview Consent Form

	Yes	No
I have had an opportunity to ask questions and discuss this study.	☐	☐
I understand that my collected data can be withdrawn up until 2 weeks after my interview date	☐	☐
The issue of confidentiality been explained to me and I understand who will have access to my personal information.	☐	☐
I give my permission to allow you to proceed with study analysis from the research findings		
I am aware that I can request to review the recorded transcript of my interview.	☐	☐

Signatures

I agree to take part in this study:

Name of Participant _____

Signature of Participant _____ Date: _____

You will be provided with a copy of this Consent form to take with you

I believe that the person signing this form understands what is involved in the study and voluntarily agrees to participate in the study.

Name of Researcher_____

Signature of Researcher _____

Appendix B: Study Information Poster

Oral Care in Long-Term Care Homes: An Institutional Ethnography
(UAlberta Study - Pro00083521)

Canada's population is aging and many people over the age of 65 have dementia and live in long term care (LTC) homes. Individuals with dementia face many challenges looking after themselves, including keeping their mouth healthy.

The purpose of this study is to learn how LTC homes can create an environment that helps care staff manage oral health for residents with dementia. This study will seek to understand the influence of organizational practices and processes on care staffs' ability to impact the oral health of residents. Results of this study may help to make system-wide changes to policies and procedures that support oral health for residents with dementia in LTC homes.

If you are a Health Care Aide, LPN or RN and may be interested in participating in this study, I would like to hear from you. Participating in this study will include an interview that will take approximately one hour.

To learn more, please contact the principal investigator:

Arlynn Brodie
Phone number: 780-292-5808
E-mail: abrodie@ualberta.ca

Appendix C: Study Information Letter

INFORMATION LETTER for the Health Care Aide

Study Title: Oral Care in Long Term Care Homes – an Institutional Ethnography

Research Investigator:
Arlynn Brodie
abrodie@ualberta.ca
780-292-5808

Supervisors:

Dr. Tammy Hopper, PhD, R-SLP
Professor
Department of Communication Sciences and Disorders
Edmonton, Alberta, Canada, T6G 2G7
tammy.hopper@ualberta.ca
780-492-2280

Dr. Sienna Caspar, PhD, CTRS
Assistant Professor, Therapeutic Recreation,
University of Lethbridge,
4401 University Dr.,
Lethbridge, AB, T1K3M4
Sienna.caspar@uleth.ca
403-329-2724

This study is being conducted in partial fulfillment of the requirements for Arlynn's graduate degree

What is the purpose of this letter?

This information letter is part of the process of informed consent. It gives you a basic idea of what the research is about and what it means to participate. If you have any questions or need more information after reading this letter, please ask. Take time to read this letter carefully. You will be given a copy of this form to keep for your records.

Appendix C: Study Information Letter

Why am I being asked to take part in this research study?

You are being asked to be in this study because you are a Health Care Aide (HCA) in a long-term care (LTC) home. Participating in this study will help the researcher, (Arlynn) complete her PhD thesis. Before you decide to take part, Arlynn will go over this form with you. Please ask questions if something is not clear.

What is the reason for doing the study?

Background and Purpose

Canada's population is aging. Many people over the age of 65 have dementia. People with dementia may have trouble taking care of themselves as their dementia gets worse. When people with dementia live in long-term care homes, they often need help with things like taking care of their teeth, gums and mouth. In this study, the researcher wants to find out more about how long-term care homes work to help staff members take care of residents with dementia. For example, are there rules about the ways things need to be done that affect the care that you give to residents with dementia? The researcher wants to find out more about the ways things work in long-term care to see what works and what might need to be changed. The goal is to improve care for residents with dementia.

What will I be asked to do?

If you agree to participate you will be observed during one of your shifts and you will have an interview with the researcher. The interview will take about 30 minutes to one hour. During this conversation you will be asked to describe your experiences (e.g., what you do in a regular day) working in a LTC home. The interview will be audiotaped so the researcher can remember what you said. A copy of the audiotape will be made, and any information that could identify you will be removed.

What are the risks and discomforts?

There is a minimal risk. Your co-workers could be aware that you are participating in this study. However, everything you say will be confidential. No one will know what you have said, except the researcher. It is not possible to know all the risks that may happen in a study, but all reasonable safeguards have been taken to minimize any known risks to a study participant.

What are the benefits to me?

There may be no direct benefit from being in this research study. To thank-you for your participation in the interview, you will be given a $20 gift certificate following your interview.

Appendix C: Study Information Letter

Do I have to take part in this study?

- Participating in this study is your choice.
- You can change your mind and stop participating at any time, without giving any reasons.
- Your decision to stop participating will not affect your employment; your decision will remain confidential.
- You may also request your collected data to be withdrawn and removed from the study.

Will my information be kept private?

The study will occur in the LTC home and interviews will occur onsite. Everything will be done to make sure information is kept private. In order to keep study results confidential you will be asked to make up a code name (a made-up name) for yourself that will be attached to your interview and any notes taken during the job shadowing.

What if I have questions?

The plan for this study has been reviewed by a Research Ethics Board at the University of Alberta. If you have any questions about your rights, or how research should be conducted, you can call (780) 492-2615. This office is independent of the researchers. Additionally, if you have any questions about the research study, now or later, please contact Arlynn Brodie at 780-292-5808 or abrodie@ualberta.ca

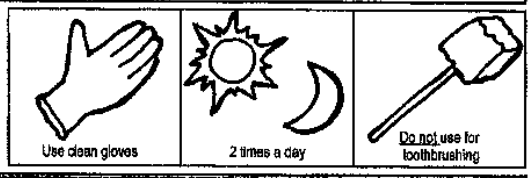
Appendix D: ADL Mouthcare Plan

ADL Mouth Care Plan

Developed by:_____ **Date:**___/___/___

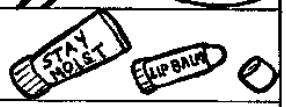
Teeth Status

- ☐ Natural Teeth
- ☐ Partial Denture(s)
- ☐ Full Denture(s)
  - ☐ Upper
  - ☐ Lower



Addressograph

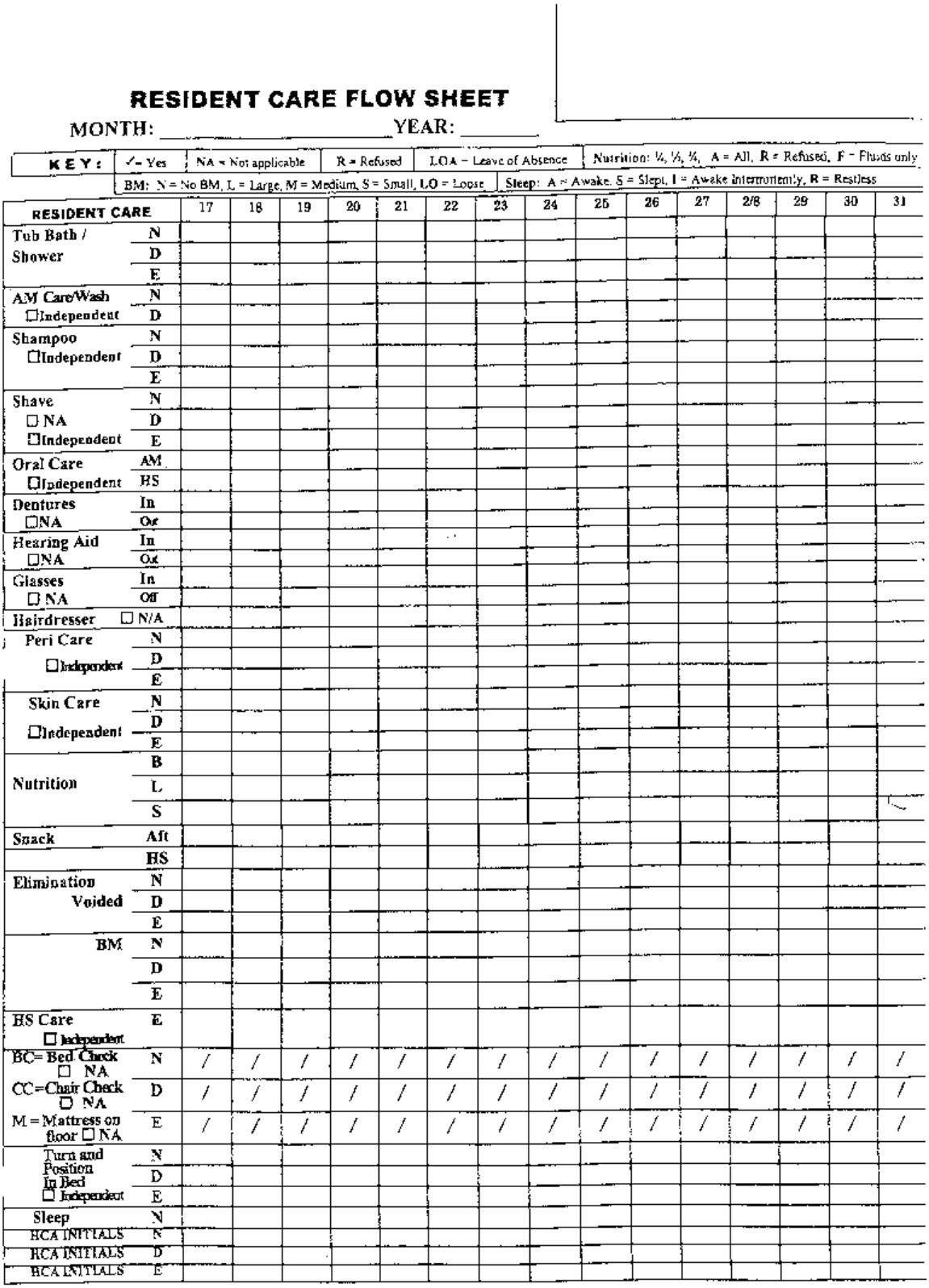
Mouthcare = teeth, gums & tongue

Recommended Toothcare Products	
Toothbrush ☐ Soft bristled, compact head toothbrush ☐ Powered toothbrush ☐ Specialized toothbrush _____	
Toothpaste ☐ With fluoride ☐ With extra fluoride_____ ☐ Dry mouth toothpaste (non foaming) _____ ☐ Sensitivity protection toothpaste _____	
Cleaning In-Between Teeth ☐ Floss, floss holder, floss piks ☐ Proxa-brush, soft piks, stimudent	
Partial / Full Denture ☐ Denture brush ☐ Denture container ☐ Denture cleanser or liquid soap ☐ Denture cleaning tablets	
Lip / Mouth Moisturizer (water based): ☐ Oral moisturizer: _____ ☐ Lip balm: _____	
Difficulty Keeping Mouth Open ☐ Mouth prop ☐ Two toothbrush technique ☐ Rolled up clean wash cloth	

Recommended Denture Products
With teeth ☐ Set-up for mouth care ☐ Set-up for mouth care, cue & observe toothbrushing ☐ Provide all aspects of mouth care
Partial(s) ☐ Set-up for mouth care & denture care ☐ Set-up for mouth care & denture care : observe, cue ☐ Provide all aspects of mouth & denture care
Denture(s) ☐ Set-up for denture care ☐ Set-up for denture care, gums & tongue cleaning: observe, cue ☐ Provide all aspects of mouth & denture care

Any additional product recommendations

Appendix E: Resident Care Flow Sheet



RESIDENT CARE FLOW SHEET

MONTH: _____ YEAR: _____

KEY: ✓ – Yes | NA = Not applicable | R = Refused | LOA – Leave of Absence | Nutrition: ¼, ½, ¾, A = All, R = Refused, F = Fluids only

BM: N = No BM, L = Large, M = Medium, S = Small, LO = Loose | Sleep: A = Awake, S = Slept, I = Awake Intermittently, R = Restless

RESIDENT CARE		17	18	19	20	21	22	23	24	25	26	27	2/8	29	30	31
Tub Bath / Shower	N															
	D															
	E															
AM Care/Wash ☐Independent	N															
	D															
Shampoo ☐Independent	N															
	D															
	E															
Shave ☐ NA ☐Independent	N															
	D															
	E															
Oral Care ☐Independent	AM															
	HS															
Dentures ☐NA	In															
	Out															
Hearing Aid ☐NA	In															
	Out															
Glasses ☐ NA	In															
	Off															
Hairdresser ☐ N/A																
Peri Care ☐Independent	N															
	D															
	E															
Skin Care ☐Independent	N															
	D															
	E															
Nutrition	B															
	L															
	S															
Snack	Aft															
	HS															
Elimination Voided	N															
	D															
	E															
BM	N															
	D															
	E															
HS Care ☐ Independent	E															
BC= Bed Check ☐ NA	N	/	/	/	/	/	/	/	/	/	/	/	/	/	/	/
CC=Chair Check ☐ NA	D	/	/	/	/	/	/	/	/	/	/	/	/	/	/	/
M = Mattress on floor ☐ NA	E	/	/	/	/	/	/	/	/	/	/	/	/	/	/	/
Turn and Position In Bed ☐ Independent	N															
	D															
	E															
Sleep	N															
HCA INITIALS	N															
HCA INITIALS	D															
HCA INITIALS	E															

Appendix F: ADL Status Sheet/Basic Care Plan

ADL STATUS SHEET

NAME_____ ROOM # _____ DATE _____
NURSE: _____

REVIEW DETAILS: _____
REVIEW DETAILS: _____
REVIEW DETAILS: _____
REVIEW DETAILS: _____
REVIEW DETAILS: _____

NUTRITION
Diet Type: _____
Diet Consistency: _____
Independent ___ Encourage ___
Partial Assist ___ Total Assist ___
Resource _____
Likes: _____
Dislikes: _____
Special Needs/Devices:
_____
_____

ORAL CARE
___Own teeth
___ Partial dentures
___Dentures

___Upper ___Lower
___Independent
___Partial Assist
___ Total Assist

VISION
_____ Adequate
_____ Impaired
_____ Blind
_____ Eyeglasses
_____ Reads/writes

HEARING
_____ Adequate
_____ Impaired
_____ Deaf
_____ Aids:
____ Left ____ Right

Revised January 2014

Language Spoken _____
Language Understood _____
Communication:
- ☐ Communicates well
- ☐ Difficulty communicating
- ☐ Unable to communicate

HYGIENE
___Independent
___Partial Assist
___2 person Assist
___Total Assist

SHAVING/MAKEUP
___Independent
___Requires Assistance
___Total Care

Dressing
_____ Independent
_____ Partial assist
_____ Full assist
_____ 1 assist _____2 assist

Laundry: SEPCH____ Family_____

Special Needs and preferences:
____ open back clothing
____ medical stockings
____ splint/brace/tensor
____ special shoes
____ grip socks

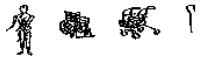
Bed Positioning:
_____ Independent
_____ 1 Person Assist
_____ 2 Person Assist

Bath _____1 ____2 **Assist/s**

Type: Tub Shower
Day: M T W T F S S
Time: _____ AM _____PM

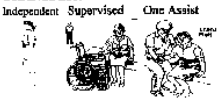
Hairdresser Y/N
Nail care: HCA / Nurses
Foot Care: HCA /Nurse/Foot Nurse

MOBILITY/ASSISTIVE DEVICES
___Independent
___uses walker in room only
___uses walker/walking aide
___wheelchair
___short distances
___all distances out/into bed
___own aide ____rental aide



Sling Size: S M L XL XXL

TRANSFERS
Independent Supervised One Assist



Two Assist Sit-to-Stand Lift Mechanical

ELIMINATION
Bladder:
_____ Continent
_____ Incontinent

Drainage:
_____ Catheter – Catheter size_____

Bowel:
_____ Continent
_____ Incontinent
_____ Ostomy Pouch size_____

TOILETING

	D	E	N
Independent	___	___	___
1 person	___	___	___
2 person	___	___	___
Total Assist	___	___	___
Q 2 hr routine	___	___	___
Bedpan	___	___	___
Urinal	___	___	___
Peri-care	___	___	___

Incontinent Products

Days	Evenings	Nights

SKIN CARE
_____ Normal
____ Tears easily
____ Dry ____ Lotion 2x Day

Special mattress/overlay _____
Wheelchair cushion_____
REST/SLEEP
Nap: AM ☐ PM ☐
Complete Bed rest Yes ☐ No ☐
Up Meals Only Yes ☐ No ☐
Bed Time _____
Usual Wake Time: _____
Sleeps Well Yes ☐ No ☐
If no, describe: _____
_____

Safety/Risks
Call Bell Pinned___ In Reach___
Bed Level Floor_____ Knee ____
Wanderer Yes____ No ____
Restraints
___Tilt wheelchair – Being tilted
___ lap tray
___Seatbelt
Seatbelt:
_____front When in Chair___
___rear Outings only ____
___anti tamper Restraint _____

Safety checks: _____
Circle Applicable:
Floor Pad Chair Alarm

Hip Protectors Bed Alarm

Appendix G: Medication Standing Orders

Long Term Care

PCH Medication Standing Orders

Medications listed on standing orders may be used for a maximum of 24 hours. If symptoms persist or the maximum daily dose is reached, contact the prescriber.

■ = Automatically activated. Prescriber: if not in agreement with an order, cross out and initial

FEVER, HEADACHE OR NON-SPECIFIC PAIN

Fever is defined as: single oral temperature greater than 37.8°C OR repeated oral temperatures of greater than 37.2°C OR rectal temperature greater than 37.5°C OR single temperature greater than a 1.1°C increase over baseline from any site (e.g. oral, tympanic, auxiliary). ***Warning: Total dose of acetaminophen from all sources shall not exceed 4 g in 24 hours. Contact prescriber if total dose will exceed 3 g in 24 hours.***

■	acetaminophen tablet	325-1000 mg	po	Stat + q4h prn or
■	acetaminophen liquid	325-1000 mg (10-30 mL)	po	Stat + q4h prn or
■	acetaminophen suppository	650 mg	rectal	Stat + q4h prn

MUSCULOSKELETAL PAIN

■	triethanolamine salicylate 13.3% (no odour)	topical	QID prn

INDIGESTION/HEARTBURN

■	Regular strength generic antacid (Mg or Al hydroxide 200 mg/5 mL)	15-30 mL	po	Stat + q2h prn (max 4 doses)

NAUSEA OR VOMITING

■	dimenhyDRINATE tablet	25 mg	po	Stat + q4h prn or
■	dimenhyDRINATE suppository	50 mg	rectal	Stat + q4h prn or
■	dimenhyDRINATE injection	25 mg	IM	Stat + q4h prn

MILD ALLERGIC REACTION

■	diphenhydrAMINE	25-50 mg	po	Stat & repeat in 6h if required

ANAPHYLACTIC SHOCK

Call 911 and obtain the anaphylaxis kit from the medication room. Inform prescriber.

■	EPINEPHrine 1 mg/mL	0.3 mg (0.3 mL)	IM	Stat and repeat at 10-15 minute intervals to a maximum of 3 doses.
■	diphenhydrAMINE 50 mg/mL	50 mg	IM	Stat

CHEST PAIN

If chest pain does not resolve or worsens after 3 doses of nitroglycerin, call 911. Provide oxygen to maintain O_2 saturation of greater than or equal to 90% or their normal baseline. Give ASA and inform prescriber.

■	nitroglycerin tablet	0.3 mg (1 tab)	sublingual	Repeat x 3 at 5 minute intervals if required.
■	acetylsalicylic acid (ASA)	160-162 mg (2 x 80 mg or 2 x 81 mg tabs)	chew	Stat if chest pain is unresponsive to 3 doses of nitroglycerin.

RESPIRATORY DISTRESS

Call prescriber promptly for new or worsening respiratory distress and/or hypoxemia (O_2 saturation less than 90%). Initiate O_2 at 1 L/min via nasal cannulae and titrate to maintain O_2 sat greater than 90% or their normal baseline.

■	salbutamol inhaler 100 mcg/dose	2 puffs	inhaled	Stat & contact prescriber

CONSTIPATION*

** The number of days is a guideline and is dependent on a resident's usual bowel habits and symptoms.*

■	Dietary measures (e.g. prune juice 120 mL po daily prn, fruitlax 25 g po daily prn)				
If no bowel movement after **2 days**, perform abdominal assessment					
■	Increase fluid intake and give the following:	sennosides 8.6 mg	2 tabs	po	HS
If no bowel movement by the next morning, perform abdominal assessment and rectal check					
■	If stool is **hard**, give the following:	glycerin suppository	1 supp	rectal	Stat
■	If stool is **soft**, give the following:	bisacodyl suppository	10 mg	rectal	Stat
■	If suppository is not effective after 2 hours, give the following:	enema (Microlax® or equivalent)	1 dose	rectal	Stat
■	If there is **no stool** in the rectum, give the following:	polyethylene glycol (PEG) 17 g **or** lactulose 15-30 mL		po	Stat

Generic substitutions will be used unless otherwise specified by the prescriber. Note: This document is to be copied as a 2-sided form
Approved by Provincial Pharmacy Working Group: February 5, 2019
Endorsed by Manitoba Clinical Leadership Council (MCLC): March 21, 2019
Approved by LTC Medical Director Advisory Council: May 15, 2019

Appendix H: Oral Health Assessment Worksheet

Oral Health Assessment Worksheet

Completed by: Date:

Natural Teeth Circle or highlight all that apply	**Upper**	All teeth	Some missing	Root tips	No teeth	
	Lower	All teeth	Some missing	Root tips	No teeth	
Dentures Circle or highlight all that apply	**Upper**	Full	Partial	Not worn	No denture	Name on denture
	Lower	Full	Partial	Not worn	No denture	Name on denture

Factors Affecting Daily Mouth Care

- ☐ ADL: independent
- ☐ ADL: some assistance required
- ☐ ADL: fully dependent
- ☐ Physical issues (i.e. mobility, balance, dexterity, facial paralysis)
- ☐ Responsive behaviors (i.e. refusal, biting, grabbing, pushing)

Addressograph here

Oral Assessment Timing: ☐ **Admission** ☐ **Quarterly Assessment** ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ **Other:** _____

Instructions: Circle or highlight all conditions that apply in all categories ; A-H findings of 'Moderate' and 'High Oral Health Risks' require follow-up; I and J impact upon oral care and health. Use the highest # recorded to score each category

Category	Low Oral Health Risk = 0	Moderate Oral Health Risk = 1	High Oral Health Risk = 2	Score
A. Lips	Smooth, pink, moist	Dry, chapped, or red at corners	White/red/ulcerated patch; swelling or lump; bleeding/ulcerated at corners	0 - 1 - 2
B. Tongue	Normal texture, pink, moist	Patchy, fissured, red, lightly coated	White/red/ulcerated area, smooth, swelling/lump, heavily coated	0 - 1 - 2
C. Gums and Tissues	Pink, moist, no bleeding	Localized: 1-2 areas with red, swollen or bleeding gums; one mouth ulcer, one sore spot under denture	Generalized: red, swollen, bleeding gums; loose teeth; abscess on gum; white/red/ulcerated area; red/sores under dentures	0 - 1 - 2
D. Saliva	Moist tissues; watery, free flowing saliva	Dry, sticky tissues; saliva reduced/thick	Tissues parched and red; very little/no saliva present	0 - 1 - 2
E. Natural Teeth	No decayed or broken teeth/roots	1-2 decayed or broken teeth/roots	3+ decayed or broken teeth/roots, very worn down teeth; fewer than 10 teeth and no dentures	0 - 1 - 2
F. Dentures	Dentures have no broken areas or teeth; worn regularly; removed daily	Denture has 1 broken area/tooth; worn 1-2 hours/day; worn 24 hours/day	Denture has more than 1 broken area/tooth; poor fit/worn with adhesive, never worn or missing	0 - 1 - 2
G. Oral Cleanliness	Clean, no food particles/plaque/tartar in mouth/on teeth or on dentures	Localized: food particles/plaque/tartar in 1-2 areas in mouth/on teeth or 1-2 areas on dentures; bad breath	Generalized: food particles/plaque/tartar in most areas in mouth/ on teeth or on most of dentures, severe bad breath	0 - 1 - 2
H. Dental Pain	No verbal, behavioral, or physical signs of oral pain	Reports or shows signs of pain such as pulling at face, chewing lips, not eating, aggression	Reports or shows signs of pain, physical signs present such as abscess on gum, facial swelling, broken teeth, large ulcers	0 - 1 - 2
I. Swallowing	No swallowing problems	Some pain or difficulty on swallowing	Unable to swallow	0 - 1 - 2
J. Cognitive Status	No cognitive impairment; able to communicate; typically able to do mouth care independently	Early to mild stage of dementia; some difficulty communicating; typically requires prompting, cuing or assistance for mouth care	End stage dementia; significant difficulty communicating, typically requires provision of mouth care	0 - 1 - 2

Follow-up:

	Completed
☐ Complete oral hygiene daily care plan and begin daily mouth care	☐
☐ Refer for dental consult to: _____	☐
☐ Refer to _____ for: _____	☐
☐ Discuss concerns with: _____	☐
☐ Review oral health again on (date): _____	☐

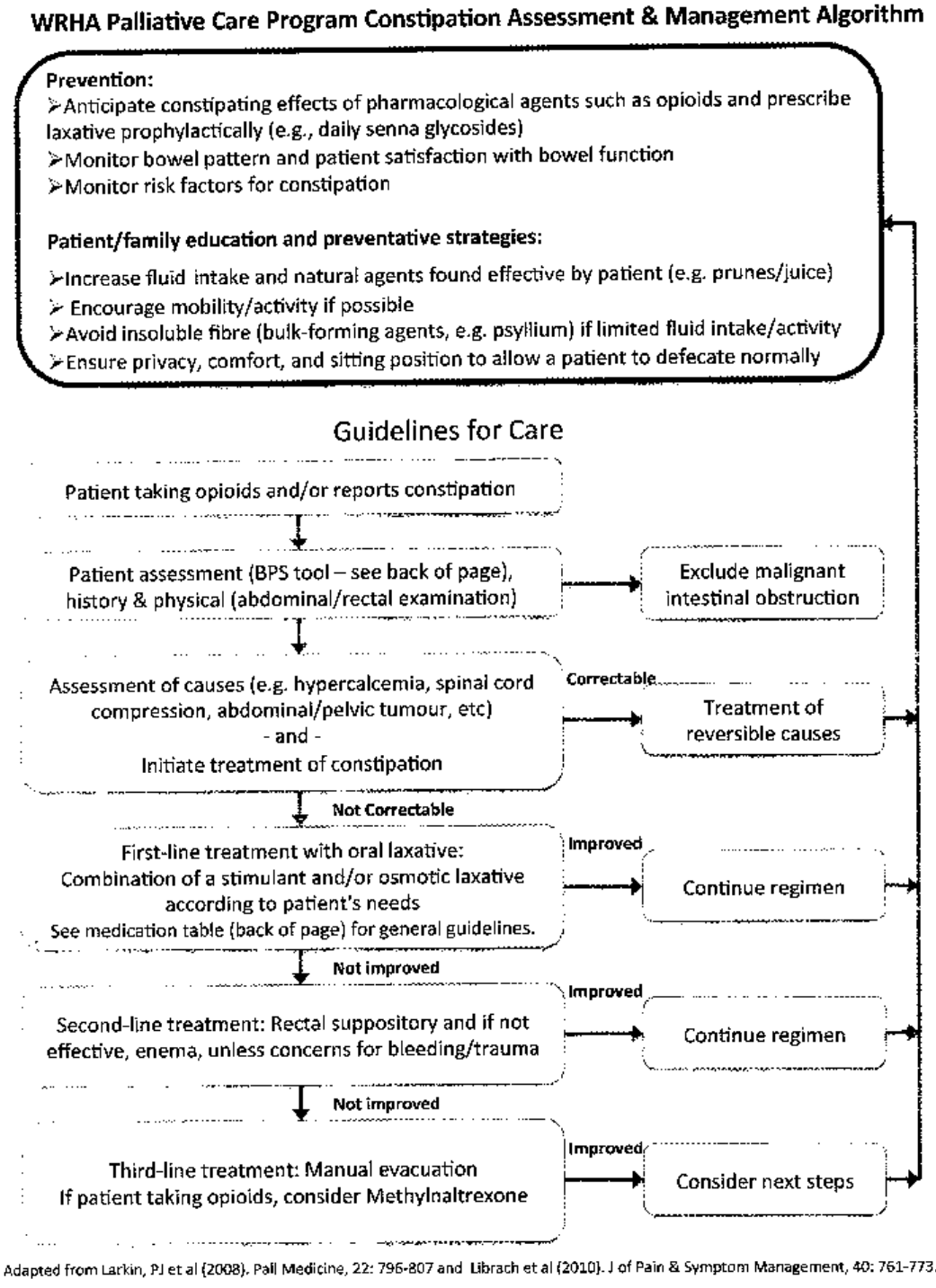
Circle or mark any areas of concern

Level of Mouth Care Assistance Required

- ☐ Remind and encourage—prompt & cue
- ☐ Assist—help as needed
- ☐ Provide—total mouth and denture care
- ☐ Palliative—oral comfort measures

Score Total /20

Appendix I: Constipation Assessment and Management Algorithm



Adapted from Larkin, PJ et al (2008). Pall Medicine, 22: 796-807 and Librach et al (2010). J of Pain & Symptom Management, 40: 761-773.