Quality of Work-Life for Ontario's Interprofessional Long-Term Care Staff: Employee Work-Life Satisfaction

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Abstract

For decades, the staffing and workload challenges facing the long-term care (LTC) sector have been studied. Many difficulties that existed prior to the pandemic were exacerbated during COVID and have continued in the post-pandemic environment. This study focused on the experiences of quality of work-life among interprofessional LTC workers in the post-pandemic environment. The project considered work demands, interprofessional dynamics, and personal well-being of staff in a post-COVID context. The study was undertaken utilizing semi-structured interviews with participants from a single LTC home in southern Ontario. A series of 20 interviews were completed virtually and in-person with personnel across different departments. Participants included office workers, medical and nursing staff, support staff, and members of allied health professions. Interviews were recorded, transcribed and analyzed using Nvivo. Thematic analysis was applied to these transcripts using a priori and emergent themes. Key findings include: staffing and workload; collaboration, communication and relationships; staff mental health and work-life satisfaction; and residual impacts of COVID-19. A key concern raised by interview participants was the quantity and quality of the staff making up LTC teams. This in turn impacts workload, which considers the ease and challenges faced by teams, either supporting or hindering the quality of their work and work-life. Collaboration and communication, including the quality of relationships and knowledge sharing between staff was another key concern raised by interview participants. Relationships extended to include residents and family members, who make up a significant portion of the LTC environment. Staff well-being and work-life balance hinged on many of the previous factors, affecting staff satisfaction and retention. Each of these concerns — which play into work-life experiences — have residual effects from the pandemic. Staffing levels have increased, as has workload related to reporting

and infection, prevention and control. These lasting effects continue to impact staff's work-life balance. These findings expand understanding of Ontario LTC work experiences, highlighting perspectives of staff often missing from the literature. Understanding the quality of work-life of LTC teams provides insights into worker satisfaction and retention, which have a direct impact on the quality of care provided to residents.

Keywords: Long-term care, staffing, workload, collaboration, satisfaction, post-COVID-19

Introduction

The Canadian population is ageing, with predictions suggesting that by 2068 the old-age population could account for anywhere between 21.6% to 29.8% of the total population (Statistics Canada, 2022). An ageing population has implications for numerous service industries, including the long-term care (LTC) sector. LTC homes provide full-time medical and physical care for residents (CIHI, 2021). The type of care services provided to residents varies depending on individual need. Due to the population being older on average, along with increased wait times to access LTC, residents have been found to require a greater scope of care (OLTCA, n.d.). Additionally, LTC residents, as a result of factors such as age and health status were disproportionately affected by COVID-19 outbreaks (CIHI, 2021). The increased vulnerability of the LTC population meant that new policies were required to prioritize resident health and safety. For instance, new policies on infection and prevention control were required (e.g., personal protective equipment) (CIHI, 2021). As such, demand on the LTC sector has been increasing and the COVID-19 pandemic exacerbated the impacts of this increasing demand.

Though the demand for LTC has risen, workforce growth and retention has not reflected this increase (Ministry of Long-Term Care, 2020). As such, there has been increased pressure placed on the remaining workforce. This pressure has been reflected in staff reports of high stress levels and turnover rates (Estabrooks, 2021). LTC work also has an additional emotional labour associated with the job. LTC is the final home for many residents until they pass on. As such, staff must balance the stressors of their workplace, while also dealing with continuous loss of residents (Harrad & Sulla, 2018). These trends have only been exacerbated by the recent COVID-19 pandemic, which significantly impacted all health care sectors. These changes for resident safety also had an impact on the staff's work experience. Beyond the pandemic,

COVID-19 continues to have lasting effects in the world of healthcare; a reality which requires closer consideration.

To provide support to the various needs of residents, LTC homes require a diverse workforce made up of a mixture of skill sets. Research has shown that interprofessional care contributes to higher quality care being provided to residents, while also improving staff's work experiences (Bosch & Mansell, 2015). Interprofessional teams are more able to address the range of demands in the LTC environment, while also working to address the issue of supply. LTC teams made up of workers across roles reduces the strain on individual team members. Having interprofessional teams is essential for a holistic care plan. Thus, a study on quality of work experience in LTC requires consideration of all staff who contribute to the care journey.

Purpose

The study focused on the experiences of quality of work-life among interprofessional LTC workers in the post-pandemic environment. The study considered the work demands, changing roles and interprofessional dynamics, some of which reflect the continued impacts of COVID-19.

Research Questions

1. How do different LTC workers' experience quality of work-life in a post-COVID context?
    a. What is the impact of changing workloads and work demands on workers' experiences?
    b. What is the impact of the workers' role and interprofessional dynamics in LTC on workers' experiences?

c. How does the gendered nature of LTC affect workers' experiences?

Theoretical Framework

In this project, I will use the Karasek's Demand-Control Model informed by a gender lens. Karasek's Demands-Control Model considers the relationship between high workload demands and low decision-making ability (Karasek, 1979). In this model, Karasek identifies four types of work environments. They are the passive job, the low strain job, the active job, and the high strain job. The argument being made is that job environments that have low decision-making ability and job demand result in a lower stress environment (Karasek, 1979). Alternatively, work environments with high decision-making ability and job demand result in a more positive work experience (Karasek, 1979). Employees in these environments can adequately direct their skills to accomplish their work-based objectives. One major problem that can arise is seen with the high stress job model. The high stress job is made up of high demand, but low decision-making capabilities for the worker (Karasek, 1979). The combined effects of high demand and low control is thought to result in higher levels of dissatisfaction among workers (Karasek, 1979).

Karasek's model has been employed in several studies over the years in a variety of work settings. One such setting includes Laschinger et al.'s study in LTC, which supported Karasek's model (Laschinger et al., 2001). Laschinger et al. found that nurses in LTC with high demand and low control felt less empowered than those with higher control (Laschinger et al., 2001). When nurses reported high levels of demand and control, they reported feeling more empowered in their roles and confident in their ability to do their jobs (Laschinger et al., 2001). Laschinger et al.'s work highlights the relevancy of this model in an analysis of the current LTC work experience.

Additionally, I will consider the role of gender in the work experience of LTC employees. LTC workers, like most care work, is a work sector where women predominate (Khanam et al., 2022). As such, we may consider how the gendered environment of LTC may contribute to the experience of LTC work. A study in Sweden by Grönlund found that high job demand may have negative impacts on an individual's private life, regardless of gender (Grönlund, 2007). Despite these seemingly equal impacts, women were found to experience more conflicts between their work and private life (Grönlund, 2007). Additionally, women were found to be more likely to have high strain (i.e., high demand and low control) (Grönlund, 2007). One potential explanation for this distortion may be due to women being less likely to hold positions of power, thus reducing their decision-making abilities within their role. Another explanation for the high strain LTC workers may feel in their role is due to the emotional labour associated with the work. LTC is an environment with high mortality rates (Puyat et al., 2019). Thus, the predominantly female LTC workers are left to deal with uncontrollable loss as a part of their regular work-life. The gendered reality of LTC makes it an interesting and vital consideration in the overall present-day work experience.

Literature Review

There are three main bodies that are identified as areas of importance to consider. These include quality of work-life, demand (workload), and control (autonomy, collaboration, and emotional labour). These bodies of literature have been organized in three major time periods: pre-COVID-19, COVID-19, and a post-COVID-19 context.

Pre-COVID-19 Context

Prior to the COVID-19 pandemic, the LTC system was already under strain. One reason for this strain is tied to the increasing size of the old-age population, which results in a disconnect between resident demand and worker supply (Ministry of Long-Term Care, 2020). Studies on nurse retention within LTC have shown a lack of career development opportunities is a key factor on nurse's decisions to leave the sector (Tummers et al., 2013). On the other hand, retention has been linked to worker considerations of job stress versus job satisfaction (Tummers et al., 2013; McGilton et al., 2013). The work environment is at the core of the worker's experience on the job (Tummers et al., 2013). The literature shows a mix of positive and negative experiences within the LTC work environment. For instance, some studies have shown that LTC workers receive individual satisfaction at the hand they play in caring for residents in their final years (Braedley et al., 2018). On the other hand, issues of racism and sexism are commonly faced by LTC workers (Braedley et al., 2018; Laxer, 2013). LTC workers have also reported issues of bullying within the workplace, a possible manifestation of the hierarchical nature of the LTC setting (Syed et al., 2016). Ultimately, the literature shows that job stress and job satisfaction are vital considerations for determining why nurses leave LTC (Tummers et al., 2013; McGilton et al., 2013). Both job stress and job satisfaction are broad terms, which are made up of several other variables. Some of these variables include burnout and turnover, emotional labour, workload, autonomy and collaboration. These bodies of the literature will be discussed further in the following sections.

Quality of Work-Life

Burnout and Turnover.

The relationship between burnout and turnover is made clear within the literature. Workers who experience high levels of job stress are of a higher likelihood to express their intention to leave (Harrad & Sulla, 2018). Job stress is tied to feeling overworked, which can emerge from several experiences. For instance, staff stress may be a result of feeling forced to prioritize tasks due to inadequate time, dealing with grief over losing a resident, and workplace violence (e.g., physical, sexual, etc.) (Harrad & Sulla, 2018; Syed et al., 2016). These experiences of feeling overworked may contribute to a worker's feelings of exhaustion, which then lends itself into feelings of burnout (Braedley et al., 2018). On top of these concerns, though LTC workers care for a large portion of our population, they are often undervalued in their care work, which is seen through their poor financial compensation (McGilton et al., 2013). All these experiences may accumulate to negatively impact quality of work-life (McGilton et al., 2013). Job satisfaction and burnout are shown to be strong indicators of the intention of LTC nurses to leave the profession (McGilton et al., 2013).

Demand

Workload.

LTC homes in Canada have traditionally been modeled as an institutional setting with a strict division of labour (Daly, T., & Szebehely, 2012). The task-orientated approach of labour means that tasks are segmented by worker role. The introduction of workers across a variety of roles introduces complications such as issues of role clarity (Bosch & Mansell, 2015). Division of labour ties back to the issue of the amount of time a worker has versus the number of tasks they are responsible for handling (Banerjee et al, 2015; Daly, T., & Szebehely, 2012). This division of labour may create the feeling of more work to be done, thus increasing the stress felt

by the LTC worker (Daly, T., & Szebehely, 2012). As such, the literature indicates a clear relationship between job demand and quality of work-life.

Control

Collaboration & Autonomy.

Interprofessional care is a core concept in the literature surrounding LTC. Due to the diverse needs of LTC residents, there has been an increasing recognition to have care teams made up of various skill sets to improve quality of care (Kesonen et al., 2022). Bosch and Mansell pulled from the experience of competitive sports to apply interprofessional collaboration to the healthcare setting (Bosch & Mansell, 2015). Their work expressed how interprofessional care benefits both the resident and the worker, with higher levels of care being reported along with improved reports of staff's quality of work-life (Bosch & Mansell, 2015).

The structure of Canadian LTC homes has also been said to produce a hierarchical environment (Syed et al., 2016). A hierarchical environment prioritizes the voices of some over others, thus impacting worker autonomy (Braedley et al., 2018; Tummers et al., 2013). Care workers across all fields have important contributions to the care journey, yet the literature shows that these workers are not always able to express their knowledge (Banerjee et al, 2015). Communication among staff is essential for collaboration for passing on resident information and identifying challenge areas requiring additional support (Banerjee et al, 2015). Poor communication may result in workers not being consistently made aware of important updates regarding their residents (Banerjee et al, 2015). Each of these experiences have the potential to impact quality of work-life and intention to stay.

Emotional Labour.

LTC is often a final home for residents before the pass on. As such, it is part of the regular workday for LTC workers to watch a resident's health deteriorate (Braedley et al., 2018). Continuous exposure to death has been identified as being related to worker's feelings of being burned out (Puyat et al., 2019). Grief is a form of stress that LTC workers are in a constant cycle of dealing with (Harrad & Sulla, 2018). LTC workers spend significant amounts of time with residents, forming bonds with these individuals, and eventually watching as they pass away (Harrad & Sulla, 2018; Marcella & Kelley, 2015). When the resident passes away, LTC workers have a professional responsibility to maintain a level of emotional control for the family and other residents (Braedley et al., 2018; Harrad & Sulla, 2018). There also tends to be a lack of official support pathways for workers to turn to in their times of grief at work (Harrad & Sulla, 2018; Marcella & Kelley, 2015). As a result of this emotional suppression, workers are left with a burden to find their own ways to manage their grief (Marcella & Kelley, 2015). This lack of support is emphasized through LTC home's culture of silence. Death is seen as a part of the job, but is also hidden (Marcella & Kelley, 2015). LTC are the homes of residents, so avoiding a constant parade of death for those who remain does hold some value. Though, the ignorance of death also results in a lack of formal communication when death does occur (Marcella & Kelley, 2015). As such, workers may learn of residents' deaths through informal systems of communication, leaving them even more unsupported (Marcella & Kelley, 2015).

COVID-19 Context

The above section of the literature review shows how LTC workers and indeed the whole sector has been dealing with several challenges. The literature that has emerged since the

COVID-19 pandemic has shown that LTC's pre-existing challenges were exacerbated in the pandemic context (Estbrooks et al., 2020; Estabrooks, 2021; Kirkham et al., 2022). Adequate staffing levels were shown to be a key concern for LTC's ability to provide quality care to its residents, as well as its related impact on worker stress (Estbrooks et al., 2020; Kirkham et al., 2022). Scholars showing difficulties raised by the COVID context on LTC have emphasized worker well-being. Within the literature, quality of work-life remains a core consideration for worker retention. Quality of work-life was again shown to be influenced by several variables, such as autonomy, collaboration, job involvement, and many more (Aloisio et al., 2021; Hardy et al., 2023). Additionally, the importance of adequate training and continued education was emphasized in relation to its impact on worker satisfaction (Hardy et al., 2023; Nasser et al., 2021). The following sections will now consider some of the themes related to job satisfaction within the context of the COVID-19 pandemic.

Quality of Work-Life

Burnout and Turnover.

Pre-existing stressors in the LTC work environment were exacerbated by the COVID-19 pandemic (Nizzer et al., 2023; Schulze et al., 2022). The increase of these stressors had an impact on the work experience for LTC workers. This impact is an important consideration because high feelings of job stress have been tied to an increased burnout and desire to leave the profession (Hardy et al., 2023; Nizzer et al., 2023). A study on LTC managers found that mental health worsened during the pandemic (Iyamu et al., 2023). As a result, nursing managers reported lower job satisfaction, higher rates of burnout, and increased desire to leave their job (Iyamu et al., 2023). Similar findings were reported for nurses in LTC, with work exhaustion and

stress negatively affecting nurse's quality of work-life (Aloisio et al., 2021; Schulze et al., 2022). Due to the severe nature of the COVID-19 pandemic, public health goals (e.g., reducing the spread of the disease) were prioritized over worker well-being (Iyamu et al., 2023). The potential spread of the disease contributed to worker's feelings of anxiety for both them and their loved ones (González-Spinoglio et al., 2024; Hung et al., 2022; Nizzer et al., 2023). Despite these hardships, the resilience of PSWs in LTC was reflected in a study that found PSWs were driven by their duty to provide care (Nizzer et al., 2023). Passion for their work and duty to care were core drivers for LTC workers during the hardest of times (Hung et al., 2022; Nizzer et al., 2023).

Demand

Workload.

The COVID-19 pandemic introduced several restrictions to LTC homes that affected staff's work experiences. For instance, the pandemic resulted in restrictions around accessing LTC homes, meaning previous outside assistance from volunteers and family members was impacted (Niki, 2023, White et al., 2021). Volunteers and family members had previously been an important supporter in easing the workload of LTC staff as part of LTC's unofficial workforce (Niki, 2023). Volunteers and family members who had built up relationships with staff and residents were suddenly unable to aid the homes (Niki, 2023). A study by White et al. reported LTC staff across various roles (e.g., certified nursing assistant, physician, etc.) noted an increase to their workload (White et al. 2021). Staff were working longer hours and under more strenuous conditions, partially related to the personal protective equipment regulations (White et al., 2021). As such, LTC workers felt an increased demand being placed on their work-life during the pandemic.

Control

Collaboration & Autonomy.

There were reports of the pandemic negatively affecting collaboration and communication within teams (McGilton et al. 2023). As was discussed above, communication is a vital component to strong collaborative teams. The literature reflected that a particular barrier to communication was created with the personal protective equipment that workers were required to wear (Kirkham et al. 2022; Nizzer et al., 2023). Though facing many challenges, the literature shows that some LTC teams were able to find strategies to mitigate these experiences. For instance, having regular team huddles or team meetings was found to be a way to encourage better communication among teams (Hardy et al., 2023; Hung et al., 2022; McGilton et al., 2023). These designated times for teams to gather allowed for important information to be shared in an efficient way. Having strong leadership and management being open to their teams were some other strategies identified (Estabrooks et al., 2021; McGilton et al., 2023). Team skill mix, meaning staff with different strengths and the proper training, was found to be vital for the ability of teams to provide quality care (Estabrooks et al., 2021). The current hierarchical nature of Canadian LTC homes does not necessarily produce the ideal environment. Care aids such as PSWs are undertrained and undervalued; these are concerns also linked with their low standing on the hierarchy (Estabrooks et al., 2021).

Emotional Labour.

The COVID-19 pandemic had a clear emotional toll on LTC workers. Due to the residents of LTC facilities being older on average, there tends to be increased health conditions faced by residents (Pott et al., 2020). Residents' age and health status are two explanations for the

disproportionate effect COVID-19 had on this demographic (CIHI, 2021). Thus, the COVID-19 pandemic resulted in an increased mortality rate in LTC homes (Levin et al., 2022). While already expressing concerns pre-pandemic, support systems and resources for LTC staff continued to remain lacking in the COVID-19 context (González-Spinoglio et al., 2024). COVID-19 was also felt to be a difficult time for everyone, resulting in PSWs reporting difficulty in seeking help for concerns of creating further burdens (Nizzer et al., 2023). During the COVID-19 outbreak, LTC workers reported their highest levels of emotional distress (González-Spinoglio et al., 2024). Exposure to high quantities of death within the home was found to be one reason for experiences of distress (González-Spinoglio et al., 2024). Death was not limited to just within the home, with workers also dealing with personal losses in the outside world (González-Spinoglio et al., 2024). As such, emotional distress was experienced by workers both in the workplace and in their personal lives.

Summary and Next Steps: A Post-COVID Context

Over different temporal periods (pre- and post-COVID), we can see common variables affecting quality of work that have continued to exist or be exacerbated by the pandemic. Lingering effects of the pandemic potentially continue to exist within this post-pandemic context; a topic which requires further research. In conducting the literature review not only did it appear there is a need for more research on the post-pandemic work environment for LTC staff, but there also appeared to be limited data focused on the broad range of LTC workers. Managers, nurses, and PSWs are highlighted in the literature, but research on the work experiences of other kinds of LTC workers (e.g., dietary, laundry, housekeeping, spiritual, etc.) are sparse, especially in the Canada-specific context. Research on these workers tends to be focused on residents' health and well-being, rather than on the worker (Syed et al., 2016). My

research project will thus seek to collect data from LTC workers across various roles, emphasizing support staff, where I will consider their experiences in a post-COVID context.

Methods

Background

In 2020, Ontario LTC homes had approximately 78,000 residents and 100,000 staff (Ministry of Long-Term Care, 2020). The majority (58%) of the staff workforce is made up of personal support workers (PSWs), followed by nursing staff (Ministry of Long-Term Care, 2020). Some other examples of LTC team members include managers, paid care workers, laundry, housekeeping, dietary, recreation, spiritual, social work as well as residents, families, volunteers, and students. Each of these workers contributes to the daily care of residents.

Study Design

I adopted a qualitative approach using a social constructivist perspective to co-create knowledge with the study's participants. Social constructivism seeks to provide understanding of experiences of individuals within our society, while recognizing their meanings may vary (Creswell & Poth, 2018). In this way, social constructivism recognizes that human experiences are not uniform and thus give value to the diversity of perspectives. The social constructivist framework was an important perspective for this project, which sought to analyze the experiences of LTC workers post-COVID-19. As such, this research project aimed at identifying any commonalities or differences in experiences across worker roles. The differences that were shown to exist produce implications for existing one-size-fits-all solutions that are implemented, thus suggesting the need for a research design that accounts for expected differences. Therefore, exploring the reality of work experiences for all LTC workers has important implications on policy and practice considerations within LTC homes.

Positionality

I have previous experience working and volunteering in a LTC home I volunteered at the project site LTC home for many years, in a pre-COVID context. I then took a job in housekeeping and laundry during the first summer of COVID-19. I saw firsthand some of the major impacts of the pandemic on the work of LTC workers, such as the effects of personal protective equipment. These experiences have provided me with some initial insights into the potential experiences that will be discussed throughout the data collection phases. I also have familial ties within the home, which were considered in the ethical construction of the study.

Therefore, in this project, I combined my existing knowledge with the findings from the literature review and the lived experience of present-day LTC workers to develop the data used for this research project. In combining these sources of knowledge, I was able to provide more depth to the findings that a single source might be able to provide.

Site Selection

Participants were sought from a single LTC home in southern Ontario. The home is a not-for-profit LTC home, with a Board of Directors that contributes to its operation (*note, the citations in this section have been changed to anonymous to maintain the anonymity of the site*) (Anonymous, 2024). The home was originally run by a specific Christian order but such ties have since been separated on the LTC home. The home continues to have Christian religious services, with a chaplain operating on site and religious services being held within the home. The home reports having approximately 300 staff, 270 residents, and 200 volunteers (Anonymous, 2024). The chosen site, like all Ontario LTC homes, is currently operating during a time of LTC worker shortages (Ministry of Long-Term Care, 2020). They have a Family Council, which is

mandated to provide support and feedback to the home in order to ensure the best quality of service is being provided to its residents (Anonymous, 2024). This research project was given permission to take place within the home by the Chief Executive Office. The document of approval was omitted to maintain site anonymity.

Participants, Sampling and Recruitment

Participants were recruited from one LTC home in southern Ontario. To be considered eligible for participation, the following inclusion criteria was developed:

- Currently work at the chosen site location;
- Participants may work at this institution on a full time, part time, or causal basis. Volunteers are included as part of long-term care's informal staff workforce;
- Participants must have been working at a long-term care facility (not limited to only the chosen site) during the COVID-19 pandemic (latest start date will be April 2023);
- The participant must be 18 or older at the time of the interview;
- The participant must be able to communicate in English for the interviews;

To participate in the study, applicants had to meet the above criteria. Additionally, an exclusion criterion was developed to avoid issues of coercion or biases in the data collection. No participant may be a family member of mine. This criterion was created because at the time of recruitment, I had two family members working within the chosen LTC site.

To address the gap in literature on the experiences of some LTC workers, I used purposive sampling. Purposive sampling allowed me to ensure a selection of participants across the broad expanse of LTC worker roles. Interviews were conducted with participants across various fields of work, including managers, registered nurses, registered practical nurses, personal support workers, laundry and housekeeping, dietary, recreation, restorative care, in-

house doctor, and other office staff. When recruiting, I originally started by hanging up posters throughout the home. I placed posters throughout various hot spot locations for staff to gather, such as in staff break rooms, the staff elevators, by the sign-in machine, and so on. I also had the home send out an email on the Surge Learning Platform to promote the study, emphasizing that the study is taking place separate from the home itself. From these strategies I received only four expressions of interest to participate. As such, I planned a trip to visit the home in-person so that I could speak to staff directly. I went between the floors and gave a short pitch to staff on the project and what their role would be as a participant. This turned out to be a much more effective manner of recruitment. I was able to answer questions and book timeslots on the spot. A number of staff expressed having had interest upon seeing the poster, but would forget by the time they finished their shift. So, being in-person addressed the issue of follow through. As I was interviewing participants, and still recruiting, word of mouth was also important. After completing an interview, some participants would share with coworkers about the study, helping to expand my recruitment reach.

Being in-person also allowed me to have interactions with a great number of staff, including those who did not end up participating in the study. From these conversations, I received a great deal of positive feedback on creating a study that seeks to highlight voices across all LTC roles. One housekeeper in particular shared her gratitude, saying that they have a lot to say, but no one ever thinks to ask them. These interactions strengthen my drive on the necessity for a study to be done that was inclusive of LTC roles across the board. In the end, a total of 20 interviews were conducted over a two month period in the autumn of 2025. By having 20 voices across worker roles, I was able to construct a meta-narrative that includes variation in the roles included.

Of the participants, 100% (n=20) were female and 75% (n=15) were aged 50 and older. The age of participants is especially important to note, as many reflections came from the perspective of having been in LTC work for many decades. Topics of discussion were also led by the reality of many of these staff approaching the age of retirement. The majority of participants, 75% (n=15), were white. The remaining participants identified themselves as being East Indian, Hispanic, Southeast Asian, and bi-racial. All participants held Canadian citizenship, with one holding dual. College level education was the most common at 70% of participants (n=14). Only two participants held up to a high school degree, and four had a bachelor's degree or higher. The marital status of participants ranged, with 30% (n=6) being single, 15% (n=3) being common law, 50% (n=10) being married, and one being widowed. During one of my interviews, I was made aware of an issue with my demographic surveys including "divorced" as an option for marital status. The participant expressed that they identify as single, rather than divorced. As such, this category was integrated with the category of being single. Only one participant identified having a child under the age of 18 within the home, but other participants did acknowledge having older children living within their household, which was not accounted for within the survey. 85% (n=17) participants contribute 50% or more to their household income. Lastly, 50% of participants were in medical staff or nursing roles (i.e., doctor, RN, RPN, PSW). 15% (n=3) were in administrative or management roles, which also included any staff that were considered office staff. Only 10% (n=2) were allied health professionals (i.e., recreation and restorative care) and 25% (n=5) worked in support roles (i.e., housekeeping and dietary). The findings from the demographic survey provide additional detail on the similarities and differences between participants, which may contribute to their worldviews expressed throughout the interviews.

Data Collection and Guides

The 20 semi-structured interviews to co-construction of a meta-narrative on the post-COVID-19 reality of LTC work. Interviews were semi-structured because this aligns with my decision to co-create knowledge with the participants. A semi-structured interview guide included a mix of open and closed ended questions that build upon the themes that have emerged within the literature. The knowledge I have gathered from the literature review was used to develop a priori questions, which also allowed space for emerging topics for discussion. Interview length varied depending on the availability of the team member, ranging from 27 to 50 minutes.

Interviews were conducted both online (n=6) and in-person (n=14) depending on the participant's preference and my availability. Online interviews were completed both via phone and using Microsoft Teams, with a combination of the two being used for those not comfortable to operate Teams. Both in-person and online interviews were audio recorded and transcribed using Microsoft Teams. Following the interviews, all AI-generated transcripts were reviewed for accuracy.

Data Analysis

All edited transcripts were then entered into Nvivo to enable the coding process. I used a combined deductive and inductive approach when working with my data. Using my pre-existing knowledge, and the findings from the literature, I had expectations of findings that would emerge from the interviews. For instance, I expected that I would have codes related to job satisfaction, burnout, teamwork, and communication. These were some of my a priori codes that I had going into the data coding process.

My first phase of working through the data involved highlighting the key words in my data passages. I identified a total of 633 key words from my data which I then sorted into similar groupings. In this process, I was able to cut down the number of codes I had. Some were duplicates that were merged, and others had similar sentiments that came together. After reducing my coding, I found that I still had approximately 188 codes. As my next approach to working through the data, I began to create a coding schema so that I could better visualize how the data worked together. From this process, I developed seven overarching conceptual themes. These were staffing, workload, collaboration and communication, relationships with residents and families, mental health, work-life satisfaction, and COVID-19 impacts. Within these categories, a total of 41 themes were identified. While drafting the results section, the number of codes continued to be reduced as more overlap was identified. By writing out my code definitions, and working to explain them in the results section, I identified some codes that were expressing the same or a very similar message. As such, I merged these codes into each other as these situations arose. For example, assisting other departments during COVID and work description changes were merged during this phase. I found that the passages under work description changed were referring to the way the staff began to assist other departments as part of their role during COVID. Additionally, some codes were removed during the writing of the results section, as they were found to be beyond the scope of the research question of this paper. In the end, 140 codes remained as part of the final coding schema. Each of those codes include an accompanying definition and a quote from the interviews, though not all quotes from each code were included.

Prior to starting to write my results, I reorganized the codes within each category from most to least prominent. Saturation was reached for the direct research questions, but less

directly for the research objectives. For instance, gender is pervasive, but also often invisible. I did not directly ask the participants about their experience of gender within the workplace, but some of their answers pointed towards a gendered influence. More contemplation for the gender dynamics were required, but we ultimately included it in the discussion section of the paper.

Using the data from the interviews, I was able to verify that my a priori expectations rang true. The codes I had expected to emerge did. Then, I used thematic analysis to work through the data, which allowed for me to identify the emerging descriptive and analytic codes. In addition to what I expected to find within the data, new/unexpected experiences emerged. For example, I was not anticipating having so many staff discuss having worked multiple roles within LTC. These findings spoke to the impact of LTC work on one's body and individual desires to have change within one's career. The a priori and emergent codes were then combined to identify common themes or narratives that contribute to the meta-narrative. These themes create the basis for my interpretation of the findings on the post-COVID-19 reality of work for LTC workers.

Ethical Considerations

This project was submitted to the University of Ottawa's Research Ethics Board for approval. In my submission to the ethics committee, my previous experience and other connections to the LTC home were made clear. Once approval was provided, I began the process of recruiting participants via recruitment posters, a recruitment email, and in-person recruitment. Interviews were scheduled as participants signed up and participants were given the letter of consent for review. The letter of consent included details on the purpose of the project, potential benefits and risks to their participation, the voluntary and confidential nature of their participation, and a note on compensation. Participants were compensated with a $20 gift card to a local business. The digital documents from participants will be kept for the duration of five

years, beginning once the thesis has been successfully defended. After the retention period, the files will be deleted. The hardcopy documents will be shredded at the beginning of the retention period, leaving only the digital version of files to be retained.

Results

The following section outlines the findings from the four key thematic categories identified. Starting with staffing and workload, as these (often quantitative) measures set the basis for which all other work-life experiences build off of. Then, relationships, communication and collaboration introduce a number of qualitative elements to work-life experience. Next, staff well-being and work-life satisfaction is discussed, much of which stems from the context provided in the previous two thematic categories. Lastly, discussions on the impacts of COVID-19 are considered, including the pre, during, and post temporal periods. Each of these thematic categories influence one another in the larger picture of what LTC staff work-life looks like today.

Staffing and Workload

Some of the key concerns raised by interview participants addressed the integrated issues of staffing and workload. Staffing considers both the quantity and quality of who makes up the LTC teams. This in turn has an impact on workload which considers the ease and challenges faced by LTC teams, either supporting or hindering the quality of their work and work-life. Staffing and workload were foundational experiences that have strong and lasting impacts on the other remaining themes that will be explored.

Staffing

When issues of staffing were discussed with participants, their pathway into LTC was described. Staff training and competency challenges were raised by the LTC staff. Participants also noted important concerns regarding the number and quality of staff with which they worked.

Unplanned LTC Worker.

The staff that make up the LTC sector come from a variety of backgrounds and experiences. A number of staff in roles from administration & management, medical & nursing staff, and support team expressed the unplanned nature of their LTC career. These reflections make mention of the surprise entry into the LTC sector, as well as a note on their level of satisfaction with this turn of events.

Several staff reflected on LTC as being a career that did not fulfill a dream. Where some expressed having had a clear disinterest in being in the LTC sector, others noted it as being a career of conveniences and security. As one participant shared:

> Honestly, I finished school and I had done a placement here. I did the placement here because…it was close, and then…the director of nursing at the time was like, do you want a full-time job? And I finished in like June and I'm like, yeah, I'll have a full-time summer job, like I'll be able to pay my debt off over the summer and I'll be good to go. And I just never left.

Despite the unexpected nature of some staff's LTC career, many of these staff found themselves growing fond of their work in LTC over time. One participant found the adjustment to be immediate, stating, "oh, as soon as I start working, I'll start loving it".

Though convenience and/or security plays a role in several staff member's retention, the growing love for the work they do also affected a number of staff's decisions to stay. These stories highlight the diversity of reasons and experiences staff have for entering and remaining within the LTC sector.

Staff Training and Capability.

The current staff in LTC face hurdles in response to training and competency. The interpretation of staff training, its adequacy, and staff competency varied between participants. Considerations included how training is similar or different, language barriers, and onboarding challenges.

Some staff felt that team members within the same department were all trained the same mechanically, minimizing differences in care approaches. A PSW stated, "...as far as mechanically, like lifts and things like that, we all are trained the same way…there's nothing different that way".

Alternatively, other staff felt that they could not assume their coworkers had been trained the same on all aspects of care, specifically quality of life forms of care. One PSW shared:

> I always like to have the men shaved on a daily basis and a lot of the other people don't do that...I just always assume people should know…I'm getting better at trying to assume that maybe she doesn't realize that he needs to be shaved.

Some participants amounted variances in training and practice to generational differences. Older staff noted issues of worker motivation towards the job and increased complaining or avoidance of tasks being seen among younger staff members. A PSW reflected, "sometimes the senior person will also work differently and have a bit of a different work ethic than some of the other people…we learned things a little bit differently and did things differently".

Staff capability was brought into question in relation to language barriers. When orientating new staff, there were concerns whether staff were adequately understanding instructions if they were not native English speakers. One PSW shared:

> And if it's one of the people from India, then you've also got language barriers too where you're trying to explain something and I'm not sure if they're fully understanding…So I have to always monitor and watch and make sure that they're doing OK.

Current staff are responsible for onboarding new hires. Staff expressed a mixed of positive or negative reflections on the responsibility, but the majority leaned towards the negative. One PSWs experience was, "and then we always have to say, sorry, it's not nothing to do with you. We just don't like to do it. It just slows us down".

Quality of onboarding was noted by some as being poor, impacting the quality of work being produced. The impact relates to issues of quality of care and quality of work experience for coworkers. One dietary staff expressed her frustration with the poor onboarding of new staff:

> I find that the way the new system is…too overwhelming for people and that because say you have a new trainee and because that there's so many different positions now…you get thrown into it too quickly….You're just you're a body and you're being put into positions that you really have no business being in because you don't fully comprehend the job.

In addition to affecting coworkers, menial onboarding also impacts the new staff hires. A lack of adequate onboarding was associated with feelings of being unprepared or tossed into the deep end. These concerns were seen across departments such as housekeeping and dietary. One participant shared her experience of receiving minimal training by saying, "that's all they have is…two day training…I think they could do more with more, but that's what they allotted…You kind of have to pick it up yourself as you go".

Staff were found to have different perspectives on the quality of training and competency that they received themselves, as well as that of their coworkers. Differences in training have the ability to cause tension between coworkers. Additionally, these differences affect the type and consistency of care being provided to residents. Similarly, the process of onboarding, though a necessary phase of hiring, also puts stress on staff when done inadequately or too minimally. These experiences all relate to the following sub-sections on staff workload and teamwork & collaboration.

Quantity and Quality of Staffing Issues.

Though many staff have found themselves growing to love LTC, that does not leave the sector without its difficulties. Staffing issues address areas of concern including the quantity of

staff on teams and the quality of the work these staff produce. They were expressed through mentions of problematic staff, the need for more staff to be hired, and issues of high turnover.

Some staff were labelled as problematic when they were identified as being unmotivated to do their job. This was seen through passing off responsibility to someone else or leaving the task incomplete. Some cases also included staff who were rude to residents and other staff members. One dietary staff shared her experience of witnessing unmotivated staff, stating, “yeah, there are the people that have the attitude, ‘it's not my job’, you know?”

Staffing issues were tied to the need to hire additional staff. There was a particular emphasis towards needing more afternoon activity staff, as is seen through the thoughts of one PSW:

> The sundowning is huge on this shift… I feel that there should be more activities or any kind of engagement between the hours of 4:00 [PM] and like 8:00 PM for these people... after supper, and there's just no one…. There's a lot of, ‘now what do I do?...Do I go to bed at 5:00/6:00 [PM]’?

High turnover was another factor affecting staffing issues, which was mentioned across various departments, including dietary, PSWs, and RNs. The impact of high turnover was articulated by one PSW who stated:

> It is hard to stay positive when you don’t have enough staff working on the floor…you're just running like crazy all day… trying to meet the needs of 29 people. And some days that can really weigh on you because you know you have given everything that you can possibly give that day, but you still weren't able to do it all.

The experience of staffing issues reflect difficulties of staff to maintain a positive morale when support is inadequate. These experiences also highlight the way staffing issues affect the quality of care being provided to residents — some of which operate outside the level of control of the individual staff member. The quantity and quality of staffing has implications on the experience of workload.

Workload

Discussions around workload covered a broad range of topics. Staff reflected on what makes their workload manageable or unmanageable, the level of schedule rigidity experienced, levels of control, impact of shift type, achievability to breaks, role clarity, and additional duties of advocacy.

Manageable Workload.

Without erasing the reality of the challenges LTC staff face with regard to their workload, it is important to take a moment to acknowledge what is manageable. Staff reflected on the benefit of having new roles introduced within the home, the impact of low external interruptions, the speed of their days, their contentment in their roles, the continuous nature of LTC, the impact of new technology, and how their workload can teeter between manageable and unmanageable.

Within the LTC home, a number of new roles were identified as having emerged within recent years. These roles have been found to produce greater support for pre-existing staff, positively affecting workload. One in-house doctor reflected on her positive experience with these changes:

> Previous to having her [Nurse Practitioner], I would get probably 8 to 10 phone calls or emails a day about patient issues. With her there…they go to her first and she triages and then they'll come to me. So sometimes I'll get one to three issues during the days when I'm not there…because she'll call me about urgent things and then the rest will be saved for when I come in. So it's definitely changed the balance.

Due to the study covering a range of roles, many staff found that they had only minimal interactions with residents. Interactions with residents and family members were noted as sometimes being interruptions to the flow of one's schedule. Not all participants were happy with this separation, especially those who changed roles leading to less interactions than they

previously had. One participant shared her experience of this change, saying, “as a manager it is much different. There are times where I definitely miss that interaction with the residents and being able to provide direct hands-on care”.

Having a busy workload was not always considered a negative by staff. Some found that busier days helped pass the shift faster than slower ones, and was thus preferred. One staff member said, “maybe it's better if it's a little busier than [when] you're not doing anything. I mean, it's kind of boring… you're just there waiting. To me, [I] rather [be] a little bit busy”.

The work of LTC never ends; there is always something that will need to be done. As such, some staff emphasized their mindset of coming in with the intention to do their best, whether or not that means getting everything done. One RN shared:

> Whatever I [can] do, I will do. That's how I come on the duty…I will do my best…This is my job. I want to put my 100%. I want…my work flow honestly…the whole shift and make sure that things are rolling.

Part of some staff’s contentment to simply try their best was tied to the idea of LTC being a continuous care environment. When one shift ends, another shift begins. The sentiment being, if an item cannot be finished during one person’s shift, it should be carried over to the next. One RN’s mindset is, “I do try to wrap things within a time…To me, the goal is it's a continued care. It's 24/7 nursing. If it's my time to leave, [another] person should pick up from that”.

Technological changes within the home have had a positive impact on reducing workload for some staff. The introduction of a new application used internally to cover shifts has reduced the time required by staff to find replacements. The impact of this change was highlighted by an RN who said:

> Since we got this new staff app, it's flowing a little bit better. But before we have to go by the roster…one by one. That was…very time consuming…now we have a staff [app] that is much easier. We just post and then look up who applied for it instead of calling those 50-60 people, you know, one by one.

For some staff, despite some of these promising mindsets and changes, their workload teeters between manageable and unmanageable. Part of this teetering is linked to the volatile nature of LTC work. One moment everything can be calm, and the next there can be complete chaos. One in-house doctor commented about this experience by sharing, “there are some odd weeks where there's outbreaks and people are sick and it's more than just your usual that it can become quite intense”.

From these reflections, staff shared some of the positive experience of their work in LTC. New changes being implemented within the home, such as new staff and technology, has the potential to improve workload for staff. Positive mindsets when approaching work also were noted as contributing to a greater sense of ease towards staff's work-life.

Workload Challenges.

Even with the positive aspects to LTC work, there continue to be a number of challenges faced by LTC workers. Struggling with a heavy workload, picking up residual roles, and dealing with the bodily toll of LTC work were explored. Additionally, dealing with having inconsistent support, challenges requiring creative solutions, time constraints, and unequal divisions of workload are faced by some staff. Challenges such as these have led to staff creating their own well-being coping strategies.

Dealing with a heavy workload takes a toll on staff. Some staff shared feeling overwhelmed at work. Others expressed frustration towards their workload. One RN shared her frustration, saying, “it's so overwhelming some days, you know? Yeah, I'm in tears. I'm telling you the truth. And I want to walk out the door and never come back”.

On top of already heavy workloads, some staff are left to handle residual roles. For instance, during afternoons and evenings when there are less staff in the building, the staff on

hand have to fill in the gaps. One RN shared the large number of additional duties she is left to handle:

> Suppose that they have a staffing issue and when someone is not present or something is wrong with the meal, I have to go and check. [If] something…happened to the kitchen stove or there's a gas leak, or there's laundry in the laundry. If they have a water leak or something is not working, then I have to call the maintenance guy and they'll follow up with that, including even if there's the fire alarm, other issues, power outage.

The work in LTC is also very physical for the majority of roles. This reality puts a strain on workers' bodies over time. One participant reflected on her experience aging in the role, stating, “it is getting a little harder now only because I'm getting older”. The strain of LTC work is physical, as well as mental. Some staff reflected on how they felt emotionally drained as a result of the stressful nature of their work.

When facing a heavy workload, some staff may turn to the support of their coworkers within or external to their department. Unfortunately, staff support varies depending on the workload they themselves are facing. One participant summarized this by saying, “I mean if they're busy too…then you're kind of on your own, right?”.

Due to the difficult nature of some tasks in LTC work, some staff have found they have been forced to adopt creative solutions to get the job done. Though these solutions help achieve their goal, some staff felt tension towards having to implement such approaches. One RN’s approach to a creative solution was, “like one lady…I know she loves butterscotch pudding and I lie my little *** off every day...Eat this…She needs her meds”.

The heavy workload of LTC staff is exacerbated by the time constraints staff face. Staff are forced to fit as much as they can into a limited amount of time. One PSW shared her experience with the limited time she had with residents by saying:

> We've got from 6:30 to 8:30 to get up 29, basically 30 people. Rounded off to 30 people and I think I did the math. 2 hours is 120 minutes, right? And if I've got 30 people, that's giving them 4 minutes each. If I do the math right.

Workload was found by some staff to be unequal. This could be in terms of individual responsibility, as well as responsibility by department or section of the home. Some staff found one shortcoming of the LTC home's distribution of residents to be the lack of consideration of the level of care required by the resident. As a result, some floors experienced higher care needs of residents than other floors. The unequal distribution of work left some staff feeling burdened with heavier workloads.

Dealing with these challenges, some staff have taken the initiative to develop personal coping strategies to manage their well-being. An RN shared, "you have to work on your well-being, which I have my own personal things that I do at home to relieve and stay that way at work…the softest music going on while I'm working…keeps me focused".

Staff were found to struggle with a number of workload challenges. Heavy workloads, along with minimal time and support put pressure on staff. Some found creative strategies and coping to deal with this increased level of stress, while others did not. Workload challenges bleed into a number of other key areas of findings.

Worker Routine.

LTC is often described as being a repetitive setting. Staff reflected on the need for flexibility and adaptability within their roles in LTC, while also noting the routine nature of the environment.

LTC is an environment with a mix of residents with various needs and behaviours. Many staff found that LTC work requires a degree of adaptability when the unexpected arises. A task at one moment may need to be paused to deal with a more pressing concern that has arisen. One

RPN shared, “you have to be very flexible. It's yeah, it's not really a job if you want everything…all laid out, cause it never goes that way. Something always happens where you have to be flexible”.

Even with the changing nature of the work environment, LTC does require a level of routine. Certain tasks or needs must be done by particular times in the day. One PSW reflected on this balance by saying:

> It's very routine…not a lot changes except for obviously if there's an incident with a resident or…someone gets sick or they have a fall. But other than that, the days are pretty much the same every day.

Staff reported having certain expectations of what the workday would be like, yet acknowledged the need to be prepared for the unexpected. Routine and volatility work in equal measures within the work environment.

Type of Shift.

Another important reflection for staff in regard to their workload is the shift they work. Staff discussed availability of certain types of shifts, as well as the differences between day shift and afternoon/evening shifts.

Though staff may have a preference to the shift they work (e.g., day, afternoon, evening), they might not always have as much say in what they are assigned. Rather, shift lines are awarded by seniority and availability. As such, some staff have found themselves dealing with the shift lines they have been dealt.

The duties between a day shift staff member and an evening staff member can vary greatly. Day staff are covering tasks such as wake up, two meals, and other auxiliary tasks. The afternoon shift on the other hand has to put residents to bed, do auxiliary tasks, and deal with any issues should they arise. The nightshift then deals with outstanding tasks and assists if residents

need any assistance throughout the night. To compensate for these differences, the number of staff assigned to these shifts differ. One PSW reflected on the differences of workload as someone working the day shift, saying:

> You do have…two meals that you're serving. You have a lot more baths that you have to do. You have a lot more people coming in and out…sometimes we have psychologists that put on little seminars, so you have meetings and things like that you need to attend to. It's just a lot busier. There's activities going on, so there's a lot more happening.

Staff working within the same LTC home may be navigating vastly different environments depending on their shift type. These differences are not highlighted to mitigate the contribution everyone makes, but to acknowledge the range of duties that have to be done for resident care. These factors affect what the workload of a staff member might look like at any given time.

Ability to Take Breaks.

Often taken for granted, the idea of having a break is not uniformly accessed by all staff. Some staff report having a harder time being able to take their break and still get done what needs to be done. This is due to reasons such as not enough staff on the floor (e.g., during COVID especially), needing to do certain tasks during very specific times, and picking up the slack from other staff. One RPN shared her struggles to take breaks, saying:

> More often than not, though I find in this role I miss breaks because…I'm one person for 8 units. I'm trying to figure out…how I can complete a lot of these tasks. With that said, any wounds that are on like the lower part of the body, I have to do when those residents are in bed. So when I get a slew of those residents, that's hard for me to start timing it to get all that done, right? Because residents don't go to bed till later, right? I can't do them when I [first] come in. So that puts me behind, which then…I've usually missed my evening break.

On the other hand, other staff recognized the importance of taking their breaks. One allied health professional shared her belief that breaks should always be taken, as they are a worker's right. Her perspective came from the background of being a union steward.

Though breaks offer an important pause for staff to recharge during their shift, not all staff find they are able to take their breaks. This comes not from being physically incapable, but rather from the personal obligation to fulfill certain tasks that they feel takes priority over themselves. Perspective from a union steward re-emphasised the importance of staff accessing their rights to a break.

Job Control.

Related to the scheduled nature of LTC work is the staff's experience of having control over their duties. Participants were split on their opinion of their level of control, as well as whether control was even an appropriate measure. Some staff felt confident that they held control in shaping their workday. Others felt they did have control, but had not thought about it in such terms before. Often, staff connected their level of control with the ability to set their own routine.

One particular RPN felt that control was an inappropriate word for the experience of nursing. The daily experience of those working in LTC is dealing with the expected and unexpected. The unexpected is such a prevalent part of their job that having control may be thought as impossible. They shared:

> It's not a great word for nursing because…so much is just out of our control…the other night we were feeding, all of a sudden someone starts choking, you know, then we're suctioning and we're doing this and this. You just never know what's gonna happen.

Control, though existent, is not necessarily always achievable by staff in LTC. Those who did feel a sense of control referenced it in terms of scheduling their routine or duties.

Reporting Requirements.

A related concern to workload challenges is the changing sphere of reporting requirements. Reporting contributes to a staff member's tasks, but participants were mixed on

the effect of reporting on their workload. Those leaning towards reporting requirements being unmanageable also tended to reflect on the Ministry of LTC's role in dictating these requirements.

The majority of staff who commented on reporting requirements found that there was too much reporting required. Reporting was found to be a somewhat tedious task that took away from their ability to do other jobs, some of which were argued to be more important. Other staff noted that high reporting requirements took time away from being with the resident — something that many staff agreed was of top priority. One RPN shared:

> I just feel there's so much charting. That's fine and I can understand. However, when you think of the amount of us…that's just the amount of charting that is required to complete a shift. I look at that as time taken away from me spending with residents and that's where I have a problem.

Reporting requirements are determined by the Ministry of LTC. Some staff felt that the Ministry was unrealistic with their expectations. Some expressed a belief of a disconnect between the reality of LTC work and ministry expectations. This issue was articulated by one participant who said:

> They're putting [in] more and more paperwork…Where are the resident[s]? Where are those people who need our time? They're not focusing on them. They're focusing, make sure when they have a fall, do this…and that.

A small subset of staff found that reporting requirements were manageable for them. One PSW shared how the repetitive nature of reporting made it easier to complete the task, saying, "It's easy…because we chart every day, right? We know the behaviors".

Reporting is an important stage of tracking care and behaviours of residents residing within the LTC sector. These duties have been increasing in recent years, which has resulted in some staff feeling overwhelmed and frustrated by the increasing load of the task.

Staff Advocacy.

The floor staff within the case study home are unionized. Sentiments towards the current union were mixed, with some finding it to be satisfactory and others struggling with the disproportionate power of unions. Working as a union steward and advocating for resident rights adds to individual workloads both in a practical and mental sense. Concerns of limited staff rights may affect staff morale.

The topic of unions raised some discomfort for participants. Where some felt that unions were fine, or held no strong attitudes towards them, others expressed more frustration. The case study home has two unions, one for the RNs and one for the remaining floor staff. Some staff felt that the RN union held a disproportionate amount of power, whereas the other union lacked the same perks. This created tension and difficulty for some.

Many staff interviewed have experience working as a union steward, which adds additional responsibilities to their role on top of their regular duties. There are a mix of reflections of this experience and how it impacts workload. Some do so out of passion, whereas others simply found themselves in the role. Either way, operating as a union steward adds to the workload of staff, as they are expected to complete their regular duties on top of dealing with any union related items as is necessary.

Staff and resident relationships are closely intertwined. Some staff expressed feeling a duty to advocate for resident rights to care when they see areas for improvement. Gaps in care and workload issues cannot be separated. One allied health professional stated, “...if someone wanted to go to the bathroom, they keep asking, they keep asking and they keep getting ignored. I'll make sure someone takes him to the bathroom”.

Some staff struggle with the knowledge that change is needed within LTC, but options for advocating for that change are limited. One RPN expressed her frustration, saying “We can't strike. We're not allowed”.

LTC staff have a range of experiences — both positive and negative — in relation to their workload. Staff’s routine and control, shift type, ability to take breaks, and the clarity of roles all impact their experience with their workloads. Additional considerations of staff advocacy, for staff and for residents, may add to their workload. The underlying conditions of staffing and workload heavily relates to the dynamic of teamwork and collaboration that exists within the LTC home.

Relationships, Communication, and Collaboration

Collaboration and communication among staff and relationships they have with residents/family members was another key concern raised by interview participants. Collaboration and communication considers the quality of relationships and knowledge sharing between staff. Relationships are then extended out to include residents and family members, who make up a significant portion of the LTC environment. Collaboration, communication, and relationships experienced by staff play majorly into work-life experience.

Collaboration and Communication

Communication dynamics were discussed at peer, interdepartmental, and managerial levels. These themes include experiences of support and a sense of being valued.

Role Clarity and Boundaries.

Roles, both old and new, have been faced with issues of role clarity. With changes emerging within the home, such as the creation of new roles, there has been an adjustment period

for some staff to identify their job boundaries. This includes needing stricter boundaries to emerge, as well as recognizing the process of allowing for role clarity to develop.

Failing to have defined job boundaries was identified as a point of contention. Confusion around roles added to workload in some cases, while also diminishing staff's ability to dedicate their time to their role specific duties. One PSW spoke to her struggles of her work being stretched too thin, saying “I think nursing should be nursing”.

In addition to needing to clarify job boundaries for existing roles, new positions are going through a period of growing pains as role clarity is established for both the workers themselves and their coworkers. This adjustment period is explained by an RPN in a new role:

> It's a new role. So maybe it hasn't been explained properly from management and from us, 'cause we're learning, right?...[coworker] and I have tried to be quite consistent in our language used to indicate that we're here to assess, not…do every single thing...So it's, I think, a learning curve.

A lack of clear boundaries and clarity around roles create tensions between staff. A need for both to be developed for old and new roles is emphasized as an important step for improving staff’s work-life.

Team Dynamic.

Staff have different experiences with team dynamics, including the strengths or weaknesses of their teams. A number of staff felt content with the team dynamic they experienced within the home. This sentiment was shared by participants across a number of roles, including those working as medical and nursing staff, as well as allied health professionals. One perspective shared by a contract employee was:

> It's a really great team. And so the team part of this place, they work well together. They're good to each other for the most part. They treat each other well. Everybody works as a team instead of like this hierarchy. It's a lovely place to be.

Not all staff felt as closely connected to their team networks. Some expressed feeling disconnected from teams due to the independent nature of their work, whereas others attributed the feeling to changing staff dynamics within the home. One RN shared:

> So I will really love to see if there are small teams…where they guide each other. There's teamwork. That's one I'm missing big time…in long term care [is] missing …teamwork and communication flow.

Related to issues of reduced sense of team dynamic was the concern of departmental tension. For instance, participants spoke of struggles with departmental drama, which had a negative effect on team dynamics.

Noting the difficulties that arise from poor team dynamics, management has organized workshops in an effort to improve these dilemmas. One director of nursing described one of these workshops as follows, “we did a workshop…a motivational speaker and how to work with teammates that might not be so positive and focusing on gossip and just promoting a positive workplace.”

Some participants have experienced movement in their position within LTC, including shifts from or to supervisory/managerial roles. This shift has affected these staff member’s experience with the team dynamic. One previous RN explained how this transition affected her, stating:

> …as a nurse I was more their, I don't want to say superior, but I felt separated…they were still my team, right? And I knew to treat them well, but I felt kind of like it was me doing my job alone. And then they were together doing their job. So I still felt part of the team, but it was different.

Experience of team dynamics varied by staff member. Where some felt their teams were positive, others felt their sense of team was minimal or problematic. While some efforts have been made to educate staff on how to improve team dynamics within the workplace, work is still needed. Team dynamics are not stable, but rather are subject to change.

Teamwork.

Related to team dynamics, teams are expected to work together as a system to complete their duties. Teamwork includes supporting staff intra and interdepartmentally. There are also some teams that exist in more independent roles, affecting the experience of teamwork. Teamwork includes the sense of trust coworkers feel for their teams and its reflection on overall team performance.

Staff found the level of support they experienced from within their department was often satisfactory. When in need of assistance, respondents reported feeling able to turn to their coworkers. One Nurse Director said, "...for the most part I do feel like my colleagues support me…Feels pretty positive".

Support extends beyond just within departments. Some staff reflected on the support they give or receive to coworkers in other departments. One allied health professional shared her positive experience with receiving PSW assistance, stating, "a lot of them help me cause sometimes I need someone to push a wheelchair behind me or something and they'll always jump in and help".

Though much of the work in LTC relies on some form of teamwork, a number of participants work in roles that are independent in nature. For some, this separation led to lesser team feelings, but others enjoyed this aspect of their work. One participant shared, "I like that I have a lot of independence and [the] people (staff) are very nice".

Trust was identified as being an important aspect of teamwork. Being able to go about one's tasks without having to micromanage their team left staff free to focus on their own tasks. Confidence in each other's competence was essential for trust.

As a whole, some staff felt that worker performance had improved within the home now that staffing levels have risen. Refer to the introduction of new roles, discussed in the workload section, for more details. With adequate staffing levels, staff found the quality of their work was positively impacted.

Participants mostly had a positive perspective on their experience of teamwork. Support was felt within and between departments. Teams were found to be positive, even for those in independent roles. These experiences of teamwork rely on continued positive trends of support, trust, and quality of work.

Communication.

A cornerstone to positive teamwork is having strong communication. Staff within LTC need to be communicating constantly. Communication, may it be written or verbal, occurs within and between departments, and across shift times. There are some struggles that staff experience with communication, as well as some improvements. The safety of communication was also considered.

LTC is a multidisciplinary work environment. Staff from different roles come together to provide care to residents. As such, staff find that communication between departments is often needed to maintain up-to-date knowledge on the going ons. One allied health profession said:

> I interact with nursing a lot because I have to make sure that…if somebody had a fall or something, I have to make sure, are they OK? Can I still walk them? Like I have to ask the registered staff, stuff like that. PSWs, I'll ask how was so and so today?

A common method of communication noted by participants was written communication. There are various ways to utilize written communication within the home to provide updates to staff on resident's health, changes to care needs, and outstanding tasks. There is a 24-hour report utilized within the home, which was commonly mentioned as the first thing many staff review

upon arriving for their shift. However, written communication has its limitations if not all staff are reviewing these notes, or if updates are not captured. One PSW reflected on these challenges:

> Lots of people don't read the communication book…it's a guessing game. When you get on the floor, it's like, OK, well, they didn't tell me that, you know, Molly had a temp…You know what I mean? It's not written down unless it's in the report, like the RPN's and stuff like that.

Shift changes between staff represents one of the major moments of passing off information required within the LTC home. Staff communicate using some medium (e.g., verbal, written, etc.) to the next shift before they leave for the day. Numerous participants noted this process as an integral part of starting and ending their shift.

Failure to communicate clearly with staff, whether it being inter or intradepartmentally can have effects on staff. Some staff noted their difficulties when communication is poor. One RN shared:

> We used to have monthly team meetings or biweekly team meetings where we [would] sit and discuss… [we would] meet every morning for half an hour and discuss everything in the building [so] everybody is on the same page. Now we have three times more staff in the management than the building. It's falling apart.

Verbal communication is another common form of knowledge transfer within the home. Some staff noted preferring to speak verbally with other staff, including during shift pass off, in order to get their update. This preference included a mix of sentiments, such as finding less gets missed, whereas others simply enjoy the old-school method. One PSW said, “I come in early. I always come in. I always like a verbal [update]. That's just old school me...I like to know from the staff before they leave, whether they're charging or not, what actually happened”.

Staff had mixed experiences with whether safe lines of communication existed within their department and/or within the home more generally. Some found they had no problem turning to management if support was needed. Others felt very differently, with one dietary staff

member finding there to be pushback from communication challenges. She stated, “it seems if you're quiet, complacent, and you have nothing to say, you're golden. But if you do express yourself then you're [labelled] a troublemaker”.

Participants recognized the importance of strong communication for maintaining a well organized work environment. In some cases, communication flow was felt to be well utilized; whether it be through written or verbal communication. Other staff shared experiences of difficulties of information being lost in the cracks, or feeling unsafe in communicating openly.

Valued

With the interdisciplinary nature of LTC, staff work in a variety of roles contributing to the smooth running of the home. Despite everyone’s work contributing to this goal, not all staff are valued to the same extent. Some participants expressed feeling undervalued in their role. Other staff found management and residents have expressed verbally or through their actions their appreciation of the staff.

Every staff member within LTC plays a role in the greater picture of the running of the organization. Unfortunately, some staff feel underappreciated within their role. This may include a general sense of negativity. One PSW shared her experience of this negativity, saying, “there's not a lot of, ‘Wow, you did a great job.’ But they will always point out what you did wrong, like the next shift or the next staff member or management or whatever”.

On the other hand, some staff feel that they are being valued, specifically by management. Some of this experience was tied to the funding being allocated to certain departments. One housekeeper was happy with this change, sharing, “[it] feels good to come into work, feels good to get all the new equipment and just it just feels like they care about you, you know, and they're investing in trying to make our jobs better”.

Residents also play a role in staff appreciation. Some staff shared that they felt valued by the residents. Participants emphasized the importance of residents, with some believing this to be the most important place to be valued.

Staff have mixed experiences with their sense of being valued. Sentiments varied within and across departments, and in terms of the source of the expression of value.

Staff Appreciation Events

One way that staff may be shown that they are valued, especially by management, is through staff appreciation events. In recent years, the study site has begun offering appreciation events for their staff. Some staff love these events, finding they improve morale and team building. Others are less interested or have difficulties with the limited accessibility of the events.

The introduction of new staff appreciation events within the home was positively received by many participants. They shared that they enjoyed seeing these events begin and have seen a general positive uptake in sentiment and attendance.

Staff appreciation events were noted by some to be tied to improved sense of morale and team building. Some found that these events offered an external opportunity for staff to bond with coworkers and management, learning who they are outside of their work role. One in-house doctor reflected, “...they've tried to increase team morale and so they've reintroduced Christmas parties and team functions and festivals and so all of those kinds of things that are better for building up your team”.

Not all staff were interested in these events. Some expressed a general lack of interest, whereas others felt that work-life and personal life should be kept separate.

There was also a note by some participants that staff events are not always accessible to afternoon and evening staff. Many events, such as the annual Christmas party, are held in the evening. This means that staff working that day are unable to attend the event. Some departments noted their problem-solving of this challenge by offering department-specific events that they coordinate together.

Staff appreciation events are one way for management to show they appreciate each other and their staff. While some appreciate the gesture, others are more comfortable maintaining work-life balance. Though many feel positively towards these events, they are not yet being offered in an inclusive way to be available to all staff.

Communication and collaboration plays a significant role in the work-life of LTC staff. Though there are positive experiences of team dynamic, teamwork, communication, value and appreciation, there are also areas for improvement. Many staff find they support one another and value their teams, but the need for continued improvements is emphasized.

Relationship with Residents and Families

Residents, and by extension their families, are a significant element of LTC work. Though not all staff work directly with residents, the majority share their workspace with the living space of the residents. This reality results in the development of relationships for many staff, residents, and families, while also affecting staff's work experience.

Staff Can Become like the Resident's Family.

Many LTC staff interact with residents on a daily basis. Whether they be providing direct care to the resident, or working within their shared space, interactions are an inevitable part of many staff's work-life. Many staff appreciate and enjoy these relationships as they prioritize and

care deeply for the residents. Many staff understand they play pivotal roles in the lives of residents. These relationships are also two way streets for staff and residents.

The nature of working with or around residents in LTC is a selling feature for many staff. Participants shared how they valued these interactions with residents. Some staff who have transitioned into roles that are less directly related to resident care have noted how they miss this aspect of their job. One PSW shared, " I like best the interaction with the residents. I do feel that I make a difference there for them".

Despite busy workloads, many staff express a desire to prioritize the resident's needs. Many staff recognize the role they play in resident's lives, and wish to focus on providing residents with some socialization. One allied health profession said, "I don't mind the documentation. I just would rather spend time with the residents".

The socialization of residents hits hard for a number of staff. Not all residents have frequent visitors, making staff a main point of socialization for them. Many participants expressed sympathizing with the residents, wishing to reduce their loneliness. One RN shared:

> That's why I love residents…This is why sometimes it hurts me more. The staff has a lot of time on their hands and there are people, they're so desperate for a little touch. Little hug, little talk, little massage on their hand, right? But the phone, the phone are taking all the time.

Staff's pivotal role in resident's lives does not go unnoticed by the staff. Participants note how residents come to rely on particular staff, which may contribute to a sense of benign valued or appreciated. One nursing staff said:

> It's good having the same residents and they know you and they kind of get to depend on you too. Like when you're off on vacation or like, Oh my God, thank God you're back. Like when you were gone, this and that. And they have a list of things that they want you to do. And it's a good feeling that they know they can depend on you, right?

Relationships are often meant to be two-way streets. Some staff found that they not only provide for the resident's, but the residents also affect the staff's lives. One RN shared this experience, saying:

> I started looking at life [from a] different perspective. This palliative, this long term care changed my life big time. The way I went through my divorce, the lot of ups and downs, they went so smoothly just because they prepared me. My resident prepared me…It's like life. You don't know [the] next minute.

Staff and residents often develop relationships with one another. They come to care for and rely on one physically, mentally, and emotionally.

Family Interactions.

Along with residents is the experience of interacting with the resident's family members. Family interactions can be positive or negative in nature. Sometimes these interactions add to workload, or interrupt workflow, which then must be juggled by the staff member.

Similar to resident interactions, many family-based interactions can be positive for staff. These interactions could include just a nice conversation or a show of support. One allied health professional said:

> For the most part, it's positive feedback…We do interact a lot with families…we're like kind of the front line, PSW's and rec staff. They're all like we're always on the floor. So they get to know us and you know, very, very supportive.

On the other hand, other staff note they have experienced some difficulties with families. One RPN expressed the reasoning she has had to deal with difficult families, sharing:

> I mean, obviously you're not going to please everybody because some people… [are] very self-centered, selfish. They want their family members. I don't care about anybody else, but they want this for my whoever, which I understand to the point that you're being selfish, not considering other people.

Family interactions can also be an interruption to workflow for some staff. Some staff find this to be a part of the job, whereas others struggle when they are completing sensitive tasks and are interrupted. One RPN shared:

> Sometimes you'll have like families that'll have a minor question. You'll be in the middle of your medpas. So can you go check when mom's last bowel movement was, which, you stop what you're doing to go check. It puts you behind and just things like that. A lot of interruptions.

While staff and family interactions can be a positive experience, there are also some instances of challenges. Interruptions to workflow constitutes one concern by staff experiencing these encounters.

LTC as a Home Versus an Institution.

Recognizing the dynamic of staff being a sort of family to residents, LTC is also considered by many to be more of a home than an institution. Though many practices and procedures reflect a more institutional setting, many staff note a preference towards changes that would make LTC feel more like a home environment. Two contributing thoughts were covered, with staff expressing the need to improve diversity accommodations within the home, and the need to improve resident pairings.

The case study site has seen an increase in diversity within the home. As a result, staff note the need to improve accommodations, such as improving menu options. One PSW said:

> There is lots of diversity…But then you've got your I don't eat pork…I don't eat chicken, I don't eat any bird…So there's a lot of that for sure. Like there has to be diversity here, whether they accommodate it or not on a daily basis, it's not.

Residents within the home are also split between private and single rooms. Residents who share a room are not currently paired using any sort of criteria. Some staff find this to be a missed opportunity to connect residents with similar temperaments and/or interests. One PSWs perspective is:

> …people that come in, they're going, ‘oh, [Joe is] going to move into room 521, right? And he's a male and he likes this and this…And he's not paired up with the same like because they're either they're on another floor or whatever. And I know it's hard for them to get together and engage, but they need that…I wish management or the people that come in here go, hey, let's ask the staff what they think that this guy…would fit it?...I mean there is, there's a couple on five that…their roommates are nightmares.

LTC is a resident’s home. Participants feel that there needs to be more done to improve resident’s comfort into a space that can feel like home for them.

Changing LTC Resident Demographics.

As resident diversity is changing, so are other variables of their demographics. LTC is often associated with being a home for the aged population. Some staff note a trend towards younger residents being admitted within the home. This trend is worrying to some staff.

Some staff worry that LTC was not designed to care for the increasingly complex needs being introduced into the home.

Staff also note some fears with residents being admitted with needs that extend beyond the capabilities of LTC. One PSW expressed her fear of caring for disgruntled, younger, and physically stronger residents, sharing, “and no is a word. I find no is a word. Like if they don't want their bathroom, you go [to the] bathroom then you go try. Like I'm not getting beaten up for that”.

Staff play an intimate role in the lives of residents and resident’s families. These relationships can be positive, but they also have their challenges. The residents of LTC are changing, and adjustments to improve accommodations are also needed. Some of these changes are welcomed, but some staff have concerns for the capacity of the current structure of LTC to handle other changing variables such as resident’s age and condition.

Staffing Mental Health and Work-Life Satisfaction

A key concern for staff well-being within the workplace was related to their experience of mental health and work-life balance. Staff mental health was impacted by their ability to cope with death and dying within the home, which was also affected by their access to mental health services. Work-life satisfaction was affected by their level of position satisfaction, work-life balance, and experiences of negativity within the workplace. Staff mental health and work-life satisfaction contribute greatly to overall work experiences.

Staff Mental Health

Staff mental health was explored in terms of staff's ability to cope with resident's deaths. There was also the consideration of whether staff had access to mental health services to support them in their experiences.

Coping with Resident Deaths.

Coping with death and dying within the workplace includes staff sentiments of being able to handle death, feeling comfortable with the experience, and being able to lean on coworkers or external support when needed. A number of staff found that they have a positive ability to cope with death and dying within the workplace. Some of this was tied to the process of becoming accustomed to loss as part of the job. One PSW shared:

> When the time comes that…they're end of life care…I'm OK with the whole process that they are going to pass because I've kind of been through the journey with them and I always try to give the best care possible right to the very end.

Staff also found comfort in turning to their coworkers during times of loss. Being able to reminisce with one another, sharing their common experiences, was found to be therapeutic for some staff.

On the other hand, some staff found that they struggle to deal with death and dying. These experiences include having negative coping strategies and the tendency to feel emotionally detached.

There are staff who deal with death within the home who expressed having negative coping strategies to process these losses. These staff either express having a hard time to deal with death, or find they have to separate themselves from the emotions. Some staff find that they have learned to become desensitized to the process as a way of being able to get through the day. Depending on one's position, this coping mechanism may be considered more or less healthy. One housekeeper shared:

> How do you answer this without sounding, I hate to use the word desensitized, but you do. I think it's a coping mechanism…Maybe that's a better way to put it. I think we just develop coping mechanisms to not feel.

Access to Mental Health Supports.

Recognizing the difficult nature of loss, especially continuous loss, which is experienced within LTC homes, the topic of access to mental health services was essential to explore. Staff had mixed experiences on this topic area; some were unsure of services offered by the home or feelings of needing more, whereas others felt they had access to support both internally and externally.

A few staff expressed being unsure whether the home offered any sort of mental health support. Based on conversations with other staff, these supports do exist. As such, the experiences of staff unaware of these services express a lack of clear communication of available support. Other staff that were aware of the mental health services provided by the home felt that there was room for improvements. The common sentiment amongst this group of respondents was that there needs to be more support offered.

On the other hand, there were staff who felt that the mental health support services being provided within the home were improving. One RN shared her perspective on these changes, saying:

> I would say up until about two years ago there was no support for that kind of situation, but I think that as an organization, they've learned from that. We've even brought in counselors after a specific resident had passed away in kind of a more tragic way and we had drop in sessions for staff to come in if they felt like they needed someone to talk to…So I feel like we're in a different position now than we were before.

Some participants shared that they access external mental health support services. Some of these services are covered through benefits and an existing employee assistance program (EAP).

Though the experience of death and dying is common within the LTC sector, staff share different experiences with this reality. Some find death to be a part of the life cycle, being able to positively cope with these losses. Others find death to be hard to cope with, no matter how long they have worked in the sector. Either way, these experiences highlight the need for adequate mental health support services.

Work-Life Satisfaction

Work-life satisfaction includes consideration of level of position satisfaction, work-life balance, experience of challenges such as negativity within the workplace, and an exploration into the driving force behind staff movement between LTC roles.

Position Satisfaction.

A number of participants expressed benign satisfaction in their positions. This includes being content with the work itself, the role flexibility, and the environment.

Satisfaction with work was one aspect of position satisfaction. Staff reflected on being content with the work they do and the contribution their work makes. One RN said, “I do find it

is rewarding to be able to make change and for staff to be positive about things and then also [for] the residents to be satisfied with the care that they're getting".

Some staff felt that their roles included a level of flexibility that was appreciated. Role flexibility includes factors such as location and hours. An RPN shared the reason for her retention in her role, saying:

> I mean, truthfully, it's probably…one of the main reasons I stayed there all those years, simply because of family life, especially when the children were young. And I was also blessed whereby my days off were always two in a row.

A positive environment was found to also be important for positive satisfaction with one's position. A positive environment includes friendly coworker dynamics. One support worker shared, "I've made friends, people are friendly and co-workers are great. So it's a positive environment for me".

Some staff express feeling merely content towards their role until retirement. They do not express feeling particularly fulfilled by the role, but that they are content to stay for the remainder of their working life. One nursing staff member said:

> I think I'm done because I'm home now. When I was young, I was thinking of…moving to nursing while working here. But then I said I'm old. I'm going to retire soon…I'll just wait for my retirement.

Work-Life Balance.

Having a balance between work and personal life was experienced very differently between participants. Some found they had good work-life balance, some felt they had poor work-life balance, and the others found themselves in a middle stage.

Staff who find that they have difficulties with their work-life balance includes bringing work home, physically or emotionally. One RN in a supervisory role explained:

> Yeah, it's very hard in my current role to kind of disconnect from work when you're in a more supervisory role. Um, it just feels like I'm never off unless - like my phone's always

> by me. We do the on-call piece as well, so it is hard to sometimes feel like I'm off the clock.

Good work-life balance was seen most often with staff who set clear, strict boundaries between their personal and professional life. Some staff noted the need to work at the ability to create and maintain these boundaries. One medical professional shared her experience creating work-life balance:

> Yeah, it truly - my work-life balance has changed because I have forcefully created that change over the last three years…so if you had talked to me three years ago, my work-life balance was pretty terrible. But now I actually create time in my schedule so that I can do that work.

The variability of LTC work came to light once more when some staff shared the feeling that their work-life balance was mixed. At times, they felt it could be very good. Other times, they find the work to be quite overwhelming.

Experience Working in Different LTC Positions.

A number of participants shared having experience working across various roles within the LTC sector. Staff changes roles for many reasons, including changing interests and a desire for change. Staff who shifted roles, but remained within the same home location, expressed facing various adjustments as they settled into their new roles.

LTC work can be quite repetitive in nature. Some staff found this to be tedious at times, feeling the need to change their position in order to improve work-life satisfaction. One housekeeper shared:

> So I look to switch because for however many years…I worked…housekeeping…and I've always enjoyed what I did. The residents, staff, but I was finding it was starting to become a little bit every day. And I felt like this time in my life, I thought I needed a change.

Transitioning into a new role has an adjustment period. Staff need to learn the ropes, and reconcile differences in seniority or level of management. One PSW that worked previous in a more supervisory role explained:

> It was interesting because they had to kind of get me to relax a bit a lot because I was still focused on having to make sure everything was done and there they were like, no, we will, we'll get, we'll make sure that they're taken care of, but just relax and it it took some time some time for me to just decompress and just do my job, right? Just go and do my job.

Position Dissatisfaction.

Not all staff were found to be satisfied in their position. Some shared the challenges they juggled, such as changing workplace dynamics affect satisfaction and the worker's desire to leave their role. Some of those who were found to be unhappy in their role also mentioned a desire to potentially leave their position. Turnover was spoken about in relation to the role and the sector itself.

A feeling of discontentment was expressed by some participants. Some have felt dissatisfied for quite some time, whereas others have recently felt the change as dynamics with their role have changed. For example, changing schedules and coworkers. One RN shared:

> You know, and compared to my previous nursing years to now or I will say even in the last four or five years, I don't feel satisfied when I leave work. I don't have that job satisfaction that I haven't done what I wanted to do.

Workplace Negativity.

Contributing to a sense of dissatisfaction is the experience of negativity within the workplace. Negativity affects staff morale and sets unreasonable expectations. Some of these experiences are interesting as being a reflection of the sector itself going downhill. Negativity within the workplace, such as only acknowledging what is missed in a shift, leads to a negative

impact on staff morale. This experience can be tied to a sense of a lack of support from coworkers.

Some staff have unreasonable expectations for what can be done in a shift. This unreasonable expectation weighs on staff who feel as though they can never do enough. An RPN shares how these unrealistic expectations weighs on her, saying:

> There's one or two who just have…it's an expectation that we're gonna do everything for them, which again, it's a support role. It's not for me to walk in and do absolutely everything extra that you need to do.

Several of the interviewees have been in the LTC sector for many years. As such, they were able to reflect on how LTC has changed over the years. Some of these changes have missed the mark on improving the quality of the sector for workers and residents alike. One dietary staff said:

> I started when I was 16 and I worked at the first nursing home for 16 years…long term care has really gone downhill. I know they're trying to make improvements. Well, the government's trying to make so-called improvements. Do I think that's happened? No.

Staff well-being and satisfaction is a vital consideration for the quality of work-life for Ontario's LTC staff. Considering the mental health of staff, especially in relation to their experience with death and dying, and work-life satisfaction, show a range of experiences. Some staff report positive experiences with their well-being and satisfaction, whereas others have more challenges. These differences in experiences are essential for understanding what is and is not currently working for LTC staff.

Lingering Implications of COVID-19 on LTC

As was explored in different ways throughout the findings, LTC has changed over the years. In some ways there have been improvements, but there have also been emerging challenges. One such cause of emerging challenges was the COVID-19 pandemic. Existing

issues were exacerbated, new challenges emerged, and lasting effects are currently being seen. Considering these elements provides insight into the staff experience in LTC in recent years.The COVID-19 analysis has been broken up into 3 temporal periods. The first being pre-COVID.

Pre-COVID-19

Though not discussed in depth, a few staff members reflected on the state of LTC prior to the pandemic. This included differences in isolation policies, staff training, and workload.

LTC Work Environment Prior to COVID-19.

Before the COVID-19 pandemic, staff found that isolation policies did not exist to the same extent or intensity. This shift created an adjustment period for staff. One PSW shared:

> It's funny because before COVID, this kind of thing just never really happened. You know, for the most part, we didn't have people being isolated every couple weeks, you know, because they had a sniffle or, you know, they had a loose BM [bowel movement].

The level of training provided in some roles was also found to be less standard. For example, housekeepers found that their training on how to clean was much more subjective than it was during and after COVID. There were less specifics on the details of how they should be cleaning. This potentially affected the quality and consistency of work being produced.

Despite the uptick in workload during COVID, staff emphasized that LTC was still extremely busy prior to the pandemic. There was much to be done and challenges such as staffing shortages being experienced. One PSW said:

> It was crazy. It was busy…it was insanely busy…you got your next shift that you didn't get this done, this done, this done. I didn't get done because I was busy. I'm only one person. You know, that bed didn't get stripped or whatever. It didn't happen.

These reflections, however short, paint the picture of LTC having challenges long before the pandemic was introduced to the equation.

During COVID-19

Next, and most discussed, was the period of COVID-19. Reflections included staffing levels, workload, infection, prevention & control (IPAC), family interactions, mental & emotional toll, and media/public perceptions.

COVID-19 Staffing Levels.

During the pandemic, staffing turnover was very high, leading to staff having to work short staffed more often. This experience contributed to stress as well as team building. High turnover was caused by a number of factors. Staff were getting sick, some staff quit due to fears of getting/spreading the disease, and some staff were unable to work if they refused the vaccine. One medical professional shared:

> I think the thing that always struck me during COVID was we just, we lost so many personnel, like we lost so many of our colleagues. For lots of reasons. Some didn't want to get vaccines, some did not. Some just did not want to take the risk of getting sick. Many retired early so that we were always short staffed. It always seemed like we were short staffed.

Due to high turnover and factors such as illness, the LTC home was often short staffed. This majorly affected staff in their ability to get their jobs done. One RN said:

> The staff was, I will say, 25% of the staff ratio from the one we have now. So these days we get a four, four floor person, like a nine PSW staff on each floor. At that time we have two to three for each floor.

Despite the hardships caused by COVID, working through such a difficult time gave some staff a new respect for their coworkers and all that they do. This includes a new respect for coworkers in other departments as well. One RPN reflected on this respect, saying:

> And you know, and then I have to give my hat off to her because she would do the same thing. She would go to her side and then she would go run and help the other PSW on her side, right?...getting newer respect for each other too. After going through that…[we] learned how to lean on each other and support each other.

COVID-19 IPAC.

As a result of the pandemic, IPAC changed within LTC, such as the introduction of a new dedicated IPAC personnel role. Not all of these changes occurred with ease, creating challenges for staff. LTC was being closely observed by the Ministry of LTC, adding pressure to the homes. The sudden onset of the pandemic resulted in PPE shortages that staff had to manage.

During COVID, LTC was under additional observation by the Ministry and the world. One housekeeper shared how this shift was somewhat overwhelming, saying:

> Oh my gosh, it was like, you know, everything was us. Everything fell on like everything. Our department was under a microscope for public health for the Ministry of Long Term Care and for, you know, our own management team and um, it was a lot, yeah, for sure.

PPE shortages were faced in healthcare settings across the board. Staff felt that this impacted their level of safety within the home, risking picking up the disease due to inadequate protection. One RPN said:

> And the PPE, sometimes there were short PPE. [I] remember having a mask, one mask per shift, having to put it in a brown paper bag when you wanted to break and then putting the same mask on. And it wasn't anything. It wasn't just here, it was everywhere. It was doing that because there was such a shortage of supplies, you know?

Along with these changes, the site location got dedicated IPAC personnel. Staff who reflected on this new role felt they did a good job considering the weight of their task. This helped somewhat in the sense of safety within the workplace knowing there was someone dedicated to ensuring staff and resident safety during the pandemic.

COVID-19 Workload.

Low staff levels and new IPAC contributed to the staff's experience of an increased workload during the pandemic. Staff were left to make due, having their job description changed, grappling with limited time, adjusting to the new IPAC measures, and managing the physical toll of the workload.

Acknowledging the challenges all departments faced with their workloads, staff reported assisting other departments when possible. There was a lot of teamwork to try to get the job done as best they could during the difficult times. Positions were changed to help fill in gaps wherever possible. One management and administration staff member said:

> …there were many times housekeepers would come up, they'd help feed, they'd help do whatever they could. It was like all hands on deck. Anybody that could would come up and help with whatever they could. So that was great.

Many staff found they were grappling with little to no time to get everything they had to do in a shift. Personal one-on-one time with residents was made to be almost impossible, which some staff found to be particularly difficult seeing as residents were more isolated than ever. New IPAC protocols added to workload as PPE needed to be put on and removed very frequently. This added to the amount of time it took staff to move between residents, slowing down their progress. The increased workload and IPAC had a physical toll on staff. One housekeeper shared "because [of] the extra amount of cleaning that we had to do. Just like, messed my hands up".

COVID-19 Family Interactions.

During COVID, family members expressed gratitude for staff and all they do. This was seen through their actions, such as buying snacks for staff and putting on displays outside of the home. One office worker shared:

> Yes, the best day of COVID. Several family members [were] outside and they had a sign that said they were saying thank you. They're always sending food and donuts and treats and like you got flowers. Like there's a lot of graciousness for everything we're doing in here. So yeah, I, as much as it was like a very awful day, one day, there were a lot of really thoughtful things that came out.

COVID-19 Mental & Emotional Toll.

The pandemic had a strong impact on the mental and emotional well-being of staff members. Staff struggled to see residents be separated from their loved ones. The toll of being scared about the pandemic, facing low morale, and handling burnout was also discussed. Staff also had to deal with frustration caused by COVID deniers.

Staff care very deeply for the well-being of the residents. During COVID, residents were unable to have much, if any, family or friends visit them. This created an exacerbated sense of isolation for the residents. Due to the staff workload increasing, they too had limited time to spend with residents personally. This became a difficult dynamic for many staff to manage.

There was also a lot of fear during that time. Staff were afraid to go to work, pick up the illness, and spread it to their families. On the other hand, they were also worried about bringing the illness into the home. There were a lot of unknowns during this time exacerbating the sense of fear benign felt.

COVID resulted in low morale for staff as they struggled to get through the day. Watching staff turnover continued to rise, workload appearing to be never ending, and facing the fears that they did, staff morale plummeted.

Some staff who had caregiver responsibilities outside of LTC expressed feeling additional burnout during this time. Staff were being overworked in both their personal and professional lives.

Then, staff had to deal with COVID deniers who negated the experiences of staff and their struggles. One PSW shared:

> I know that we lost three people on our unit, 5 SW as a result of COVID when I had people out in the community telling me that it was all a hoax and we were injecting them in their flu shots with something so the government didn't have to pay their pension and it was so tiring to to to be in this and having people like that, you know, when it's just so that was hard because it was such a worldwide thing and and people weren't believing in

> it. And I thought, you know what? Three of my people have died as a result of this. It's real.

COVID-19 Public Perceptions.

Related to the COVID deniers is the overall discussion of the media and public perception of LTC homes during the pandemic. Much of the media blamed LTC for the spread of the illness, leading to a sense of distrust towards the sector. Some stories painted LTC workers as heroes one day and then they reverted back to zeros the next. Some staff expressed the need for more positive media coverage to recover from the harm done.

Staff reflected on seeing how LTC and LTC workers were blamed for the spread of COVID within the media. One RN commented on the growing distrust of the sector, saying, “the media really put some bright lights on long-term care…some positive, some negative. But I think it has influenced residents and families' ability to trust what's going on in long-term care”.

Staff reflected on the experience of being called heroes one day in the media and being reduced to nothing the next once the COVID craze passed for most people. Some found it difficult to transition from finally being recognized in their role, which had largely been invisible prior to COVID, to them becoming invisible once again.

Due to the negativity of the media coverage during COVID, some feel that more positive media needs to be prioritized to recover the image of LTC. These lasting sentiments impact the credibility of the sector and the perceived quality of the work being done.

Post-COVID-19

The state of the LTC sector continues to change. There are continued impacts from the COVID-19 pandemic, some of which are positive and others are more challenging. Post-COVID

considerations included staffing levels, IPAC, reporting requirements, team dynamic, communication, and the mental/emotional toll faced by staff.

Post-COVID-19 Staffing Levels.

After COVID, staffing levels began to improve again, which impacts other areas of work-life such as workload and teamwork. One in-house doctor reflected on these changes, saying:

> I see them trying to have consistent hiring and keeping people on…I think just trying to encourage loyalty to stay by giving people the respect that they have in their positions. So yeah, that's what I've seen happen.

Post-COVID-19 IPAC.

As a result of COVID, a number of new IPAC measures were implemented. Once the COVID outbreak concluded, many of these measures remained in practice. Stuff reported mixed feelings regarding these continued measures and improvements in knowledge.

Many staff noted continued isolation policies and the use of masks within the home. There were mixed sentiments on these practices. Some staff found them to be a manageable addition to their day. Other staff disagreed with these measures, finding them to be unnecessary or adds to their workload. One participant reflected, “it's challenging because I think that staff don't always agree with keeping them isolated, especially after the lessons that we've learned in long-term care”.

Some staff have found the continuing IPAC measures have been poorly communicated, especially as some have not been consistently maintained. This creates confusion on how to implement the new rules, when they are changing without appropriate clarity being shared.

The experience of the pandemic was found to have helped improve knowledge and training for some staff, such as housekeepers who now have more uniform training on how to

clean. These staff reported feeling more confident in their ability to deal with a similar situation should it arise.

Post-COVID-19 Reporting Requirements.

During COVID and onwards, the Ministry has increased the reporting requirements for staff, adding to their workload. One RPN shared the effect of the increased charting, stating:

> …from when I first started in nursing to now, the amount of charting we used to do was basically zero to nil compared to now you have to basically chart on absolutely everything. And that's fine, but it's just time away from residents one-on-one, which overall is sad.

Post-COVID-19 Team Dynamic.

The team dynamic following COVID-19 also appeared to improve for some staff. Some felt they had more respect for each other and strengthened their resilience. One in-house doctor said, “it's a very positive outcome…because I think to some degree it's actually built our team even stronger”.

Post-COVID-19 Communication.

Along with a stronger team dynamic, some staff felt that communication had also improved. Staff noted that the home has improved their electronic communication, allowing for improved ease of access to information. One RN said, “there was definitely more focus on things like emailing and it did force the organization to kind of adopt electronic communication rather than just written notes and things of that nature”.

Post-COVID-19 Mental & Emotional Toll.

Acknowledging all the changes that happened during COVID, and after, many staff reported facing a mental and emotional toll that continues to this day. This includes having lasting memories of COVID and working through a mental recovery from the event.

COVID led to many lasting memories for staff that they are still working through processing. The pandemic was a very difficult time for many staff in their personal and professional lives. This event had an impact on mental and emotional well-being. One PSW shared:

> I don't think [I] have really processed the effects of the pandemic and it kind of puts, it's like, oh, not again. And people almost get scared like that we're going to have to completely shut down the unit. And yeah, it's almost, I don't want to say it's like PTSD, but in some ways it's – people don't want to go back there, so they get a little bit anxious about it and also I've seen staff that.

The COVID-19 pandemic was a significant event that affected the work-life of LTC staff. Some of their experiences (positive and negative) existed prior to the pandemic, whereas others have emerged as a direct result. As such, these findings show the lasting impacts of the pandemic on the staffing, workload, team dynamic, and individual mental/emotional states of staff.

Discussion

The key question that framed this research on exploring the quality of work-life satisfaction of a range of Ontario's LTC staff has been answered in part through the data collected. Using Karasek's model as my framework I was able to address how different LTC workers experience quality of work-life in a post-COVID context, including the impact of changing workloads and work demands. Karasek's model was especially helpful in considering the importance of job demand and control on work-life. Where his model was lacking was looking beyond the individual experiences of workload, such as in the analysis of relationships, collaboration, and the gendered dimensions affecting work-life. My findings reflect a broader range of worker roles than is typically present within the literature, while also pushing the boundaries of Karasek's model to further our understanding of the various dimensions impacting work-life experiences for LTC staff.

Summary of Key Findings: Compare & Contrast with the Literature Review

1) Staffing and Workload

Staffing is a cornerstone consideration in quality of work-life. When staffing was found to be low, both within the literature and my study, there was also a noted impact on workload, teamwork and collaboration, and morale (Banerjee et al, 2015; Braedley et al., 2018; Daly, T., & Szebehely, 2012). My findings show that if staff are felt to be trained poorly, or lack capability, the impacts are felt across the home, by the staff and residents, affecting both quality of work and quality of care.

The literature also spoke to the imbalance between what needs to get done and the amount of time that a staff member has to do the tasks (Banerjee et al, 2015; Daly, T., &

Szebehely, 2012). My findings supported these assertions, especially in the realm of heavy workloads taking away from staff-resident interactions. Participants emphasized the importance of spending quality time with residents and how this was not always possible, especially in cases where workload is increasing (e.g., reporting requirements). Using Karasek's model, we can see how the heavy workload (high strain) and low job control (unable to spend quality time with residents) is producing a high strain work environment for staff. These findings in the data support what was anticipated to be found, given Karasek's model.

Workload challenges were felt across all types of LTC roles included within the study, indicating a high level of demand. There was found to be a general opinion towards workload being unmanageable as a whole, but some promising practices were noted. For instance, the addition of new roles to help fill care gaps, and provide more support to staff, was noted as a positive trend towards improved workloads. On the other hand, some staff noted that heavy workloads result in a harder impact on the body. The physical impact of LTC work needs to be considered when looking at workforce retention, as this consideration.

One important consideration to the physical impact of LTC work is the experience of abuse. The literature shows that LTC staff deal with a number of difficult working considerations, including sexism and racism (Braedley et al., 2018; Laxer, 2013). In addition to these difficulties, my participants shared their challenges with being expected to deal with abuse from residents and families. Whether it be verbal or physical, there is a certain degree of abuse that the staff feel that they are expected to manage before the situation is addressed by the higher ups. These situations not only may cause an impact on mental well-being but staff also report injuries that they sustain in their role. These situations reflect additional stressors to the role that LTC staff are forced to juggle.

LTC work is separated into a number of distinct, and some less distinct roles. As Bosch & Mansell noted, the construct of worker roles being highly divided lends itself to issues of role clarity (Bosch & Mansell, 2015). Drawing on Karasek's model, role clarity poses issues for job demand. If workers have unclear boundaries to their role, they may find themselves taking on more than their role outlines, increasing strain. Additionally, if staff lack control in their role, they may be unable to carve out clearer boundaries to their role, resulting in the issue persisting. My findings showed a challenge faced by staff who lacked role clarity in their position. This was especially prevalent for staff who had entered a new position, as well as for those in newly created roles which have not been fleshed out yet. As was expected from the Karasek model, those in new roles with unclear boundaries were in a struggle to gain control in shaping clarity. Though a challenge, some staff anticipated positive adoptions of role boundaries once the transition period had more time to settle. An additional struggle was noted by participants, which was the experience of being responsible for duties beyond their typical scope. For example, evening shift RNs are responsible for every concern and problem that occurs throughout the night. They are the first line of contact until staff who only work days and/or weekdays return. These experiences result in increased workload and strain for staff juggling both their core role and additional duties they must pick up.

2) Gender, Relationship, Communication, and Collaboration

Moving beyond what Karasek's model explicitly covers are some of the more contextual and team-based dimensions of the care work being provided by LTC workers. This consideration extends into the relationships between staff and residents, as well as between coworkers. Gender may then be centred as a core feature affecting the dynamic of these relationships. These elements play a significant role in the work-life experience of LTC staff.

Care workers are often expected to work at a maximum capacity, creating high stress work conditions (Estabrooks, 2021). Collaboration may ease some of the workload tension, but difficulties surrounding role clarity may create an additional barrier (Bosch & Mansell, 2015). Collaboration within highly diverse teams requires an additional element of negotiation. Due to situations of unclear role boundaries, staff are required to communicate and negotiate amongst themselves. Time is required to work through these negotiations, adding to staff's workload. Despite these hurdles, time spent on clear communication can have positive effects on overall collaboration output. Studies have shown that when collaboration is being positively utilized, staff perceive to have lower job demand and higher control (Väisänen et al., 2024; Zou et al., 2024). By working together, staff may better share the burden of the workload, lessening its impact on any one individual. These findings are consistent with what we might see within Karasek's model.

The gendered nature of care work in LTC is inherent in staff hierarchical relationships on work-life experiences. In my study, one RPN spoke about how meaningful it was to have her voice and opinions be heard and valued by the in-house doctor and Registered Nurse Practitioner — both of whom are women. Through sharing this experience, there were underlying implications of previous encounters with doctors that were less positive, perhaps due to an undervaluing of certain voices within the LTC home. These findings combat the hierarchical nature of work discussed by Syed et al., where some voices are valued over others (Syed et al., 2015). Instead, these findings show that respectful relationships between staff may foster better lines of communication.

Tied to the nature of LTC work being divided between so many roles and staff, teamwork and communication are core features of the work-life experience. Banerjee et al. note the

importance of communicating for the smooth flow of resident care (Banerjee et al., 2015). Interruptions to communication may negatively impact staff's ability to provide care, which was emphasized both in the literature and within my findings (Banerjee et al., 2015). Participants shared the various forms of communication used, such as written and verbal forms, but noted their to be strengths and weaknesses to both. For instance, some staff may be more or less thorough in their written updates, impacting the quality of information being communicated to the following shifts. Quality of communication flow is vital for quality of care being provided to residents. Staff must work as a team to ensure that quality care is being provided to residents, which relies on clear communication within and between shifts.

In addition to staff relationships with each other, we may also consider the gendered impact of staff relationships with residents. In Grönlund's work, they note that women often face greater amounts of conflict between their work and private life (Grönlund, 2007). The reality of this assertion was seen in the way participants spoke frequently about the impact of their work on their family. A number of participants spoke about their reasoning for staying in their role due to the benefits for their family (e.g., time, benefits, etc.). These decisions reflect on the individual's prioritization of family when making career choices. Additionally, during discussions of COVID-19, staff frequently noted the fears they held toward possibly bringing the disease home (González-Spinoglio et al., 2024; Hung et al., 2022; Nizzer et al., 2023). In some cases, staff noted their decision to distance themselves from their family during this time to avoid any unnecessary spread.

Emotional Labour and Care Work

Building from both the quantitative and qualitative dimensions of LTC work, we may now explore the impact of emotional labour on worker experience and well-being. These considerations are vital for a holistic understanding of worker satisfaction.

For many LTC staff, residents are central to the job. They not only are the main client receiving the service that LTC homes provide, but they are also the people that many of these staff spend every shift with. Over time, staff often report developing relationships with residents, especially for those they note holding a soft spot. The literature spoke mainly to the impact of staff relationships with residents in times of loss (Braedley et al., 2018; Harrad & Sulla, 2018; Marcella & Kelley, 2015), but my findings noted the impact of residents in all aspects of the work experience. Staff who had moved positions in particular noted feeling a loss at no longer interacting with the same residents, or in some cases, residents at all. These reflections highlight the importance of staff-resident relationships for many LTC workers.

Death and dying is a common experience within the LTC sector. LTC homes are often the last place many residents call home before they pass on. As such, LTC staff are expected to constantly manage their feelings related to loss (Harrad & Sulla, 2018). As was discussed in the literature, and in my own findings, many LTC staff form special relationships with the residents they care for (Harrad & Sulla, 2018; Marcella & Kelley, 2015). In cases of particularly close relationships, some participants shared feeling an additional impact of grief. Turning to informal avenues of support, such as coworkers, was reported to be a helpful tool for staff to cope. This process included informing coworkers of resident's deaths on their day off if there were close relationships noted. These findings somewhat differ from Marcella and Kelley's work, which suggested that informal avenues of information may leave staff feeling unsupported (Marcella &

Kelley, 2015). My findings suggest a potential strength of relationship between coworkers when offering emotional support.

When additional support was noted as being desired, a number of participants felt that support either did not exist or they were unaware if any did. These sentiments reflected the literature findings of official pathways to support worker's mental health being minimal (Harrad & Sulla, 2018; Marcella & Kelley, 2015). These supported findings of staff struggling with loss within the home, while lacking support, is an essential piece of understanding of factors contributing to burnout and turnover. From these combined findings, the continued need to push for improvements in the available resources, such as training and professional help, are vital for health care workers' quality of life and work (Sciotto et al., 2025).

Somewhat different from the literature findings, many of my participants discussed the emotional disconnect they feel in regards to death and dying. The literature covered in depth the emotional impacts of dealing with death and dying on staff. In my study, many staff discussed not being as impacted by the experience due to a variety of reasons. Whether it be due to faith, being used to the experience, or respecting death as part of the life cycle, a number of staff felt that the impact of the death of residents was minimal. An important note that some staff felt they disconnected or disassociated with their emotions relating to death, which though a potential coping strategy, is not necessarily a healthy way to deal with emotions tied to loss.

Part of this emotional disconnect may also be linked to caregiver burnout. LTC is an environment with high mortality, which results in the work being tied closely to emotional labour (Puyat et al., 2019). Working with death and dying is a gendered matter, as women disproportionately work in caregiver roles that attend to individuals during this stage in their life. Due to the invisibility of work being gendered, the work load this invisible work encapsulates is

also invisible within LTC homes. For example, one participant spoke about using butterscotch pudding as a way to get her resident the medication that she needed. In this act, though simple on the outside, there is a level of mental and emotional labour that takes place to devise these strategies. Caregiver burnout is a feature often associated with the experience of the invisible labour women are expected to do. In the literature, González-Spinoglio et al. spoke about the difficulties LTC workers faced during COVID-19 as they struggled with loss in both their personal and professional lives (González-Spinoglio et al., 2024). This experience was shared by a participant, who noted the burnout she felt when juggling her responsibilities as an RN and as a caregiver in her family during the pandemic. An already high strain situation was exacerbated by the additional duties and pressures placed during the pandemic. We may also consider the emotional labour tied with coworkers providing support to one another over the deaths of residents. These acts are forms of additional labour that are not formally acknowledged. Traditional lenses on workload do not acknowledge these forms of labour. For instance, emotional labour is a part of workload, and it fits as part of Karasek's model even though he did not identify it within his work. Feminist literature helps make visible these additional forms of labour that have previously gone unnoticed. As such, by combining a feminist lens with Karasek, we can expand the reach of understanding gathered from his model.

In the literature, Sciotto et al. speak to the impact of the meaning associated with one's work as being a strategy to mitigate emotional burden (Sciotto et al., 2025). A similar notion was expressed by my participants, who spoke about the value they associated with their role to care for an individual at the end of their life. Several participants felt honoured to be a part of the resident's life journey, recognizing death as a natural part of the life cycle. Though not explored in more depth, these sentiments suggest that the value these workers place on their role in the

care journey acts as a strategy to come to peace with the emotional burden of the loss they experience when the resident passes away. Using a Karasek lens, we might consider how this perspective from participants takes control over the experience of loss and utilizes it as a way to mitigate the negative impact of the emotional demand being faced.

Work-life satisfaction is another important finding closely related to turnover. In Harrad & Sulla's work, they found that staff with higher levels of stress in their work are more likely to leave their job (Harrad & Sulla, 2018). These findings closely align with Karasek's model, and the experience of job strain staff may experience. Though my findings did show some staff experienced positive work-life balance and satisfaction, a number of others faced difficulties in these areas. An interesting finding on burnout and turnover from my findings was the tendency for staff to move between roles. A number of participants in my study have worked in one or more areas of LTC. Reasons for this movement were tied to needing a change for well-being reasons, previous roles being too hard on one's body, and wanting to pursue different interests. These findings were interesting as they showed staff not leaving the sector, but rather searching for a new home within the realm of LTC.

3) The Lingering Implications of COVID-19: Then and Now

The findings of this study took place in a post-COVID-19 context, with some reflections on the experience of the pandemic and its potential lasting impacts. The following include a few highlights of the staff's reflection on this time period and how the shadow of COVID continues to affect the work-lifes of LTC staff.

Supporting previous research, my study found that COVID-19 had a massive impact on the work and personal lives of LTC staff. Many of the issues expressed in the literature, and by my participants, highlighted pre-existing issues that were then exacerbated by the pandemic. As

was expressed across a number of studies, COVID created a very unique environment in which work demands increased drastically (Hardy et al., 2023; Leo et al., 2025; Nizzer et al., 2023). Burnout was running a rampage amongst health care workers alike (Aloisio et al., 2021; Schulze et al.). The mental and emotional well-being of staff across sectors was negatively impacted, affecting work-life satisfaction. (Iyamu et al., 2023; Leo et al., 2025). Similarly, my findings showed that LTC staff were juggling high staffing turnover, increased work, and a general sense of a lack of time.

The impact of COVID-19 on staffing was particularly emphasized by participants. In the literature, poor staff was shown to impact quality of care being provided to residents, as well as increasing worker stress (Estabrooks et al., 2020; Kirkham et al., 2022). Within my data, I saw many of these same themes emerged. Participants spoke about working with barebone crew, many of whom stepped up to stay later and assist other departments when possible (e.g., housekeeping helped with food delivery and feeding). COVID-19 clearly added additional job strain as described in the Karasek model.

An unexpected positive finding from the low staffing situation was the way it encouraged respect to blossom between workers. Being constantly exposed to the hard work and dedication of one's coworkers, at a level not previously seen, allowed for some participants to find that their relationship with one another improved. They developed greater respect for one another and found they were able to find flow to their work. These findings show the resiliency of LTC workers, even during the darkest of times. This is something for which the Karasek model is less able to account for.

An additional unexpected positive finding from the impact of COVID-19 was the way the relationship between staff and family changed. The pandemic created an especially difficult time

for everyone, which potentially led to greater understanding of one another. In cases where families called the LTC home in anger, some participants reflected on their understanding of the family member's frustration. They knew that the anger came from a place of fear. As such, some found that they were better able to relate to family members who were unable to see their loved ones. There were also stories of support, where participants spoke of families delivering to the staff sweet treats to say thank you for all their hard work. There were times that families would stand outside with signs and leave displays in the front yard to express their gratitude. These findings highlight the resiliency of LTC staff and families during some of the hardest of times. These expressions of gratitude also highlight an important context in which they exist — LTC workers are undervalued. LTC staff have had to do a lot of work to be resilient long before COVID due to the continued undervaluing that they face, especially as much of their labour is invisible (e.g., emotional labour). The COVID context potentially made some of the hardships that LTC staff navigate more visible to the external eye, yet as was expressed by the "hero to zero" reflections, the public quickly forgot about LTC staff once again when the pandemic concluded.

Karasek's model was especially impactful when we consider the impact of COVID-19 on the work-life of LTC workers. The pandemic created a unique period of particularly high demand and low control for all LTC staff. The impacts of this situation were found to be largely negative by most staff, resulting in lower work-life satisfaction. Though some small positives were acknowledged, such as the support by residents' families and improved appreciation of coworkers, the pandemic was a very difficult time for staff.

When looking at Karasek's model, we can see that the original model is limited by looking at only a single moment in time, rather than considering the context leading up to the

current reality. Seeing as my project spans across time periods of COVID (i.e., pre, during, and post), my project is working to make visible the additional emotional labour that creates the context for the post-COVID worker reality. So, we can see that Karasek's model is still relevant for discussing the level of strain being felt by LTC workers, but we need to also consider the context of COVID leading the LTC work environment to this point. For instance, my findings showed that in some ways, the impact of the pandemic was reported to continue to be felt. Some staff continue to work through the mental and emotional trauma caused by the pandemic, whereas others note the lingering changes to workload that affect staff's work-life (e.g., continued IPAC measures). Looking across time periods, we can develop a greater depth of understanding on the phenomena taking place than would be possible when considering only a snapshot in time with Karasek's model. Not all lasting impacts were negative either. On the positive end of lasting impacts, staff noted improvements in staffing levels, team dynamics, and the adoption of electronic communication. Many of these changes were noted as creating a positive impact on staff's sense of work-life satisfaction.

In sum, my contribution to the literature is that, using Karasek's model, we can see that job demand and control are core variables impacting the work-life experience of LTC workers. Staff in LTC homes, across many roles, are experiencing high demand with their workload. Moving beyond Karasek, my findings also speak to the impact of relationships, collaboration, and gender on staff work-life experience and satisfaction. From my analysis, we can see that there are positive and negative aspects to LTC work, showing there is good to be found while also highlighting the continued need for change to create a better environment for LTC staff alike.

Policy and Practice Implications

LTC homes are run by a diverse network of workers that includes a plethora of roles. The diverse network that exists within LTC homes requires sufficient communication and coordination for the smooth flow of work. Part of this process includes having an adequate understanding of these different roles, which requires revealing the workload that is too often left invisible. Adequate understanding of the quality of work-life for the entire LTC team is essential for providing insight into worker satisfaction and staff retention. These findings highlight the depth of the knowledge and experiences felt by a greater range of LTC staff than is typically visible within the literature. Key actors relevant to improving the quality of work-life for LTC staff include leaders within LTC homes (e.g., management) and policy-makers such as the Ontario Ministry of Long-Term Care. Through broader understanding of the existing roles, and the extent of their tasks, these key figures may better address the needs of all LTC staff.

The findings highlight the integral role that LTC teams play in the lives of residents. Residents were a core feature of many of the participant's reflections, emphasizing the care and importance of their relationships. From this, we can see how the quality of work-life is vital for the quality of care being provided to residents. Numerous staff reflected on how their ability to spend quality time with residents is negatively impacted when staffing levels are too low or workload is too high. Considerations towards staff retention are essential for ensuring a balance between staff duties. The Ontario Ministry of Long-Term Care should place an emphasis shaping policies and funding to support staffing levels within LTC homes. Staffing needs should be considered both quantitatively (i.e., assistance with daily living tasks such as dressing and bathing) and qualitatively (e.g., providing residents with social interactions). By making visible all aspects of care work, realistic parameters to staff workload can be calculated in order to meet

all aspects of a resident's care needs. By aligning institutional expectations with professional core values, such as prioritizing staff-resident social interactions, staff work-life satisfaction may be positively impacted.

Another practice implication that emerged from the study includes the stressors staff may experience throughout their work-life and personal life. The experience of death and dying is commonplace within LTC homes, and yet, many staff still find they struggle to cope with loss — especially loss on a larger scale. World events such as a global pandemic created new, intense challenges for health care workers. The findings on mental health and well-being of staff suggest the need for greater availability and advertising of support services for staff. Even in cases where mental health support exists, the lack of knowledge of these services creates a barrier for staff to access necessary support. LTC facility leaders need to create a more expansive plan for ensuring mental health is adequately provided, while also ensuring staff have access to the information regarding these services.

Limitations

This study had inherent limitations due to the methodological approach I chose to conduct my project. One limitation is that I conducted my study with LTC workers from only one LTC home. The chosen site exists within a particular context, as is described in the methods section. This context affects the transferability of findings to other homes across Ontario, which may be bigger or exist within the for-profit funding model.

Another limitation I faced was the number of staff within each role that I was able to interview. I had originally planned to interview people in roles such as the social workers, the contract employees (e.g., physiotherapists), and maintenance workers. Due to my limited number of interviews and ability to reach these audiences, I was not able to interview for every role I had

originally hoped. Additionally, the data I was able to collect on roles I did reach were limited. For example, interviewing only one or two people in particular roles makes it difficult to deduce findings of similarities or differences between roles. Rather, my findings were limited to more generalized sentiments from staff more broadly; to which the definition of staff was more inclusive than some pre-existing studies. So, though my original intent was to break down worker experiences by role, due to concerns of confidentiality (with so few participants who could be identifiable) and a lack of saturation across interprofessional roles, I was unable to reflect these intentions within my findings. Rather, I was mindful to provide a voice to workers previously unheard when developing my methodology, to work towards achieving the maximum level of variation across roles represented within my findings. As such, my findings do reflect a greater amount of diversity in role representation than is typically found within the academic literature.

Another struggle I faced was in terms of the range of participant's gender. Though I worked to include male staff voices within my study, I was unable to successfully recruit any male voices. Even if I had been able to include one or two male participants, findings would have been difficult to conclude on similarities or differences in navigating LTC work, as the sample size would have been so limited. Though men were not included in the study, a gender analysis was still possible because gender is about more than simply comparing similarities and differences between men and women. My focus in the gender analysis focused more on the gendered nature of work and roles that women have both personally and professionally.

An additional potential limitation is that I have relatives working within the chosen site for data collection. As such, this included additional considerations to minimize the risk of biases being introduced into my data collection. My connections within the chosen site location

provided ease with access to the environment and worker demographic. My positionality also worked as a strength in some aspects of my project, as my lived experience helped guide my project purpose, how I framed and reframed questions, and how I ultimately organized the collected data. On the other hand, my association with an employee in a place of power may have led some participants, or potential participants, to feel a sense of unease. This may have hindered the level of comfort to share openly and honestly that these participants may have felt, even with the reassurance of confidentiality.

These potential risks have been addressed to the best of my ability within my methods section (e.g., inclusion and exclusion and ethical considerations). Nevertheless, the project provides important insight into themes related to quality of work experiences, which may be used later as a basis to another, larger project.

Further Research

The findings from this project adds to the body of knowledge on the reality of the work experience for Ontario LTC teams, highlighting the experiences of LTC staff often missing from academic literature (e.g., dietary, housekeeping & laundry, etc.). Future research could look into increasing the voices being represented in the discussion of work-life satisfaction. More needs to be heard and shared from support and allied health professions to further our understanding of what LTC work looks like for all LTC staff. It is through hearing these voices that we can begin to draft potential changes and improvements to the sector at large.

Additionally, voices of male workers in these roles should also be considered to better understand how they navigate these concerns within a predominately female workplace. Research that includes male care workers' voices may also further our understanding of what care work looks like for men, and how this is potentially shaped by the way in which men are

socialized within our society. This study was limited in the number of voices that were able to be highlighted. Future work to add to this knowledge within the literature. Comparative studies could be conducted to explore similarities and differences between staff's perceptions of work-life satisfaction based on role. Also, a comparative study could include voices from homes across Ontario, perhaps taking into consideration the impact of funding type on the work environment. The data outlined in this paper provides a valuable stepping stone to furthering our understanding of work-life satisfaction staff across all LTC roles; with this understanding, we may work to improve work-life satisfaction, retention and quality of care being provided to residents.

Conclusion

In conclusion, though there are positive aspects and improvements to staff work-life, LTC continues to face a number of challenges affecting work-life satisfaction. Quality and quantity of staffing and workload are essential factors affecting staff's work-life experience. Supporting collaboration and communication is vital as LTC teamwork is a crucial factor for the smooth running of LTC homes. Each of these aspects of LTC work impact staff well-being and quality of work-life balance. Some of the realities of work-life are influenced by lingering effects of the COVID-19 pandemic. Continued work needs to be done to support LTC staff needs in order to not only improve quality of work-life and satisfaction, but also quality of care that can be provided to residents. By taking the time to hear the voices of all LTC staff, we can work towards making visible the workload that has previously gone without adequate acknowledgement and compensation.

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Appendix A

Interview Guide

Background Questions:

1. What is your current occupation?
    1. How long have you worked in your current role?
2. Have you worked in any other positions related to long-term care or quality care?
    1. If yes: How long did you work in those previous roles?

Quality of Work-Life Questions:

That is great, thank you. So, switching gears now, let's talk a bit about your quality of work-life in the present-day…

1. Would you say you are satisfied in your current role?
    1. If yes, what do you like best about your job?
    2. If not, what is making you feel dissatisfied in your current position? Is there something that could change within the home to address this issue?
2. How demanding do you find your role to be?
    1. Do you feel that you are able to separate your work and private life?
3. How much control do you feel you have in your role?
    1. How does this relate to who you work with (collaboration)?
4. Can you describe the emotional work you do in your role?
    1. Do you feel that your mental health is supported in your role?
        1. Is there any additional support that you think would be beneficial for workers to have access to in supporting loss at work?

Worker Role Questions:

Now, we are going to end with a brief discussion about your role as *x*…

1. Based on what we have discussed here today, do you think that your role (e.g., as a nurse, as a housekeeper, etc.) in LTC has had any impact on the experiences you have had?
2. Do you find you have control over your job?
3. Do you feel that your role is valued (e.g., by other staff, by your managers, etc.)?

COVID-19 Questions:

To wrap things up, I'd like for us to look back to COVID-19 and consider what work was like for you during that time…

1. Do you find there to be any lingering effect (e.g., policies, practices, etc.) from COVID that continues to affect your job today?
    1. Is there anything you wish would have continued?

Thank you and closing remarks.

Appendix B

Demographic Survey

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Demographic Questionnaire

Quality of Work Life for Ontario's Long-Term Care Staff: A Post-COVID-19 Analysis

Name:_____

1. What is your gender identity:_____

2. What is your age range?
   - 18-29 years old
   - 30-39 years old
   - 40-49 years old
   - 50-59 years old
   - 59-69 years old
   - 70+

3. What is your ethnic background:_____

4. What country do you hold citizenship:_____

5. What is your current highest degree of education attained?
   - High school
   - College diploma
   - University degree
   - Master's degree
   - PhD
   - Other:_____

6. What is your marital status?
   - Single
   - Common law
   - Married
   - Widow

7. Do you have children living within your household under the age of 18?
   - Yes
   - No

8. Approximately how much do you contribute to the family income?
   - 0% (I do not contribute to the household income)
   - 1–24%
   - 25–49%
   - 50% (I contribute equally with another household member)
   - 51–74%
   - 75–99%
   - 100% (I am the sole provider of the household income)
   - Prefer not to say

Appendix C

Participant Table

		Interview Participants	
		Number (n=20)	Percent
Gender			
	Female	20	100%
Age Range			
	30-39	2	10%
	40-49	3	15%
	50-59	5	25%
	60+	10	50%
Ethnic Background			
	White	15	75%
	East Indian	2	10%
	Hispanic	1	5%
	South East Asian	1	5%
	Bi-Racial	1	5%
Citizenship			
	Canadian	19	95%
	Duel	1	5%
Education Level			
	High School	2	10%
	Collage	14	70%
	University +	4	20%
Marital Status			
	Single	6	30%
	Common Law	3	15%
	Married	10	50%
	Widowed	1	5%
Children in Household			

	Yes	1	5%
	No	19	95%
Household Contributions			
	25% - 49%	3	15%
	50%	9	45%
	51% - 74%	1	5%
	100%	7	35%
Position			
	Administration and Management	3	15%
	Medical and Nursing Staff	10	50%
	Allied Health professional	2	10%
	Support Staff	5	25%